PUBLIC PACKET

OREGON BOARD OF DENTISTRY

BOARD MEETING
AUGUST 21, 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: **August 21, 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/82671832977?pwd=xeZua8WGaEPg2xju4sHoPeors0MRM0.1
Phone # 1-253 205 0468 Meeting ID: 826 7183 2977 Passcode: 157850

Confirm Quorum & Review Agenda

1. Approval of Minutes
   - June 12, 2026 Board Meeting Minutes

NEW BUSINESS

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

3. Committee and Liaison Reports
   - Updated Committee and Liaison Assignments – August 2026

4 Executive Director's Report
   - OBD Budget Report
   - Customer Service Survey
   - Agency Head Financial Transactions FY 2026
   - Board Best Practices Self-Assessment & Score Card
   - Dental Hygiene & Dental Therapy License Renewal
   - Dental Testing & Regulatory Summit – Educators Conference
   - Newsletter
   - Dental Assisting Survey
   - Dental Assistant Registry Draft

5. Unfinished Business and Rules
   - AAO clarification request regarding 818-042-0110 Certification – EFODA
   - Dental Assisting Rules Clarification & Cleanup
   - 818-013-0005 - Participation in Health Professionals' Services Program (HPSP)
   - ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students
   - Minimal Sedation Rules for Review and Discussion
   - Artificial Intelligence (AI) Draft Policy

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.

6. Correspondence
   - Curodont Application by Registered Dental Hygienists
   - Rule Making Proposal for RDH Scope of Practice to Include Noninvasive Remineralization Products
   - Dr. Zaid Badr Request for Licensure Requirements Exception

7. Other
   - OBD 2026-2029 Strategic Plan Final Review and Ratification
   - Strategic Planning Activity with Facilitator Jen Coyne, Co-Founder & CEO - The PEAK Fleet
   - 2025 Oregon Wellness Program Report
   - OBD Affirmative Action Plan 2027-29
   - Annual Performance Progress Report FY 2026

8. Articles & Newsletters (No Action Necessary)
   - 4 Ways Dentists Can Make Dental Assistants Feel Valued - DANB
   - The State of the U.S. Dental Economy – Health Policy Institute
   - State Dental Insurance Reforms Continue Momentum in 2026 Legislative Sessions

EXECUTIVE SESSION **10:30 a.m.**

The Board will meet in Executive Session pursuant to ORS 192.660(2)(f)(L) and 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.

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 Report
14. Licensing and Examination Issues
15. Consult with Counsel

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

OPEN SESSION **12:00 p.m.**
(Zoom option available)
https://us02web.zoom.us/j/82671832977?pwd=xeZua8WGaEPg2xju4sHoPeors0MRM0.1
Phone # 1-253 205 0468 Meeting ID: 826 7183 2977 Passcode: 157850

Enforcement Actions (vote on cases reviewed in Executive Session)
LICENSURE AND EXAMINATION

16. Ratification of Licenses Issued
17. License and Examination Issues
    - Request for Reinstatement of an Expired License – Jasmine Hodgert, R.D.H.
    - Request for Reinstatement of an Expired License – Julie C. McClaire, R.D.H.
    - Request for Reinstatement of a Retired License – Holly K. Beck, R.D.H.
    - Request for Approval of Soft Reline Course – Andrew Martinez, EFDA
    - Request for Approval of Soft Reline Course – Alyssa Kobylinsky, EFDA-RF
    - Request for Approval of a Local Anesthesia Course for Oregon Local Anesthesia Functions Certificate (LAFC) for Dental Assistants – Sam Boehm, R.D.H.

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The next regular Board Meeting is scheduled for October 23, 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.
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APPROVAL OF MINUTES

OREGON BOARD OF DENTISTRY
MINUTES
JUNE 12, 2026

MEMBERS PRESENT:	Sheena Kalia, D.D.S., President Sharity Ludwig, R.D.H., E.P.P., Vice President Reza Sharifi, D.M.D. Terrence Clark, D.M.D. Michelle Aldrich, D.M.D. Olesya Salathe, D.M.D. Kristen Simmons, 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); Amy Coplen, R.D.H., D.T. (ODHA/Pacific University); Mary Harrison, Vice President, Oregon Dental Assistants Association (ODAA); Molly McGrew (ODHA)
VIA ZOOM*:	Amberlena Fairlee, D.M.D., President, Oregon Dental Association (ODA); Lisa Rowley, Advocacy & Membership Director, Oregon Dental Hygienists' Association (ODHA); Catrice Opichka; Richael Cobler; Dan Ta; Alicia Riedman; Michelle Lee; Kelly Jones; Karan Bershaw; Mary Ellen Murphy, Government Relations Associate at DANB; Amanda Cameron; Stephen Prisby; Kari Hiatt;

*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 8:00 a.m. President Kalia 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 Kalia welcomed everyone to the meeting and had the Board Members, Joanna Tucker-Davis, Haley Robinson, and OBD staff introduce themselves. President Kalia announced that the Board had a quorum.

NEW BUSINESS

Approval of April 24, 2026 Minutes

Ms. Simmons moved and Dr. Aldrich seconded that the Board approve the minutes from the April 24, 2026, Board Meeting as presented. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

ASSOCIATION REPORTS

Oregon Dental Association (ODA)

Dr. Amberena Fairlee, President of ODA, congratulated Dr. Aaron Tinkle and Dr. Jared Thompson on being appointed to serve on the Board of Dentistry. Dr. Fairlee said the ODA is excited to have the opportunity to work with them. Dr. Fairlee thanked Dr. Michelle Aldrich and Dr. Terrence Cark again for their four years of service to the Oregon Board of Dentistry.

Dr. Fairlee reported that on the previous weekend she had the privilege of participating in the OHSU School of Dentistry Hooding Ceremony welcoming 70 new dentists to that wonderful profession. Dr. Fairlee said the ODA always appreciates the school allowing ODA to speak at the Hooding Ceremony.

Dr. Fairlee reported that she had the pleasure of giving the ODA's Student Leadership Award to recipient Dr. Aaron Bell-Cares. Dr. Fairlee noted that Dr. Bell-Cares served as the ASDA Student Liaison to the ODA Advocacy team in 2024-26, adding that during that time, Dr. Bell-Cares was a strong advocate for dentistry and oral health at the state and national level and provided invaluable insight to the ODA.

Dr. Fairlee shared that she recently had the pleasure of watching the Portland Fire play the Indiana Fever with Governor Kotek. Dr. Fairlee said the Governor has always been a big supporter of dentistry and oral health. Dr. Fairlee shared that they discussed the current workforce shortages, the growing expense of dental education/student debt, and the weight of operating a practice with increasing costs and stagnant reimbursements.

Dr. Fairlee announced that the date of the 2027 Oregon Dental Conference (ODC) has been changed to April 29-May 1, 2027. Dr. Fairlee explained that the adjustment was made to support the overall success of the meeting, noting that it is important that the ODA not overlap dates with other West Coast conferences so that the best exhibitors and speakers would be available for OCD attendees.

Oregon Dental Hygienists' Association (ODHA)

Amy Coplen, R.D.H., D.T., ODHA member, reported that the first class has completed the new dental hygiene program at **Rogue Community College**. Ms. Coplen stated that

all **20 students** have passed the National Board Dental Hygiene Exam and the Local Anesthesia Clinical Board Exam. Ms. Coplen said they will receive their associate degrees on June 13, 2026, at Rogue's Commencement Ceremony.

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

Oregon Dental Assistants Association (ODAA)

Mary Harrison, Vice President of ODAA, thanked the Board for the opportunity to share a report of some of ODAA's activities.

Ms. Harrison stated that ODAA representative, Linda Kihs, has represented ODAA for many years in meetings with Radiation Protection Services of the Public Health Division of the Oregon Health Authority. Ms. Harrison reported that during a meeting that week they discussed budget/funding, training, and product updates among other topics. Ms. Harrison clarified that no dental issues were discussed at the meeting. Ms. Harrison added that, in the past, Ms. Kihs was instrumental in the discussion and review of the thyroid collar for minors, and that the ODAA appreciates her input regarding dental safety.

Ms. Harrison said the ODAA looked forward to the graduating classes of dental assistants from the CODA programs and other dental assistant schools throughout Oregon, adding that these assistants will help with what seems to be a shortage in Oregon. Ms. Harrison stated that ODAA continues to work with many others on that issue.

Ms. Harrison shared some of ODAA's ideas for addressing the workforce shortage, including working with PCC and possible collaboration with a panel consisting of dental practices that utilize Restorative and Local Anesthesia assistants. Ms. Harrison explained that the panel would include dentists, assistants, front office, and hygienists and would explore how they work together in scheduling and the benefits for patients and for the offices that utilize this concept to show positive results for all involved. Ms. Harrison shared her hope that this activity might be part of the 2027 ODC as an example of possible improved access to care, better production, and less stress in the office.

Ms. Harrison stated that ODAA continues to support and appreciate the DAWSAC committee and supports the registration of dental assistants and the survey the Board would be working on during the meeting.

Ms. Harrison reported that the ODAA website is frequently updated with the latest

continuing education courses available, not only ODAA courses but also those of PCC and any other related dental assistant courses. Ms. Harrison reiterated that ODAA is very proud of its website and wants to share all the many links and helpful information it contains. Ms. Harrison invited everyone to take a look at the ODAA website.

Ms. Harrison reminded everyone that the 4th of July is coming up next, saying, "Be careful. I say have a fifth on the fourth."

ADEX

Stephen Prisby, Regulatory and Educational Affairs Director at ADEX, provided a report and updates to the Board.

COMMITTEE AND LIAISON REPORTS

Licensing, Standards & Competency Committee

Dr. Kalia presented items for Board discussion from the April 7, 2026, Licensing, Standards & Competency Committee meeting.

OAR 818-042-0117 - Phlebotomy

The Board reviewed prepared materials about current Board approved phlebotomy courses and discussed minimal requirements for such courses. The Board also discussed whether basic chairside dental assistants should be allowed to receive training and perform phlebotomy on patients or if the dental assistant must meet minimum certification requirements before phlebotomy training.

Dr. Kalia moved and Dr. Clark seconded that the Board refer Proposed Amendment to OAR 818-042-0117 as presented to the Rules Oversight Committee and establish parameters for phlebotomy training to include a minimum of four hours of didactic training and at least 20 direct supervised live phlebotomy starts during the education course. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, 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.

OAR 818-026-0055 – DA Administration of Nitrous Oxide
The Board discussed the issue of allowing dental assistants to assist in the administration of nitrous oxide under direct supervision. No Board action was taken.

OAR 818-035-0072 and OAR 818-042-0095 – ADEX Merger
Dr. Kalia moved and Ms. Ludwig seconded that the Board refer Proposed Amendments to OAR 818-035-0072 and OAR 818-042-0095 to require successful passage of a Dental Hygiene Restorative Examination approved by the Board as presented to the Rules Oversight Committee. The motion passed with SK, SL, RS, TC, MA, KS, GJ, and KL 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.

OAR 818-001-0087 – Predetermination on Licensure

Ms. Ludwig moved and Dr. Kalia seconded that the Board refer Proposed Amendments to Draft OAR and OAR 818-001-0087 regarding Predetermination on Licensure as presented to the Rules Oversight Committee. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL 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.

AI Guidelines

The Board discussed drafting a proposed statement on the use of AI. The Board decided to postpone that discussion until after the new Board members have been installed.

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.

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.

Dental Assistant Workforce Shortage Advisory Committee (DAWSAC)

Ms. Jorgensen announced that Dr. Salathe had joined as co-chair of the committee and provided an overview of the May 26, 2026, DAWSAC meeting.

Ms. Robinson stated she would include the May 13, 2026, article from DANB entitled *4 Ways Dentists Can Make Dental Assistants Feel Valued* in the August Board Book and in the next Newsletter.

Ms. Robinson presented the revised Dental Assistant Survey. The Board suggested changes to the survey and discussed how it would be distributed. The Board decided to email the survey to all licensees and to include an optional survey in licensure renewals.

Dr. Salathe presented data regarding enrollment and graduation rates among dental, dental hygiene, and dental assisting programs. Dr. Salathe requested that information be included in the August Board meeting for further discussion.

Ms. Jorgensen shared that Mary Ellen Murphy, Government Relations Associate at DANB, provided information regarding which states have regulatory/legislative authority over dental assistants and asked Ms. Robinson to include it in the next DAWSAC meeting.

EXECUTIVE DIRECTOR’S REPORT

Board Member and Staff Updates

On behalf of the OBD, Director Robinson thanked Dr. Michelle Aldrich for her 4 years of service on the OBD from 2022 to 2026. Ms. Robinson stated that, as a private practitioner who started as a Registered Dental Hygienist, Dr. Aldrich brought an invaluable viewpoint, passion, and scrutiny to Board actions and proceedings.

On behalf of the OBD, Director Robinson thanked Dr. Terrence Clark for his 4 years of service on the OBD from 2022 to 2026. Ms. Robinson stated that, as a private practitioner and a licensed Oregon dentist for almost 40 years, Dr. Clark brought an important viewpoint, experience, and perspective to Board actions and proceedings.

Ms. Robinson shared that Dr. Aaron Tinkle and Dr. Jared Thompson had been nominated for Senate confirmation on June 15. Ms. Robinson announced that she will be scheduling onboarding and orientation sessions in July, and that she looks forward to officially welcoming them to the Board at their first meeting in August.

Ms. Robinson thanked Sharity Ludwig for her continued service and willingness to serve a second term on the OBD. Ms. Robinson announced that Ms. Ludwig will be reappointed on June 15th.

OBD Budget Status Report
Ms. Robinson presented the attached budget report for the 2025 - 2027 Biennium. Ms. Robinson highlighted that 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
Ms. Robinson presented the attached legislatively mandated survey results from July 1, 2025 through May 31, 2026. Ms. Robinson highlighted that the results of the survey show that the OBD continues to receive positive ratings from the majority of those who submit a survey. **Attachment #2**

Memo - Delegated Duties for Executive Director & Staff
Ms. Robinson reminded everyone that 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. Ms. Robinson explained that every June Board Meeting she submits to the Board for reauthorization the attached memo outlining delegated duties to herself as Executive Director and OBD staff, along with her job description. **Attachment #3 ACTION REQUESTED**

Dr. Clark moved and Dr. Aldrich seconded that the Board reauthorize Delegated Duties of Executive Director and OBD Staff. The motion passed with SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

OBD Bylaws
Ms. Robinson directed the Board's attention to the OBD Bylaws, originally adopted in 2018, which were attached for annual review by the Board. **Attachment #4**

Staff Speaking Engagements
Ms. Robinson reported that Kathleen McNeal, Licensing Manager, gave four License Application presentations to graduating Dental Hygiene Students in April and May:

Tuesday, 3/10/26 Rogue Community College
Wednesday, 4/22/26 Pacific University
Monday, 5/18/26 Lane Community College
Tuesday, 5/19/26 Portland Community College

Ms. Robinson reported that Dr. Bernie Carter gave a presentation titled "Record Keeping, Clinical Judgement and Risk Management" on April 18th to Permanente Dental Group.

Ms. Robinson reported that Dr. Bernie Carter gave a presentation titled "Combat Periodontics" on May 2nd to the International College of Dentists – USA Section.

Dental Testing & Regulatory Summit
Ms. Robinson explained that 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. Ms. Robinson announced that the meetings are scheduled for October 14-18, 2026, in National Harbor, Maryland. Ms. Robinson added that two Board Members are most welcome to attend and can contact her for more details. Ms. Robinson said she would like to attend the summit and asked for the Board's permission to do so. **Attachment #5 ACTION REQUESTED**

Dr. Kalia moved and Ms. Ludwig seconded that the Board approve Director Robinson's Travel and Attendance at October 14-18, 2026, Dental Testing & Regulatory Summit. The motion passed with SK, SL, TC, MA, OS, KS, GJ, and KL voting Aye.

CRDTS Annual Meeting

Ms. Robinson announced that the CRDTS Annual Meeting is scheduled for August 28 – 29, 2026, in Omaha, Nebraska. Ms. Robinson invited any Board Members who are interested in attending to confirm with her so she can assist with logistics and approve travel authorization. Ms. Robinson thanked Ms. Simmons for planning to attend this meeting. **Attachment #6**

UNFINISHED BUSINESS AND RULES

OMPC Pain Module Update

Ms. Robinson provided an update on possible OMPC Pain Module changes due to funding challenges. Ms. Robinson explained that a problem arises if the one-hour pain management course that is mandated by statute is made unavailable. Ms. Robinson added that many of the other healthcare boards would be affected and that she would continue to be in discussion with the directors of those boards. Ms. Robinson expressed hope that funding would be made available for another year and added that she will be monitoring the situation and may have an update in August.

ADA Sedation Guidelines

Dr. Kalia directed the Board's attention to the updated ADA Sedation and Pain Control Guidelines. Dr. Smorra initiated a discussion about Oregon dentists currently being allowed to prescribe a single oral anxiolytic without a permit in contrast to the updated ADA guidelines defining minimal sedation as "previously known as anxiolysis." Dr. Smorra asked the Board if there should be a rule change instructing dentists who prescribe an anxiolytic to be monitoring and discharging such patients under minimal sedation guidelines. The Board asked Dr. Smorra to draft an article about best practices for patients under anxiolysis for Board review and to include the article in the next newsletter.

2026-2029 Strategic Plan

Dr. Kalia introduced the five key points in the Strategic Plan, which were (i) the future of dental regulation; (ii) emerging dental practice challenges; (iii) community & access to care; (iv) workplace environment; and (v) technology & processes. The Board discussed changes to the Strategic Plan.

Ms. Robinson said she would bring suggested edits to the facilitators and will present the final draft at the August Board meeting.

CORRESPONDENCE

- Kimberly Pennington, R.D.H. Letter in Support of a Dental Assistant Registry
- Dr. Smorra and Dr. Salathe Hygiene and Lasers Discussion

The Board discussed issues regarding emerging laser use in dental offices. Dr. Smorra gave an overview of the rules as they are currently written in which lasers are treated like any other tool in that the provider must be trained to competency, working within their scope, and supervised by a dentist. Board members discussed the uses and advantages of lasers, safety concerns, and research on requirements in other states. Dr. Smorra offered to draft a proposed rule change incorporating required training for laser use to be presented at the August board meeting.

- Karla Brumley Request for Acceptance of Out of State Credentials

The Board discussed Ms. Brumley's training and exam results.

Ms. Jorgensen moved and Dr. Kalia seconded that under OAR 818-042-0095 the Board accept the successful completion of the California University of the Pacific Arthur A. Dagoni School of Dentistry Registered Dental Assistant Extended Functions (RDAEF) Program and the RDAEF Exam as an approved course of instruction and examination for the EFDA Restorative Endorsement. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

- AAO Letter regarding 818-042-0110 Certification – EFODA

OTHER

Items were in the Board meeting packet for informational purposes.

- DDH Compact Draft Rules from May 18, 2026, Meeting

Ms. Robinson gave an update on revisions to the Compact rules that removed the requirement for a hands-on portion of accepted clinical examinations.

- Minimum Requirements for Board Approved Courses
- OHA Healthcare-Associated Infections Program Dental Resources

Ms. Robinson clarified that a cost-free Compliance Risk Review is for educational purposes only and that Compliance Consultants do not report infection control issues. Ms. Robinson further clarified that the Consultants are not medical or dental professionals but are infectious disease specialists. Ms. Robinson said she will email information about this to all licensees and will stress the non-reporting nature of this resource.

Dr. Kalia moved and Ms. Jorgensen seconded that the Board approve OBD Updated Guidelines as amended. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

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~~ allow**s** licensed dentists a 30-day payment period for each civil penalty increment of $2,500.00.
>
> **NOTE:** The Board ~~will~~ allow**s** licensed dental therapists a 30-day payment period for each civil penalty increment of $500.00.
>
> **NOTE:** The Board ~~will~~ allow**s** 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~~ allow**s** licensed dentists a 30-day payment period for each

restitution and/or refund increment of $2,500.00.

NOTE: The Board ~~will~~ allow**s** licensed dental therapists a 30-day payment period for each civil penalty increment of $500.00.

NOTE: The Board ~~will~~ allow**s** 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~~ allow**s** licensed dentists a 30-day payment period for each reimbursement increment of $2,500.00.

NOTE: The Board ~~will~~ allow**s** licensed dental therapists a 30-day payment period for each reimbursement increment of $500.00.

NOTE: The Board ~~will~~ allow**s** 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** request**s** a letter of explanation, review extenuating circumstances, and audit**s** 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** means~~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.

ARTICLES AND NEWS

- DANB Spring 2026 State Updates
- California Attorney General Reaches Settlement with Aspen Dental Over Corporate Practice Claims

The Board discussed issues related to corporate dental practices and the Board's limited jurisdiction over them. Ms. Robinson shared that in the past the Board has invited the president or dental director of a corporate dental group to the Board office with DOJ present to clarify the corporate entity's role and the Board's expectations.

- A Cavity Doesn't Always Need a Filling - The New York Times
- Oregon Dental Shortages Leave Gaps in Access to Care

Ms. Ludwig pointed out a statement in the article that Oregon does not have a dental provider shortage but instead has a dental provider distribution problem.

- 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.

Ms. Robinson presented commendations to Dr. Clark and Dr. Aldrich for their four years of service to the Board.

Dan Ta, attorney for the American Association of Orthodontists (AAO), introduced himself during the Open Public Comment Period to discuss the issues regarding EFODA certification. Mr. Ta clarified that the AAO's primary concern is not necessarily the length of the 6-month rule, but that questions remain as to how the credential pathway is intended to operate and whether the Board's interpretation is clearly reflected in the rule text.

Mr. Ta asked for the following clarifications:

- Does the 6-month limitation apply only to the exam pathway?
- May assistants pursuing that certification through the credential pathway perform EFODA duties while accumulating qualifying experience? And, if so, under what conditions?
- If certification by credential is intended to be limited to assistants already certified elsewhere, how should the licensees interpret subsection (b)?

Ms. Robinson responded to Mr. Ta that the Board would review the rules with their Assistant Attorney General and draft a response. Ms. Robinson also offered to schedule a meeting with Mr. Ta to discuss the issues.

EXECUTIVE SESSION: The Board entered into Executive Session pursuant to ORS

192.660(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 12:15 p.m. President Kalia took roll call and confirmed the Board had a quorum.

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

CONSENT AGENDA

2026-0180, 2026-0163, 2026-0177, 2026-0188, 2026-0167, 2026-0187, 2026-0182, 2026-0171, 2026-0169, 2026-0172, 2026-0158, 2026-0185, 2026-0168, 2026-0184, 2026-0141, 2026-0183, 2026-0164, 2026-0181, 2026-0176, 2026-0186, 2026-0170, 2026-0165, 2026-0173

Ms. Ludwig 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 SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

COMPLETED CASES

2026-0072, 2026-0115, 2026-0114, 2026-0064, 2026-0124, 2026-0162, 2026-0106, 2026-0034

Ms. Ludwig 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 SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

2025-0185

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

KARRILYN SUZANNE CLAYPOOL, R.D.H., E.P.D.H.; 2026-0150

Dr. Clark moved and Dr. Aldrich seconded that the Board issue a notice of proposed discipline incorporating a Reprimand, suspension of Licensee's dental hygiene license until she cooperates with the Board by providing all requested documents and until further order of the Board, and Licensee shall pay a $500.00 civil penalty, by a single payment, in the form of a cashier's check, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within 90 days of the effective date of the Order. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

2025-0176

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

2026-0013
Ms. Simmons moved and Ms. Ludwig seconded that the Board close the matter with a Letter of Concern. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

JERRI HOLBROOK, R.D.H., E.P.P.; 2026-0099
Dr. Salathe moved and Dr. Aldrich seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand and a $500.00 civil penalty to be paid within 30 days of the effective date of the order. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

2026-0127
Mr. Lewis moved and Dr. Kalia seconded that the Board close the matter with a Letter of Concern. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

STACEY M. HUTSON, R.D.H.; 2026-0102
Ms. Jorgensen moved and Dr. Sharifi seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand and a $500.00 civil penalty to be paid within 30 days of the effective date of the order. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

2026-0054
Dr. Sharifi moved and Ms. Ludwig seconded that the Board close the matter with a Letter of Concern. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

2026-0024
Dr. Clark moved and Dr. Aldrich seconded that the Board close the matter with a Letter of Concern. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

2026-0063
Dr. Aldrich moved and Ms. Ludwig seconded that the Board close the matter with a Letter of Concern. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

2026-0156
Ms. Simmons moved and Dr. Salathe seconded that the Board close the matter with a Letter of Concern. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

2025-0101
Dr. Salathe moved and Ms. Ludwig seconded that the Board close the matter to both Respondents 1 and 2. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

C. TODD, WILSON, D.D.S.; 2025-0196
Mr. Lewis moved and Dr. Kalia seconded that the Board issue a notice of Proposed discipline including a reprimand and to pay a $2,000.00 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 (**60**) days of the effective date of the Order. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

PREVIOUS CASES REQUIRING BOARD ACTION

2025-0202
Ms. Jorgensen moved and Dr. Aldrich seconded that the Board affirm the Board's previous decision to close the matter with a letter of concern. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

2025-0198 and 2026-0029
Dr. Sharifi moved and Dr. Kalia seconded that the Board combine cases 2025-0198 and 2026-0029 and issue a Final Default Order. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

2026-0195
Dr. Clark moved and Dr. Kalia seconded that the Board approve the reinstatement application by granting a probationary license within the requirement of twice-daily Soberlink testing for 24 months. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

RATIFICATION OF LICENSES

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

LICENSE, PERMIT & CERTIFICATION

Ms. Simmons moved and Ms. Jorgensen seconded that the Board approve the reinstatement of expired license for Michael J. Longlet, D.D.S. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

Dr. Salathe moved and Dr. Kalia seconded that the Board approve the reinstatement of expired license for Ashley Lee, D.D.S. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

Mr. Lewis moved and Ms. Jorgensen seconded that the Board approve Nitrous Oxide Course for McKenzie Dental Practices of Oregon. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

Ms. Jorgensen moved and Dr. Sharifi seconded that the Board approve Local Anesthesia Endorsement Course for DH and DA for McKenzie Dental Practices of Oregon. The motion passed with SK, SL, RS, TC, MA, OS, KS, GJ, and KL voting Aye.

ADJOURNMENT

The next Board Meeting was scheduled for August 21, 2026, at 8:00 a.m.

The meeting was adjourned at 12:29 p.m.

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Sheena Kalia, D.D.S., President

ASSOCIATION REPORTS

Nothing to report under this tab

COMMITTEE REPORTS

Oregon Board of Dentistry Committee and Liaison Assignments
August 2026 - April 2027
STANDING COMMITTEES

Dental Assistant Workforce Shortage Advisory Committee (DAWSAC)
Purpose: To review, discuss and make recommendations to the Board on addressing workforce shortages in accordance with HB 3223 (2023).
Committee:
Olesya Salathe, D.M.D., Co-Chair
Ginny Jorgensen, Co-Chair
Amberena Fairlee, D.M.D., ODA Rep.
Lindsay Tuel, R.D.H., ODHA Rep.
Kari Hiatt, ODAA Rep.
Kimberly Perlot R.D.H., D.T.- DT Rep.
Alyssa Kobylinsky
Lynn Murray
Alexandria Case
Jessica Andrews
Amanda Cameron
Carmen Mons
Cassie Gilbert
Megan Barron

Licensing, Standards and Competency
Purpose: To improve licensing programs and assure competency of licensees and applicants.
Committee:
Sharity Ludwig, R.D.H., Chair
Aaron Tinkle, D.M.D.
Aarati Kalluri, D.D.S.
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.

Rules Oversight
Purpose: To review and refine OBD rules.
Committee:
Sheena Kalia, D.D.S., Chair
Olesya Salathe, D.M.D.
Kristen Simmons, R.D.H.
Ginny Jorgensen
Phillip Marucha, D.M.D., ODA Rep.
Alicia Riedman, R.D.H., ODHA Rep.
Mary Harrison, ODAA Rep.
Raelene Cabrera, R.D.H., D.T., DT Rep

Dental Therapy Rules Oversight
Purpose: To draft, refine and update dental therapy rules.
Committee:
Kristen Simmons, R.D.H. Chair
Jared Thompson, D.M.D.
Ginny Jorgensen
Sarah Kowalski, R.D.H., OHA Rep.
Brandon Schwindt, D.M.D., ODA Rep.

Amy Coplen, R.D.H., D.T., ODHA Rep.
Alexandria Case, ODAA Rep.
Wilbur Ramirez-Rodriguez, R.D.H., D.T., DT Rep.
Raelene Cabrera, D.T., DT Rep.
Miranda Davis, D.D.S., DT Rep.

Communications
Purpose: To enhance communications to all constituencies.
Committee:
Kieshawn Lewis, Chair
Sharity Ludwig, R.D.H.
Aaron Tinkle, D.M.D.
Jared Thomson, D.M.D.
Alayna Schoblaske, D.M.D., ODA Rep.
Alicia Riedman, R.D.H., ODHA Rep.
Christina Becker, ODAA Rep.
Jason Mecum, D.T., DT Rep.

Dental Hygiene
Purpose: To review issues related to Dental Hygiene.
Committee:
Sharity Ludwig, R.D.H, Chair
Kristen Simmons, R.D.H.
Jared Thompson, D.M.D.
David J. Dowsett, D.M.D., ODA Rep.
Daniel Martinenez Tovar, R.D.H., ODHA Rep.
Lynn Murray, ODAA Rep.
Mark Kobylinsky, R.D.H., D.T., DT Rep.

Enforcement and Discipline
Purpose: To improve the discipline process.
Committee:
Olesya Salathe, D.M.D., Chair
Kristen Simmons, R.D.H.
Kieshawn Lewis
Jason Bajuscak, D.M.D., ODA Rep.
Jill Mason R.D.H., ODHA Rep.
Mary Harrison, ODAA Rep.
Yadira Martinez, R.D.H., D.T., DT Rep.

Anesthesia
Purpose: To review and make recommendations on the Board's rules regulating the administration of sedation in dental offices.
Committee:
Reza Sharifi, D.M.D., Chair
Sheena Kalia, D.D.S.
Julie Ann Smith, D.D.S., M.D.

Brandon Schwindt, D.M.D.
Mark Mutschler, D.D.S.
Normund Auzins, D.D.S
Ryan Allred, D.M.D.
Jay Wylam, D.M.D.
Michael Doherty, D.D.S.
Eric Downey, D.D.S
Jeffrey Kobernik, D.M.D.

LIAISONS

Haley Robinson, Executive Director, and current OBD Board Members choose assignments and interest in other entities as they arise.
American Assoc. of Dental Administrators (AADA)
American Assoc. of Dental Boards (AADB)
American Board of Dental Examiners (ADEX) (f/k/a CDCA WREB CITA)
CRDTS-SRTA

EXECUTIVE DIRECTOR'S REPORT

EXECUTIVE DIRECTOR'S REPORT
August 21, 2026

OBD Budget Status Report

Attached is the budget report for the 2025 - 2027 Biennium. This report, which is from July 1, 2025, through June 30, 2026, shows revenue of $2,188,780.24 and expenditures of $1,918,875.62. The final reconciliation and numbers for the 2025 – 2027 Biennium will be available in October. **Attachment #1**

Customer Service Survey – FY 2026

Attached are the legislatively mandated survey results for FY 2026, which is July 1, 2025 – June 30, 2026. The results of the survey show that the OBD received positive ratings from the majority of those that submitted a survey. **Attachment #2**

Agency Head Financial Transactions FY 2026 Report (July 1, 2025 – June 30, 2026)

Board Policy requires that annually the entire Board review agency head financial transactions for the last Fiscal Year and that acceptance of the report be recorded in the minutes. I request that the Board review and if there are no objections, approve this report, which follows the close of the recent fiscal year. I am happy to answer any questions regarding this report.
Attachment #3 ACTION REQUESTED

Board Best Practices Self-Assessment & Score Card

As a part of the legislatively approved Performance Measures, the Board needs to affirm or not, that the Best Practices have been completed for the fiscal year. The Self-Assessment Score Card is utilized to memorialize this, so that it can be included as a part of the FY 2026 annual progress report. I will provide the FY 2026 annual progress report at the October 23, 2026, Board Meeting. **Attachment #4 ACTION REQUESTED**

Dental Hygiene & Dental Therapy License Renewal

The license renewal period started in mid-July and ends on September 30, 2026, and it is progressing well. A heartfelt reminder that audits of Continuing Education are planned to be conducted after the renewal period closes, as it did for the dentists who renewed their licenses earlier in the year. Audits will commence in October on a select number of those that renewed their licenses. The Board has audited licensees for compliance with Continuing Education requirements since 1999.

Dental Testing & Regulatory Summit – Educators Conference

This fall a summit will host the annual meetings of the ADEX, the American Association of Dental Administrators (AADA) and the American Association of Dental Boards (AADB) for a collaborative event at the Gaylord National Resort & Convention Center in National Harbor, Maryland from Oct 14 – 18, 2025. Two Board Members and the Executive Director are attending the event. **Attachment #5**

Newsletter
The OBD Newsletter is now available. **Attachment #6**

Dental Assisting Survey
The dental assisting survey presented at the June 2026 Board meeting was distributed to all licensees via email on June 26, 2026. Licensees were encouraged to share the survey with their dental assistants and invite them to participate. Survey results received to date are attached. **Attachment #7**

Draft Dental Assistant Registry
The OBD's current licensing system provider has developed a dental assistant registry for the Board's review. Examples illustrating the proposed appearance and functionality of the registry are included for review and discussion. **Attachment #8**

Fingerprinting Fee Increase
The Federal Bureau of Investigation (FBI) completed a review of the fees charged for fingerprint-based submissions for regulatory transactions. As a result of the review, the FBI concluded the current FBI fingerprint fee will be increased by $3.00. Non-Volunteer submissions will be processed with the new rate of $15.00. Volunteer submissions based on the requirements issued by the FBI will qualify for the reduced rate of $13.00.

The effective date for the fee change is October 1, 2026.

Oregon Board of Dentistry

Date run: 7/19/2026

For the Month of **JUNE 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	89,815.00	2,042,547.00	4,174,320.00	2,131,773.00
0210	OTHER NONBUSINESS LICENSES AND FEES	1,250.00	12,850.00	14,000.00	1,150.00
0410	CHARGES FOR SERVICES	353.50	14,024.00	146,000.00	131,976.00
0505	FINES AND FORFEITS	(29,500.00)	60,458.23	240,000.00	179,541.77
0605	INTEREST AND INVESTMENTS	5,180.79	58,391.01	60,000.00	1,608.99
0975	OTHER REVENUE	0.00	510.00	9,000.00	8,490.00
Grand Total		**67,099.29**	**2,188,780.24**	**4,643,320.00**	**2,454,539.76**

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	0.00	91,819.00	200,000.00	108,181.00
Grand Total		**0.00**	**91,819.00**	**200,000.00**	**108,181.00**

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	51,248.49	662,055.68	1,560,470.00	898,414.32
3115	BOARD MEMBER STIPENDS	3,916.00	25,988.00	0.00	(25,988.00)
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	1,047.85	20,183.80	43,252.00	23,068.20
3210	ERB ASSESSMENT	15.00	204.00	504.00	300.00
3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	11,679.35	147,979.25	296,742.00	148,762.75
3221	PENSION BOND CONTRIBUTION	2,091.88	28,474.46	55,258.00	26,783.54
3230	SOCIAL SECURITY TAX	4,244.43	53,145.90	113,690.00	60,544.10
3241	PAID FAMILY MEDICAL LEAVE INSURANCE	221.93	2,773.51	5,572.00	2,798.49
3250	WORKERS' COMPENSATION ASSESSMENT	8.35	110.07	294.00	183.93
3260	MASS TRANSIT	313.76	4,093.35	10,321.00	6,227.65
3270	FLEXIBLE BENEFITS	10,945.64	134,154.93	307,874.00	173,719.07
Grand Total		**85,732.68**	**1,079,186.95**	**2,405,704.00**	**1,326,517.05**

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	720.57	6,769.44	57,512.00	50,742.56
4125	OUT-OF-STATE TRAVEL	0.00	0.00	8,564.00	8,564.00
4150	EMPLOYEE TRAINING	470.40	3,482.46	61,404.00	57,921.54
4175	OFFICE EXPENSES	2,178.98	23,163.08	103,313.00	80,149.92
4200	TELECOMM/TECH SVC AND SUPPLIES	591.08	9,850.76	28,227.00	18,376.24
4225	STATE GOVERNMENT SERVICE CHARGES	82.20	134,194.49	266,545.00	132,350.51
4250	DATA PROCESSING	57,297.85	119,327.39	170,267.00	50,939.61
4275	PUBLICITY & PUBLICATIONS	0.00	1,021.54	37,519.00	36,497.46
4300	PROFESSIONAL SERVICES	8,405.50	96,729.85	557,636.00	460,906.15
4315	IT PROFESSIONAL SERVICES	3,792.00	6,756.00	176,116.00	169,360.00

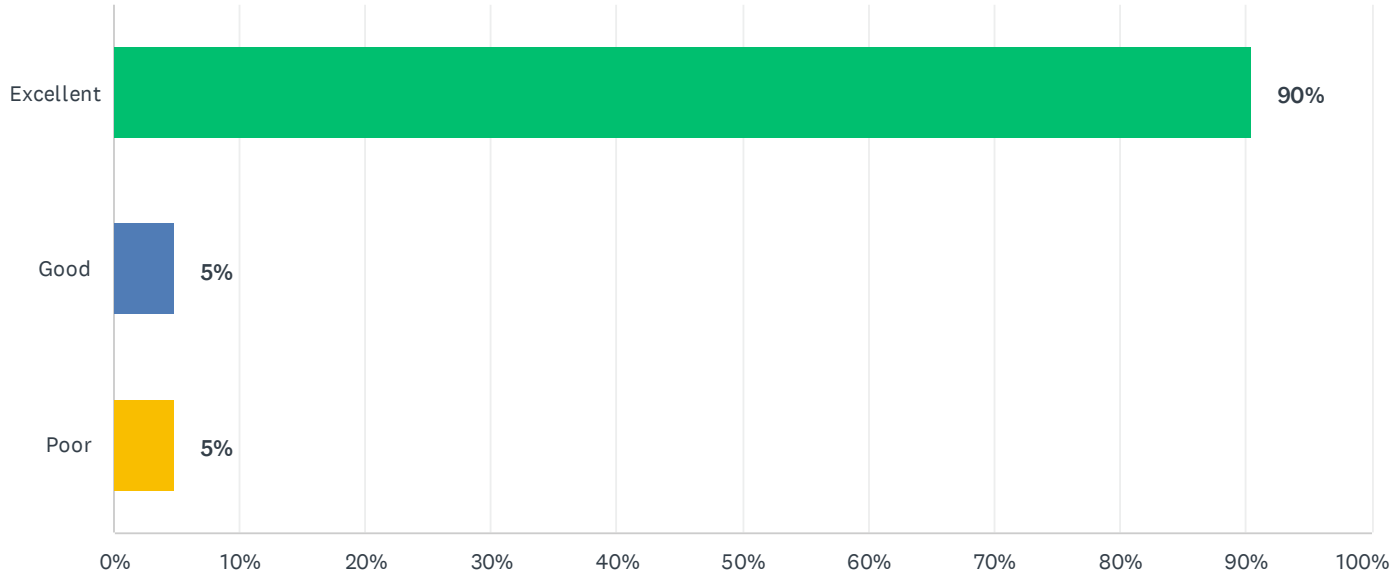
Attachment #1

D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien_To_Date	Financial Plan	Unobligated Balance
4325	ATTORNEY GENERAL LEGAL FEES	1,267.20	92,794.55	459,308.00	366,513.45
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	82,230.00	215,252.00	133,022.00
4475	FACILITIES MAINTENANCE	929.00	10,117.00	661.00	(9,456.00)
4575	AGENCY PROGRAM RELATED SVCS & SUPP	2,655.00	20,209.78	148,652.00	128,442.22
4650	OTHER SERVICES AND SUPPLIES	3,120.83	138,586.09	96,385.00	(42,201.09)
4700	EXPENDABLE PROPERTY $250-$10000	0.00	0.00	6,609.00	6,609.00
4715	IT EXPENDABLE PROPERTY	0.00	2,037.24	26,593.00	24,555.76
Grand Total		**88,428.11**	**747,869.67**	**2,433,168.00**	**1,685,298.33**

				Current Month	Bien_To_Date	Rpt Mm Bal Ytd Avg
3400	**BOARD OF DENTISTRY**	Revenue	***REVENUE***	67,099.29	2,188,780.24	569,341.72
		Revenue Total		**67,099.29**	**2,188,780.24**	**569,341.72**
		Expenditures	***PERSONAL SERVICES***	85,732.68	1,079,186.95	290,407.59
			SERVICES AND SUPPLIES	88,428.11	747,869.67	265,086.51
			TRANSFER OUT	0.00	91,819.00	24,318.25
		Expenditures Total		**174,160.79**	**1,918,875.62**	**579,812.35**

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

Answered: 21 Skipped: 0

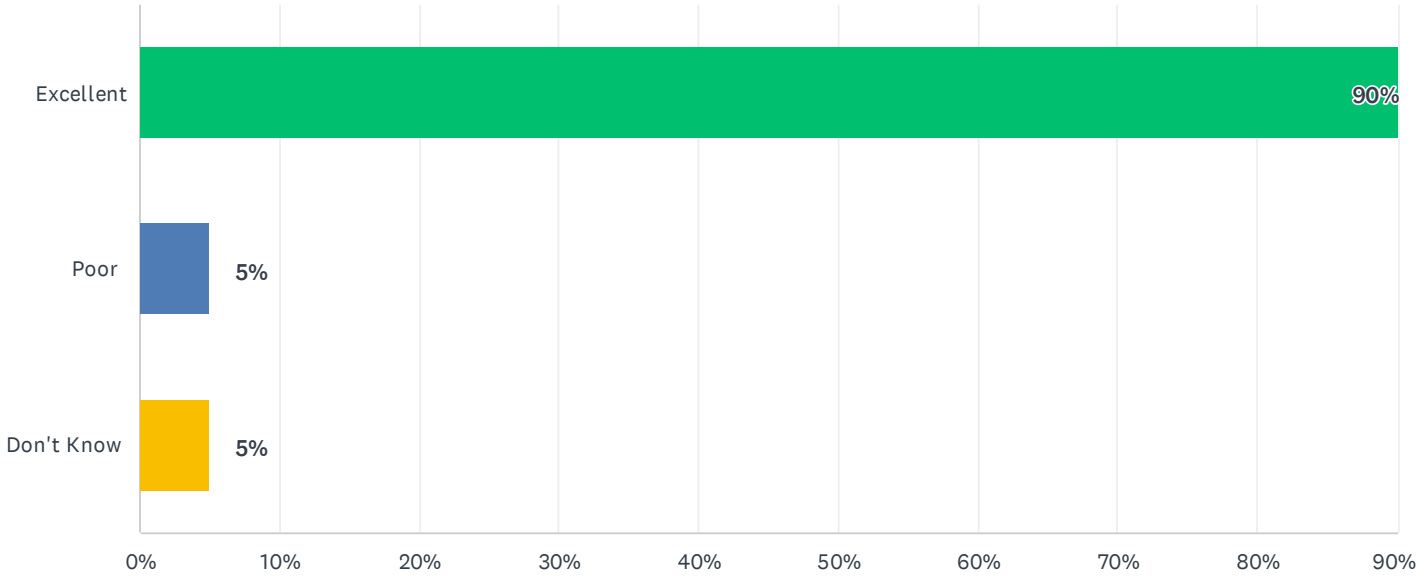


ANSWER CHOICES	RESPONSES	
Excellent	90%	19
Good	5%	1
Poor	5%	1
TOTAL		21

Attachment # 2

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

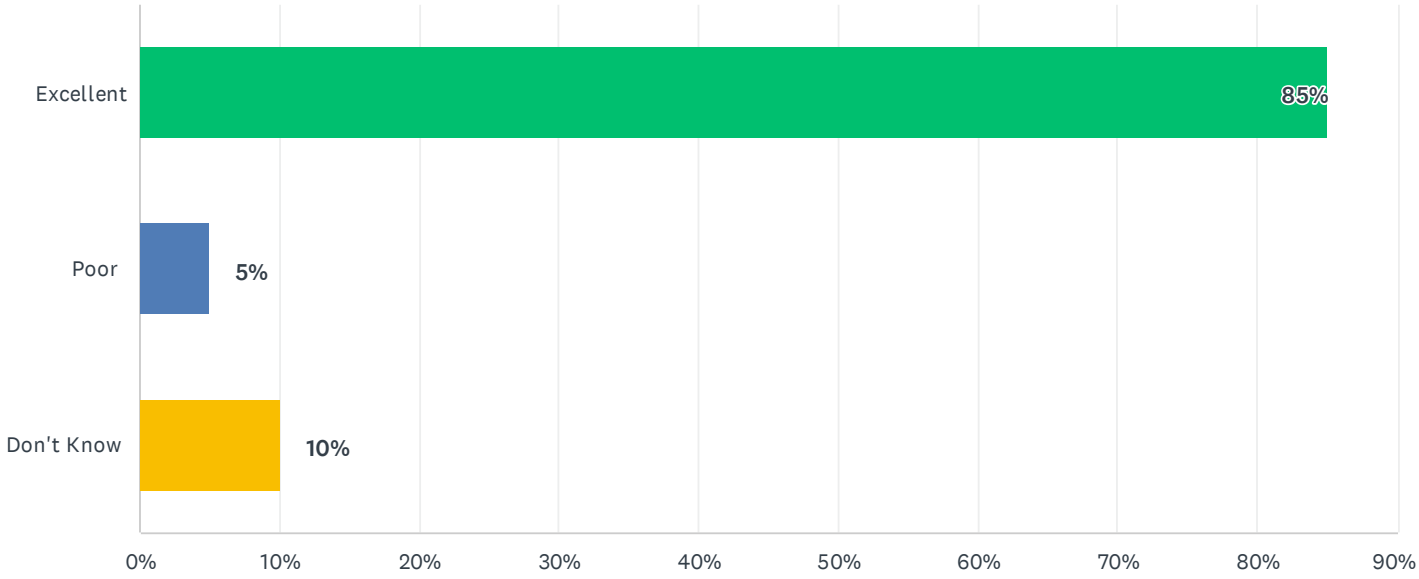
Answered: 20 Skipped: 1



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

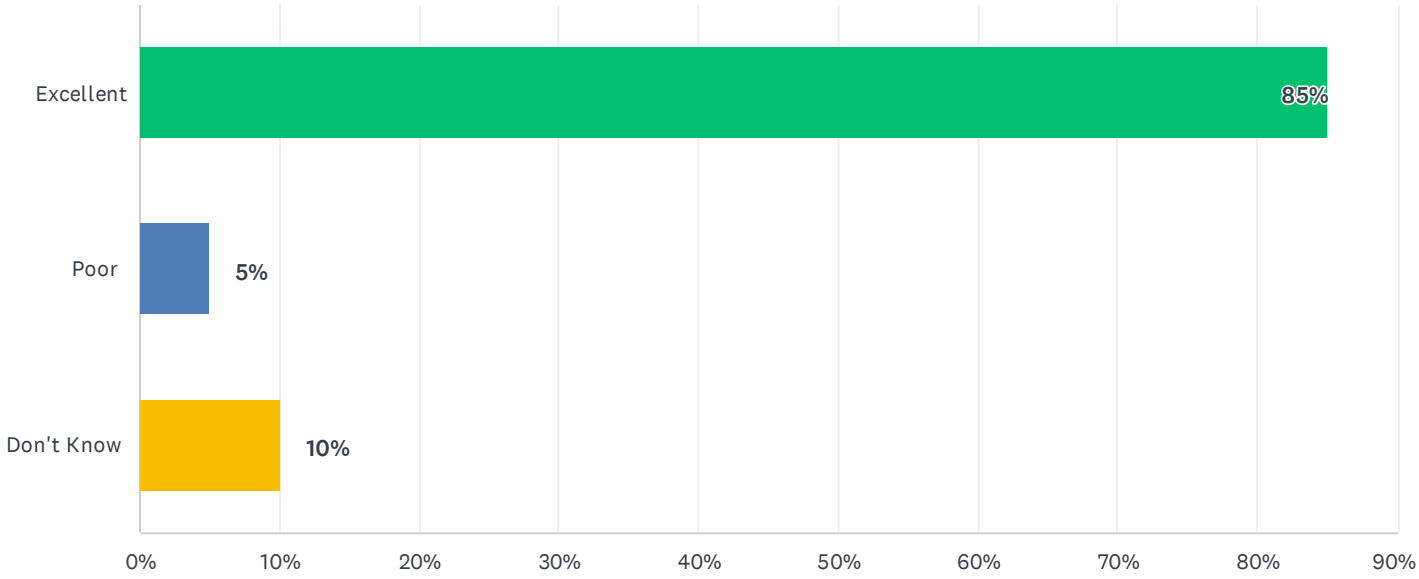


ANSWER CHOICES	RESPONSES	
Excellent	85%	17
Poor	5%	1
Don't Know	10%	2
TOTAL		20

Attachment # 2

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

Answered: 20 Skipped: 1

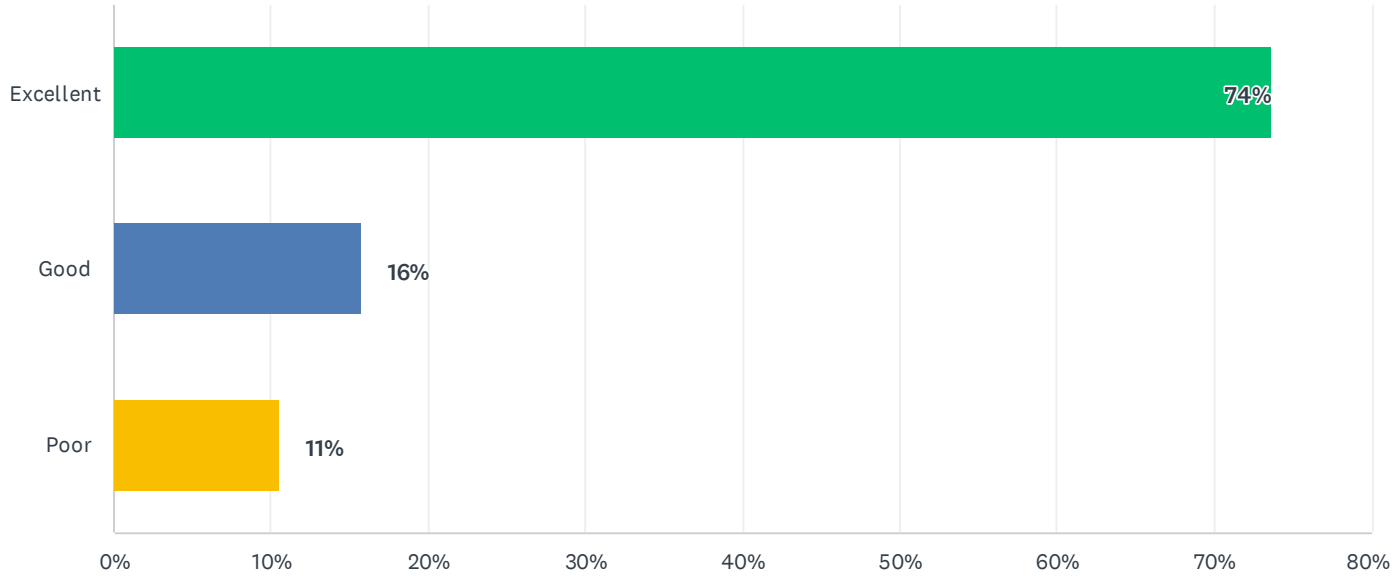


ANSWER CHOICES	RESPONSES	
Excellent	85%	17
Poor	5%	1
Don't Know	10%	2
TOTAL		20

Attachment # 2

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

Answered: 19 Skipped: 2

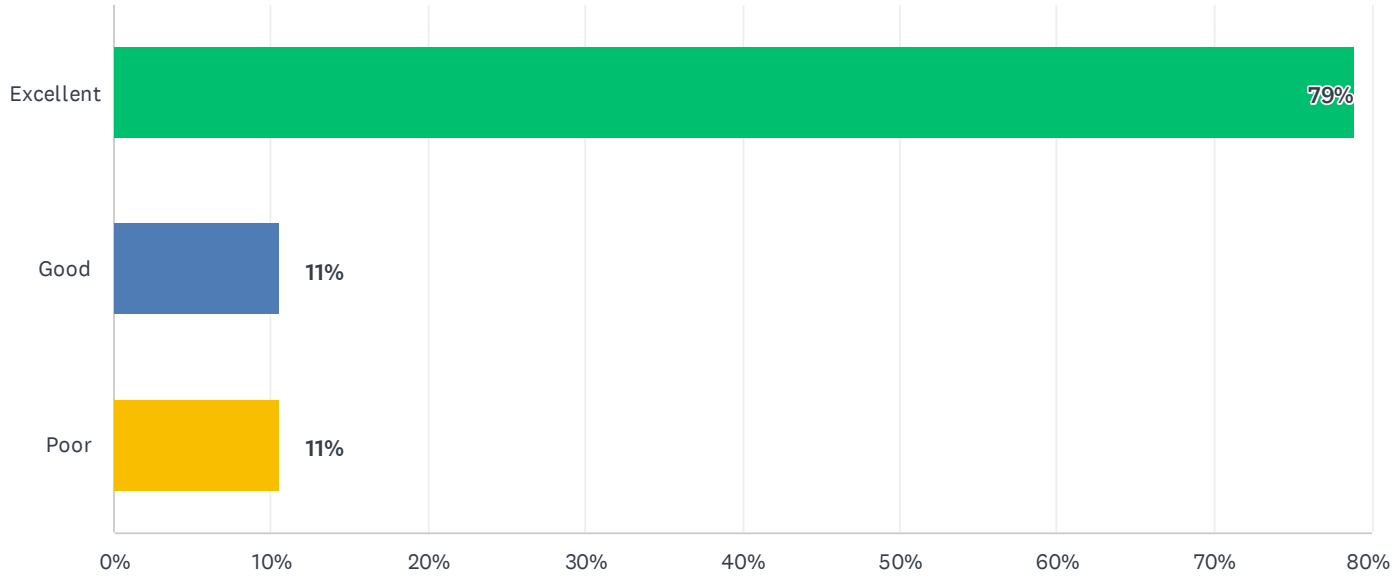


ANSWER CHOICES	RESPONSES	
Excellent	74%	14
Good	16%	3
Poor	11%	2
TOTAL		19

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

Attachment # 2

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

Annual Leave Summary July 1, 2025 – June 30, 2026

Accrual or type of leave	Balance 7/1/2025	Accrual per month	Earned	Used	Balance 6/30/2026
Vacation	331.04	11.34	136	45	350
Vacation Payout *	-	-	-	100	0
Sick Leave	241.37	8	96	20	317.37
Personal Business	24	-	-	24	0

*HR Policy allows 40 hours of Vacation Payout

Unclassified Executive Service, Unclassified Excluded and Management Service

Months Worked	Accrual Rate
First month through 60th month	10.00 hours per month
61st month through 120th month	11.34 hours per month
121st month through 180th month	13.34 hours per month
181st month through 240th month	15.34 hours per month
241st month through 300th month	17.34 hours per month
After 300th month	19.34 hours per month

Annual Travel Summary July 1, 2025 – June 30, 2026

Total In State Travel Expenses	**$0**
	$0
	$0
Total Out of State Travel Expenses	**$0**
Total Agency Head Expenses Reimbursed to Employee:	**$0**

***Agency Head did not travel in FY 2026 but will be attending the Dental Testing & Regulatory Summit which will be on the FY 2027 transactions report.**

Spots Card Purchases (Agency credit card paid directly by state)

	Total
Registrations/Memberships	$ 5260
Office Equipment/Supplies	$ 13570.35
Publications/Subscriptions	$ 468.00
Board Meeting/Staff Training Food	$ 4517.91
Misc. (FEDEX, Background checks)	$ 179.57
	$ 23,995.83

Agency Head Financial Transactions
Spots Card and Travel Reimbursement
Fiscal Year 2026 by Quarter

SPOTS Card Purchases: (Agency credit card paid directly by state)	**sub-total**	**Total**
		$3714.47
July – September		
Office Depot	$286.95	
AT&T	$443.80	
Stericycle	$100.00	
DOJ Conference	$760.00	
NIC	$877.00	
UPS	$75.00	
Board Meeting Food	$853.23	
NPDB	$22.50	
AED Superstore	$295.99	
October – December		**$5837.72**
Office Depot	$982.12	
AT&T	$594.66	
Stericycle	$100.00	
Survey Monkey	$468.00	
NIC	$1,296.00	
Board Meeting Food	$1,636.62	
NPDB	$2.50	
Quadient	$37.00	
Garten Services	$701.40	
Witco Nameplates	$19.42	

January – March		**$5543.77**
Office Depot	$1,156.95	
AT&T	$150.67	
DAS Training	$500.00	
NIC	$880.00	
Board Meeting Food	$1,347.47	
Quadient	$1,497.69	
FedEx	$10.99	
April – June		**$8899.87**
Office Depot	$1,094.85	
AT&T	$602.58	
NIC	$950.00	
Board Meeting Food	$680.59	
Quadient	$1,497.69	
Parking for Strategic Planning	$74.16	
AADB Membership Renewal	$4,000.00	

Best Practices Self-Assessment Guide: Information in Support of Best Practices

Best Practices Criteria
1. Executive Director's performance expectations are current. o The job description and performance expectations for the Executive Director are reviewed annually.
2. Executive Director receives annual performance feedback. o The full Board reviews recent 360-degree performance report for Director every two years. o The Administrative Workgroup reviews the Executive Director's performance annually and makes recommendations to the Board.
3. The agency's mission and high-level goals are current and applicable. o The OBD's 2026-2029 Strategic Plan will be ratified August 2026. o Agency performance measures, as well as short and long term goals, are reviewed annually. o Annually the Board's Bylaws are reviewed.
4. The Board reviews the Annual Performance Progress Report. o The annual performance measures are reviewed every fiscal year.
5. The Board is appropriately involved in review of agency's key communications. o Board members are informed of relevant news and information. o Board members are updated on articles and ideas for inclusion in the newsletter.
6. The Board is appropriately involved in policy-making activities. o The Board's committees review rules and policy making issues. o The Board reviews legislative proposals that could impact the Board.
7. The agency's policy option budget packages are aligned with their mission and goals. o The Board reviews agency's proposed policy option packages. o The Board reviews the Agency Request Budget.
8. The Board reviews all proposed budgets. o The Board reviews the Agency Request Budget.
9. The Board periodically reviews key financial information and audit findings. o The Board reviews agency head financial transactions annually at a Board Meeting. o The Board reviews agency fiscal transactions at every regular Board Meeting. o The Board reviews agency performance audits when they occur.
10. The Board is appropriately accounting for resources. o Board revenue and expenditures are reviewed by the Board. o Board expenditures are reviewed and approved by the Executive Director and Office Manager. o Board Executive Director updates Board on revenue or cost issues at regular Board Meeting. o Physical inventory of all agency property is conducted annually.
11. The agency adheres to accounting rules and other relevant financial controls. o Board staff prepares all transaction entries in accordance with Oregon Statute, Oregon Administrative Rules, Oregon Accounting Manual and Generally Accepted Accounting principles. o The Board has annually received the Department of Administrative Services Comprehensive Annual Financial Report Gold Star Award for timely and complete financial data.

12. Board members act in accordance with their roles as public representatives.
    - Board members appropriately recuse themselves from cases which create an actual or potential conflict of interest.
    - The Board follows public meetings and records laws.
    - The Board uses good judgment in upholding the Board's Mission Statement of Protecting the Citizens of Oregon.

13. The Board coordinates with others where responsibilities and interest overlap.
    - Board members and staff participate in appropriate professional associations.
    - The OBD works with the OHSU School of Dentistry on certain issues.
    - The OBD works with the ODA, ODHA, ODAA and others that request it: to present important practice related issues to members and licensees.
    - The OBD is actively involved in the American Association of Dental Boards (AADB), American Association of Dental Administrators (AADA) and regional testing agencies.

14. The Board members attend/complete relevant training sessions.
    - New Board members attend new Board member orientation presented by OBD Staff and assigned attorney.
    - Board members utilize the Governor's Board Training.

15. The Board reviews its management practices to ensure best practices are utilized.
    - On an annual basis, in regular board meetings and as needed.

Best Practices Self-Assessment

Annually, Board members are to self-evaluate their adherence to a set of best practices and report the percent total best practices met by the Board (percent of yes responses in the table below) in the Annual Performance Progress Report as specified in the agency Budget instructions.

Best Practices Assessment Score Card

Best Practices Criteria	Yes	No
1. Executive Director's performance expectations are current.		
2. Executive Director receives annual performance feedback.		
3. The agency's mission and high-level goals are current and applicable.		
4. The Board reviews the Annual Performance Progress Report.		
5. The Board is appropriately involved in review of agency's key communications.		
6. The Board is appropriately involved in policy-making activities.		
7. The agency's policy option budget packages are aligned with their mission and goals.		
8. The Board reviews all proposed budgets.		
9. The Board periodically reviews key financial information and audit findings.		
10. The Board is appropriately accounting for resources.		
11. The agency adheres to accounting rules and other relevant financial controls.		
12. Board members act in accordance with their roles as public representatives.		
13. The Board coordinates with others where responsibilities and interest overlap.		
14. The Board members identify and attend appropriate training sessions.		
15. The Board reviews its management practices to ensure best practices are utilized.		
Total Number	15	
Percentage of total:	100%	

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!

OREGON BOARD OF DENTISTRY

NEWS

Vol. 41 August 2026

President's Message

Sheena Kalia, D.D.S.

As I reflect on my years serving on the Oregon Board of Dentistry, I find myself thinking about the person who shaped my values more than anyone else-my father, the late Baldev Krishan Kalia.

Growing up in the small town of Moga, India, my father was known for his mischievous spirit. Family stories often recalled the trouble he managed to find, but beneath that playful nature was a young boy whose opportunities were limited. Because of childhood poverty, attending school simply was not an option.

In the late 1960s, my father immigrated to Canada through Edmonton International Airport without speaking English. He found work in a remote copper mining community off the coast of British Columbia, where he endured cultural isolation, prejudice, and physically demanding labor. Despite these hardships, he paid off his debts and devoted himself to supporting his family in India, helping provide for his widowed mother and siblings.

By the early 1980s, my parents were raising five children. Encouraged by my mother, my father earned his welder's certification and began working in the coal mining community of Sparwood, British Columbia. Although he had never received a formal education in India, he never stopped emphasizing the importance of education, hard work, discipline, and perseverance. When the mine declared bankruptcy in the early 1990s, my father once again started over. He moved our family to Calgary, found new work, built a new life, and ensured that his children would have opportunities he never had.

Years later, through resilience and determination, he became a successful entrepreneur. Yet life also brought unimaginable loss with the death of my brother. Even in grief, my father continued to greet others with warmth, generosity, and kindness, carrying himself with remarkable strength and grace.

In September 2019, my father was diagnosed with ALS. As the disease progressed, he chose medical assistance in dying and passed away in April 2020.

My father's life was defined not by the hardships he endured, but by the character with which he faced them. He was hardworking, honest, disciplined, wise, and blessed with a wonderful sense of humor. Above all, he taught me that adversity is not an excuse to give up-it is an opportunity to persevere with integrity. Those lessons continue to guide me every day. *(Continued on page 2)*

Board Staff

Haley Robinson
Executive Director
Haley.Robinson@obd.oregon.gov

Angela Smorra, D.M.D.
Dental Director/ Chief Investigator
Angela.Smorra@obd.oregon.gov

Winthrop "Bernie" Carter, D.D.S.
Dental Investigator
Bernie.Carter@obd.oregon.gov

Gabriel Kubik
Investigator
Gabriel.Kubik@obd.oregon.gov

Kathleen McNeal
Examination & Licensing Manager
Kathleen.McNeal@obd.oregon.gov

Dawn Dreasher
Office Specialist
Dawn.Dreasher@obd.oregon.gov

What's Inside

Today, I feel fortunate to have practiced dentistry for nearly 30 years and to own Hollywood Children's Dentistry. The opportunities I have been given are, in large part, a testament to the sacrifices my parents made and the values my father instilled in me. Those same values have also shaped my approach to public service and given me the privilege of serving on the Oregon Board of Dentistry.

As I serve my sixth year on the Board and my term as Board President, I am more optimistic than ever about the future of our profession. I have had the privilege of working alongside dedicated Board members and an exceptional staff whose commitment to protecting the public is evident in every decision they make. Together, we are guided by our mission:

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

That mission is more than a statement-it is a responsibility. It requires balancing public protection with fairness, transparency, thoughtful regulation, and accountability. As dentistry continues to evolve through advances in technology, changing workforce needs, and ongoing efforts to expand equitable access to care, the Board must continue to adapt while remaining steadfast in its commitment to the people of Oregon.

I am confident that the Oregon Board of Dentistry is well positioned to meet these challenges. By working collaboratively with licensees, educators, policymakers, professional associations, committees, and the public, we can strengthen trust in our profession while ensuring that Oregonians continue to receive safe, ethical, and high-quality oral health care.

Serving the people of Oregon and the profession that has given me so much has been one of the greatest honors of my career. As I look ahead, I remain inspired by the example my father set-to work hard, serve others with humility, and leave every community stronger than I found it. Those are the values I will continue to carry forward, and I know they will continue to guide the important work of the Oregon Board of Dentistry. ■

Board Members

Sheena Kalia, D.D.S.
President
Portland
Second term expires 2029

Sharity Ludwig, R.D.H.
Vice President
Bend
Second term expires 2030

Reza Sharifi, D.M.D.
Portland
Second term expires 2027

Kristen Simmons, R.D.H.
Hillsboro
First term expires 2028

Ginny Jorgensen
Wilsonville
First term expires 2028

Olesya Salathe, D.M.D.
Clackamas
First term expires 2028

Aarati Kalluri, D.D.S.
Hillsboro
Second term expires 2029

Kieshawn Lewis
Tigard
First term expires 2029

Jared Thompson, D.M.D.
Forest Grove
First term expires 2030

Aaron Tinkle, D.M.D.
Portland
First term expires 2030

Scheduled Board Meetings

2026 -27

- June 12, 2026
- August 21, 2026
- October 23, 2026
- December 11, 2026
- February 26, 2027
- April 23, 2027
- June 11, 2027
- August 20, 2027
- October 22, 2027
- December 10, 2027

A Word From the Executive Director

Haley Robinson

Outgoing Director Stephen Prisby
& Incoming Director Haley Robinson

A New Chapter: Building on a Strong Foundation

As we move through 2026, I want to take a moment to introduce myself as the new Executive Director of the Oregon Board of Dentistry and share a few updates on the work we've been doing over the past year.

Before anything else, I want to recognize Stephen Prisby for his leadership and mentorship throughout my time at the Oregon Board of Dentistry. Since I joined the OBD in June 2016, I have had the privilege of learning from Stephen's steady leadership, thoughtful approach to public service, and genuine commitment to this profession. His guidance has had a lasting impact on both the OBD and my own career. On behalf of the Board and staff, I want to thank Stephen for his many years of dedicated service to Oregon and wish him all the best in this next chapter.

It is an honor to step into the role of Executive Director, and I look forward to building on the strong foundation that has been established while continuing our mission of protecting the health, safety, and welfare of Oregonians through fair, consistent, and transparent regulation of the dental profession.

Board Leadership and Transitions

Our April Board meeting marked several important leadership transitions.

We recognized and thanked Dr. Aarati Kalluri for her dedicated service since joining the Board in 2021 and for her leadership as Board President. Her professionalism, insight, and commitment to public service have been invaluable to the Board.

We also said goodbye to Dr. Michelle Aldrich and Terrence Clark after four years of service. Both generously shared their time, expertise, and perspectives, and we are grateful for the contributions they made during their terms.

Finally, we are pleased to welcome Dr. Aaron Tinkle and Dr. Jared Thompson as our newest Board members. We are excited to have them join the Board and look forward to the experience and perspective they will bring as we continue serving the people of Oregon.

Incoming VP Sharity Ludwig, Dir. Haley Robinson, Outgoing President Dr. Kalluri & Incoming President Dr. Kalia

Looking Back on the Year

The past year has been a busy one for the Board, with several projects focused on improving our programs and supporting Oregon's dental workforce.

One of our biggest accomplishments was completing the Board's 2026–2029 Strategic Plan. The plan reflects input from licensees, stakeholders, Board members, and staff, and establishes priorities that will guide our work over the next several years. Thank you to everyone who participated in the process and shared ideas that helped shape the final plan.

We also made significant progress toward implementing a new Dental Assistant Registry. This project has involved extensive planning and collaboration and represents an important step in strengthening our understanding of Oregon's dental assisting workforce while creating a registration process.

To help guide future workforce initiatives, we recently launched a statewide Dental Assistant Workforce Survey. The information collected will help us *(Continued on page 4)*

better understand workforce trends, educational pathways, expanded function utilization, and practice needs throughout the state. If you have not already done so, I encourage you to participate. Your feedback will help inform future discussions and decisions.

License Renewal Reminder

License renewals for dental hygienists and dental therapists with a September 30, 2026 expiration date are now underway.

Renewing early helps avoid last-minute issues and ensures your license remains active without interruption. If you have questions during the renewal process, our staff are always happy to assist.

Looking Ahead

As the profession continues to evolve, so does the work of the Board. We remain committed to providing clear communication, responsive customer service, and practical guidance for licensees while carrying out our responsibility to protect the public.

I look forward to continuing our work with licensees, educators, professional organizations, and community partners as we address new opportunities and challenges together.

Thank You

To Oregon's dentists, dental hygienists, dental therapists, dental assistants, professional organizations, educators, and everyone who supports oral health across our state, thank you.

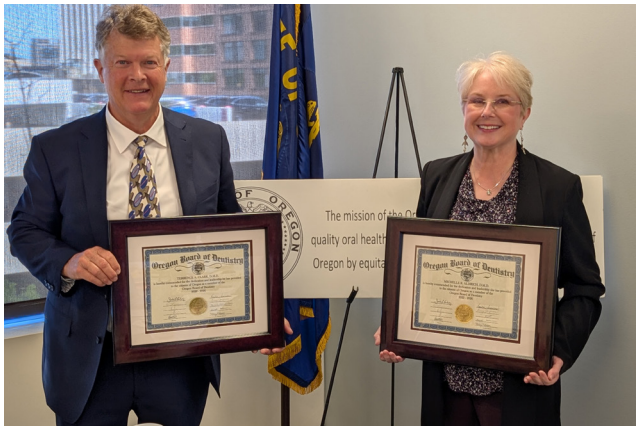
I am honored to serve as Executive Director and look forward to working alongside all of you as we continue building on the strong foundation established by those who came before us.

Thank you for your continued partnership and commitment to advancing oral health across Oregon. ■

Warm regards,

Haley Robinson
Executive Director
Oregon Board of Dentistry

Farewell & Thank You For Your Service



Farewell & Thank You for Your Service.
The OBD said farewell & thank you to two Board Members whose first terms of service concluded in spring of 2026.

Dr. Terrence Clark's service on the Board concluded on June 12, 2026. As a private practitioner and a licensed Oregon dentist for almost 40 years, Dr. Clark brought an important viewpoint, experience, and perspective to Board actions and proceedings.

Michelle Aldrich 's service on the Board concluded on June 12, 2026. As a private practitioner who started as a Registered Dental Hygienist, Dr. Aldrich brought an invaluable viewpoint, passion, and scrutiny to Board actions and proceedings. ■

Have you moved or changed work locations recently?

ORS. 679.120(4), 679.615(5), and 680.074(4) requires that licensees update the Board within 30 days of any change of address.

To update your contact info, please go to www.oregon.gov/dentistry and click "Licensee Portal" for instructions.

Welcome

Dr. Jared M. Thompson, DMD, MAGD is an Oregon native who studied at Portland State University before attending and graduating from Oregon Health Sciences University in 2005. In 2006, he completed a one year AEGD residency at the University of Michigan and then returned to Oregon to begin his career in private practice. Dr. Thompson has offices located in Forest Grove and Tillamook, and routinely volunteers for Medical Teams International. He is a past president of the Washington County Dental Society and served several years on the Oregon AGD board. Outside of his professional life, Jared is a father to two teenagers and husband of 21 years to his high school sweetheart. Together they enjoy boating, snowboarding, golfing and basically anything that involves being active and outdoors. ■

Dr. Aaron Tinkle, DMD, is a general dentist based in Portland, Oregon, with more than two decades of experience in clinical dentistry, dental education, and advanced restorative technology.

Dr. Tinkle earned his Doctor of Dental Medicine degree from Oregon Health & Science University in 2006, after completing an Honors Bachelor of Science in Zoology through the University Honors College at Oregon State University in 2002. During his dental training, he distinguished himself academically and clinically, receiving multiple competitive awards recognizing excellence in prosthodontics and endodontics, including the Pacific Coast Society for Prosthodontics and Journal of Prosthetic Dentistry Award for Excellence and the Larry Sorum Memorial Award.

After graduation, Dr. Tinkle joined the faculty at Oregon Health & Science University, where he served from 2006 to 2010 as an associate professor of operative and prosthodontic dentistry. In this role, he contributed to the education and clinical development of dental students while remaining actively engaged in restorative dentistry.

In 2009, Dr. Tinkle became the owner and lead dentist of Belmont Family Dentistry in Portland, where he continues to practice. His clinical focus emphasizes comprehensive, high-quality restorative care, with particular expertise in digital dentistry and CAD/CAM workflows.

Dr. Tinkle has been deeply involved in organized dentistry and professional leadership. He has served multiple terms on the board of the Oregon Academy of General Dentistry and was elected President of the organization in both 2012 and 2024. His commitment to professional development extends nationally through his long-standing involvement with CEREC education. Since 2013, he has worked as a mentor, trainer, and visiting faculty member for CEREC doctors in Scottsdale, Arizona, and as a CEREC trainer for Patterson Dental. He has also led and mentored CEREC study clubs at both Oregon Health & Science University School of Dentistry and in the Portland area. ■

Frequently Asked Questions

Q: May a hygienist apply SDF to treat caries on a patient that hasn't been examined by a dentist?

A: No. Under OAR 818-035-0025 (1) a dental hygienist is prohibited from diagnosing and treatment planning anything other than for dental hygiene services. Use of CDT Code D1354 (interim caries arresting medicament application) would require a dentist to diagnose active, non-symptomatic caries, and justify treatment. However, under OAR 818-035-0030 RDH's can determine the need for fluoride as a preventative measure, and some fluoride may include SDF in the formula. The RDH would bill using the appropriate CDT prevention code. The Board has noticed an uptick in complaints involving the use of SDF. At a minimum, documentation of PARQ, or its equivalent, is required under the Dental Practice Act. Review with your malpractice insurance, legal counsel, office policies, and dentist to determine how long after caries diagnosis standing orders for SDF are acceptable.

Q: I bought a new digital impression scanning system. May I have my dental assistant take the final digital impressions?

A: Dental Assistants with the proper training may take final impressions using traditional, or digital, impression materials. It is the dentist's responsibility to review all impressions to ensure accurate and clinically acceptable impressions are captured. Prior to January 1, 2020 the Dental Practice Act prohibited dental assistants from taking jaw registrations or oral impressions for supplying artificial teeth as substitutes for natural teeth, except diagnostic or opposing models or for the fabrication of temporary or provisional restorations or appliances. However, this rule has been struck.

Patient Medical Consultation

What is the fastest way for dentists to receive a patient medical consultation?

The answer to this question is not simplistic. Let's approach this question with the following iterations and by "titrating to effect."

1. The fastest response would be to activate your office medical emergency protocols for a dental patient in your office who is exhibiting a medical emergency involving a life-threatening event. A medical consultation is not needed. What is needed is immediate emergency medical intervention. No matter what the emergency is, your office team will need to keep the patient alive until medical emergency personnel arrive to take medical management of the patient from your team. Your office should run medical emergency drills periodically, actually involving a phone call for the emergency medical response team (EMTs) to come to your office and timing as to how fast that response will occur. The time it takes for the EMTs to get to your office is the time your office team will need to keep your patient alive. Your team needs to be totally aware of what that time interval is. BTW, this "titration" applies to any person in your office – patient or non-patient.

2. The next level of "the fastest response needed," would be if a patient of record is not in your office and called your office and said he/she had a dental emergency which he/she believes is life-threatening and he/she needed to come in to be evaluated in your office immediately. Your immediate response could be to instruct your patient to go to an emergency room of a hospital so that the medical emergency related to a dental problem would be evaluated in the best possible professional medical setting. Dental emergencies which would qualify include experienced trauma, infection, and swelling with or without pain involving the oral cavity. Most probably these emergencies could involve the head and neck excluding the cranium and its contents. If the person calling is not a patient of record and describes the previous scenario, that person could also be instructed to go to an emergency room of a hospital. It is reasonable to assume that a hospital emergency department will have an oral and maxillofacial surgeon on site or on call who can be contacted to come into the hospital.

3. The next "titration" of the subset of dentists to consider are the oral and maxillofacial surgeons, a number of them dual DDS, DMD/MD degreed, maxillofacial prosthodontists, pediatric dentists, dentists who practice in hospitals performing dental services privileged as professional hospital staff (VA, for example), and other dentists who have hospital privileges, who all should be able to access a patient's electronic medical record (EMR) directly and immediately. These dentists represent the group of currently existing dental healthcare providers with the quickest direct access to a patient's EMR.

4. The first three iterations involve action and direct access to patients' EMRs. The next question is, beyond the above what is the subset of dentists in the State of Oregon who would value direct access to patients' EMRs enough to have that access available to them during their daily practice of dentistry? That subset of dentists would most probably be those with hospital privileges and who treat patients in hospital settings. Typically, this scenario would be restorative dental care performed for patients with special needs and most probably geriatric patients.

If your patient is "in the chair" and you need an immediate medical consultation, prior to performing planned procedures, telephone the patient's PCP medical healthcare provider and complete the consult over the phone to be able to perform the procedures if the verbal consult will allow you to perform acceptable dental care without violating statutes or rules of the Dental Practice Act. Document the verbal consultation completed. A written medical consultation is preferred over a verbal consultation.

Recently, as requested by the Board of Dentistry, after being prompted by dentists who are finding it difficult to easily access important health information for patients, the following was sent to Dr. Jordana Gaumond, Medical Director for the Oregon Medical Board:

"Dear Dr. Gaumond,
The typical process, as far as I am aware after practicing dentistry for over 54 years, is for a dentist to receive medical information for a patient to whom he/she is performing dental procedures is to initially receive the patient's permission after informing the patient as to why the information is needed and to have the patient complete an informed consent prior to the request from the dentist to the medical doctor."

…..to which Dr. Gaumond replied:

"Dear Dr. Carter,
I agree that access to the patient's EMR would greatly expedite the access to necessary information for safe patient care, however

Attachment #6

that is not possible in today's healthcare system. Between HIPAA compliance, user license agreements, and the ongoing segregation that still exists (as you pointed out) there is no known system to access other EMR's for healthcare providers. Epic does have something called Care Everywhere, however having used Epic for many years, it still lacks in many regards and much of the information you might be looking for may not be uploaded into Care Everywhere."

The answer to this question will be determined by the value the dentist places on having direct medical consults for their daily practice of dentistry in their office.

5. From the above the next level of "titration to effect" was a Google (what else would you expect?) search. The question asked was "What is the fastest way for dentists to receive patient medical consultations?" The following response was received:

The most efficient and quickest way for dentists to receive patient medical consultations is to use a secure, digital patient portal or direct electronic exchange system that allows for immediate access to relevant medical history and treatment recommendations.

1. Use a secure patient portal. Many dental practices now integrate HIPPA-compliant patient portals where patients can submit medical records, lab results, and consultation notes directly to the dentist's secure inbox. This eliminates the need for physical mail or phone calls, which can cause delays. The portal should allow patients to upload documents, send messages, and even schedule follow-up appointments.

2. Leverage EHR or EMR integration. If your dental practice uses an Electronic Health Record (EHR) or Electronic Medical Record (EMR) system, ensure it can receive and display referral letters, consultation notes, and other medical documents from other providers. Many EHR platforms support secure file sharing with other healthcare providers, enabling instant viewing of the patient's medical history.

3. Establish direct electronic exchange with referring providers. If you have a regular network of referring physicians or specialists, set up direct secure messaging or file transfer between your office and theirs. This can be done through:

- HL7 or FHIR-based health information exchanges*
- Secure email with encrypted attachments
- Specialized dental-medical referral platforms that automate document routing

**Google HL7 and FHIR-based health information exchanges for more in-depth electronic sites with more emerging AI utilization.*

4. Provide clear instructions to patients and referring providers.

- Share a simple step-by-step guide for patients on how to submit their medical records via the portal.
- Provide referring providers with your secure contact method & any required forms.
- Confirm receipt of documents promptly to avoid delays.

5. Maintain HIPAA compliance. Even with digital methods, ensure all communication and storage are HIPAA-compliant. This includes verifying patient identity protection data with encryption, and avoiding unnecessary delays in access.

6. Automate reminders and follow-ups. Use automated reminders to patients and referring providers to ensure consultations are submitted on time. This can be integrated into your EHR or practice management software.

Lastly, but still important, the American Dental Association has provided Guidance on Dentists Requesting Medical Consultations noting When to Request a Medical Consultation, ADA Clinical Guidance, Documentation and Coding, and Best Practices. Professional colleagues are encouraged to contact the ADA for any of this information.

As always, the Oregon Board of Dentistry hopes the information and this "titration to effect" provided for our dentist licensees will be of some value when the need arises for medical consultations for our patients.

In as much as this newsletter is a forum for sharing information between all licensees of the Oregon Board of Dentistry, if anyone has more specific accurate information beyond the information presented regarding this topic please respond to the Board. Feedback from dentist licensees is always welcomed by the Board.

U*ntil next time please remember to "always do good work for your patients."* ■

Winthrop B. (Bernie) Carter, DDS, FICD, DABP

CE TIPS

- All CE, including BLS renewals, may be taken online.
- BLS for Healthcare Providers (**not CPR/AED**) is the required certification level.
- Upload **only** BLS/ACLS/PALS to licensee portal & renewal application.
- Print/Save Certificates of Completion for all courses for 4 years.

Attachment #6

Team Spotlight: Oral Cancer

Strengthening Our Oral Cancer Screening Efforts

Early detection of oral cancer can save lives — and our entire dental team plays a critical role in making that happen. Every patient visit is an opportunity for prevention, reassurance, and collaboration. Oral cancer often starts with subtle changes that patients may overlook. When we identify concerns early, treatment is more successful and far less complex. That's why consistent, team-based screening is essential.

Encouraging all team members to contribute to oral cancer screening strengthens both consistency and patient safety across the practice. Front office staff play an important role by promoting regular visits, explaining that screenings are part of standard care, and reinforcing the practice's preventive focus through scheduling and patient communication. Dental assistants support screening by noting visible abnormalities or reported symptoms, assisting with documentation and clinical handoffs, and helping prepare patients by briefly explaining what the exam involves. Hygienists contribute through thorough visual and tactile assessments during preventive care, asking patients about any changes they've noticed, and reinforcing the value of routine screenings. Dentists and Dental Therapists complete comprehensive clinical exams, evaluate suspicious findings, recommend appropriate follow-up or referral, and guide the team in maintaining a strong, unified screening culture. When each team member understands their role, oral cancer screening becomes a seamless, collaborative effort.

Our collective attention, teamwork, and communication bring value to our profession. By strengthening our oral cancer screening routine, we can make a meaningful difference in patient outcomes. Integrating screening into every adult appointment, speaking up when something looks unusual, and ensuring every team member understands their role in identifying and communicating concerns all help create consistency and confidence. Clear documentation, monthly skill refreshers, and supportive, unified language reinforce the value of screening for our patients. When we share observations and work together, we build a protective safety net that may facilitate the early detection of oral cancer. ■

Frequently Asked Questions

Q: Is an RDH allowed to use air abrasion in pits and fissures prior to sealant placement?

A: Make sure the abrasive you are using in the machine cannot cut hard tissue or operatively prepare teeth. The manufacturer should have guidelines on how to use the abrasive powder particles to be non-aggressive to healthy tooth enamel. The RDH should be trained on how to use the nozzle at the appropriate angle to avoid operatively preparing teeth, and know which structures to avoid (exposed roots, cementum, etc.) to avoid removing tooth structure.

Oregon Wellness Program

All licensees — dentists, dental therapists, and dental hygienists — have access to highly confidential mental health services through the Oregon Wellness Program (OWP). Self-referral is all that is required and the Board is not involved or aware of anyone accessing it.

Any Licensee may contact the OWP and receive up to three free visits per calendar year. Interested licensees can make a self-referral by visiting the OWP website to review available providers and contact providers directly to schedule an appointment. Visits are available in-person or via telehealth. There is no reporting to a primary health provider or billing of insurance.

The Oregon Board of Dentistry is committed to mental wellness and supportive of our licensees utilizing all available tools for success in their practice and in all aspects of life.
https://oregonwellnessprogram.org/

For program questions or help choosing a mental health provider, call 541-242-2805.

If you are experiencing a mental health crisis, call 9-1-1 or 9-8-8.

Tooth Whitening and Tooth Gem Position Statement Fall 2026

Providing teeth whitening and placing gems on teeth generally do not fall under the ORS 679.020(1) prohibition of unlicensed dentistry in Oregon as they are not listed in the definition of dentistry in ORS 67.010(6). When teeth whitening and tooth gem placement are purely cosmetic and not intended to treat medical conditions related to the oral cavity and maxillofacial region, they are generally not classified as the "practice of dentistry." The 2015 Supreme Court case North Carolina State Board of Dental Examiners vs. FTC established that market participants acting on state dental boards cannot use state licensing laws to ban non-dentists from providing cosmetic teeth-whitening services unless those services are specifically included in the Board's practice act by the legislature. If the Oregon legislature updates the statutes to include tooth whitening and tooth gem placement as the practice of dentistry, this 2026 position statement will be updated.

Consumers are encouraged to ensure they are obtaining cosmetic services that are safe and verify any potential cosmetic service provider is qualified and the right fit for the procedure they are interested in prior to obtaining any services. When consumers are researching tooth whitening procedures or tooth gem placement, they should ensure these procedures are performed with materials that are non-damaging and meet purity and safety standards. Consumers should be educated about the risks of sensitivity, pulp damage, enamel defects, dental decay, bond failure, aspiration risk, systemic effects, and the future removal of gems should be reviewed. Gems may act as traps for plaque and food debris, increasing the risk for dental decay, decalcification, and gum inflammation. Consumers are also encouraged to pay close attention to infection control practices, the credentials of service providers, and participate in a comprehensive informed consent process.

We also encourage consumers to consult with their dentist about safe removal of teeth gems and to utilize their licensed dental professional as a source of information about these cosmetic practices before obtaining a tooth gem. Dental professionals can discuss with patients the ramifications of tooth gems and whitening on their overall oral health. Having a licensed dentist remove the tooth gems will allow your dentist to evaluate the tooth structure to determine if damage has occurred. The dentist may treatment plan odontoplasty to cut and alter hard tooth structure to facilitate removal of tooth gems. Your dentist can recommend subsequent dental treatment for damaged tooth structure and discuss other remediation options if complications occur after tooth gem removal or tooth whitening procedures.

Currently, there is no specific CDT (Current Dental Terminology) code dedicated to tooth gem placement or removal. Because this is considered a cosmetic and elective procedure dental insurance is unlikely to cover the procedure. ■

Lorna Breene Award

The Oregon Board of Dentistry was Recognized as a 2025 Wellbeing First Champion

We are proud to share that the OBD has been named a 2025 Wellbeing First Champion by ALL IN: Wellbeing First for Healthcare! This annual distinction means that our license and renewal applications are free from intrusive and stigmatizing language around mental health care and treatment.

We have taken this step to ensure that our workforce can seek needed care without fear of losing their license or job. This accomplishment has been independently verified by ALL IN: Wellbeing First for Healthcare, a national coalition of leading healthcare organizations that works to remove barriers for health workers to access mental health care.

The OBD recognizes that supporting and protecting the mental health of our workers is paramount to their wellbeing and to the wellbeing of our entire community. We encourage you to share this information with your colleagues, so they know that it is safe to seek mental health care and that we support you. ■

Attachment #6

Dental Assisting

5 Ways Dentists Can Make Dental Assistants Feel Valued

May 13, 2026 (From DANB.org)

Behind every smooth procedure, calm patient, and efficient day at the practice, there's a dental assistant making it all happen. So why do many feel undervalued? Despite touching every area of the office, dental assistants often feel they are overlooked, underappreciated, and not fairly compensated for their work.

"I hope doctors and managers really realize what a dental assistant does on a daily basis," says Denys, a dental assistant in Washington. "They are the glue to the office and take on a lot that sometimes isn't recognized and appreciated! There's more to a dental assistant than many think. It's hard work that only the greatest can do!"

By taking intentional actions to recognize their impact, such as offering fair pay and encouraging career growth, dentists can ensure dental assistants feel respected and valued as essential members of the team. We talked to dental assistants from around the country about ways dentists can provide support for dental assistants.

A Simple Thank-You

Dental assistants contribute a lot to dental practices, and their position should never be taken for granted. They guide the patient experience, lead infection control processes, assist chairside, and much more. While it may seem like a small gesture, giving verbal recognition shows appreciation and boosts morale. Especially on busy days, dentists should take the time to thank their dental assistants for all they do to keep the schedule and procedures running smoothly. This recognition can help dental assistants feel valued, increase job satisfaction, and improve patient care.

Jeanne says, "Knowing I have a supervisor who recognizes our importance, how much we do behind the scenes, and is constantly letting us know how appreciative they are of our services helps me feel valued at work."

Invest in Career Development

From updated infection control protocols to new industry standards, there is always new information to learn. By investing in career development opportunities, such as certifications or continuing education(opens in a new window), dentists show they are confident in their dental assistants' careers and want them to grow within the profession.

"A well-trained dental assistant is a credit to the practice!" says Jenifer. "There are numerous duties a Certified Dental Assistant can do that take the pressure off the doctor, allowing the office to run more efficiently and helping other staff members keep the practice clean and stocked between patients."

Dental practices can benefit from dental assistants earning certifications, as shown in DANB's Dental Assistants Salary and Satisfaction Survey. The data shows that Certified Dental Assistants (CDAs) are less likely to change jobs and more likely to be leaders or trainers in the office. Investing in certification can demonstrate to dental assistants that their career growth is valued, helping practices improve staff retention and maintain a more stable, experienced workforce.

Offer Competitive Pay

Earning a fair wage is important to all dental assistants, and salary is the top factor that impacts their job satisfaction. Dentists should offer pay that reflects a dental assistant's experience and credentials to demonstrate that their contributions are valued within the practice. Competitive compensation sends a strong message of appreciation and acknowledges the work dental assistants do every day. Additionally, recognizing their value through fair pay helps build employer loyalty and increases job satisfaction. DANB's Financial Impact of Dental Assistants on the Dental Practice report explains how higher pay can increase dental assistant retention — resulting in increased productivity and higher revenues for practices.

Nicole shares, "Dental assistants deserve recognition, fair pay, and genuine respect — not as 'support staff,' but as critical professionals whose skill, dedication, and heart make quality dental care possible."

Dentists can use DANB's Salary and Satisfaction Survey or look at what other offices in the area are paying to gauge a fair wage based on factors such as location, experience, and credentials.

Honor Breaks and Time Off

Dentists can support dental assistants by ensuring they have opportunities to recharge during the day, such as encouraging short breaks. Dentists can also promote a healthy work-life balance by providing staff with reasonable paid time off. If a practice is experiencing staffing shortages and dental assistants are taking on more responsibilities, there should be an open dialogue between dental assistants and office leaders to strategize the best approach to scheduling and workload distribution.

Welcome Feedback

When dentists listen to feedback, dental assistants feel heard and more established in a professional space. Having an open line of communication between dentists and dental assistants creates a welcoming environment where staff members feel comfortable raising concerns, areas of improvement, and thoughts regarding patient care.

"Clear communication and being included in conversations about patient care matter a lot," says Courtney. "When my input is asked for or trusted — whether it's anticipating a procedure, suggesting a workflow improvement, or advocating for a patient — it reinforces that my role is seen as essential, not replaceable."

This mutual respect encourages collaboration, strengthens trust within the team, and can lead to better clinical outcomes. Over time, consistent communication builds confidence and reinforces a culture where every team member's perspective is valued. ■

TIPS FOR AVOIDING COMPLAINTS BEING FILED WITH THE BOARD

By law, the Board is required to conduct an investigation of every complaint received. Board investigations take up your valuable time and may have been avoided with clear communication and good patient relations. Following are a few tips that are worth reviewing regularly and should assist you in preventing complaints being filed by frustrated patients.

- Train front-office personnel in providing information to your patients and potential patients in a friendly and courteous manner. Also, any discussions about fees should include caveats about any additional services that may need to be performed. For instance, if a potential patient calls wanting to know the cost of an extraction, the caller should also be advised that there may be other services and fees required such as for examination and x-rays.

- Provide patients with a written copy of your office procedures including fees, payment expectations, insurance filings, management of pediatric patients, cancellations and patient responsibilities.

- Be specific with patients regarding the treatment plan and procedures that you will be following and the meaning of various terms.

- Pre-authorize treatment to be done with the patient's insurance company prior to performing the procedure and share the outcome of the prior authorization with the patient before beginning treatment.

- Document all procedures performed, anesthesia administered, x-rays taken, treatment complications, etc. in the patient record. If it isn't documented – it can be argued that it didn't happen! Documentation is your best defense. No one has ever been disciplined by the Board for over documenting.

- If in doubt about your diagnosis or treatment plan, consult with a colleague or a specialist.

- If a patient is dissatisfied with the treatment received, or the outcome, discuss their concerns with them personally and immediately. Do not be defensive, listen to the patient's concerns and work with them for a mutually acceptable outcome.

- Make sure that everyone in your practice/location that is required to have a license, permit or certificate has posted the license, permit or certificate where patients can see it and that the license, permit or certificate is current. If a license has expired, not only can the holder of the license be disciplined, the doctor can also be disciplined for allowing an unlicensed person to practice. ■

Attachment #6

OREGON BOARD OF DENTISTRY

OREGON BOARD OF DENTISTRY
1500 SW 1ST AVENUE, SUITE #770
PORTLAND, OR 97201

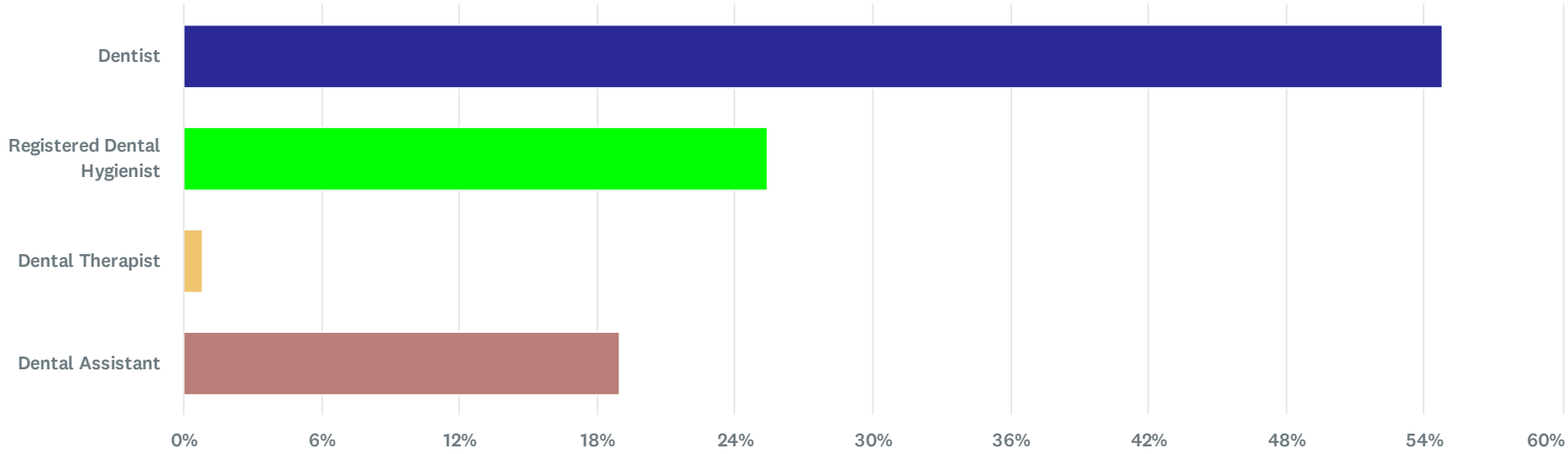
Phone: 971-673-3200

www.oregon.gov/dentistry

Email:
Information@obd.oregon.gov

Q1 374 responses

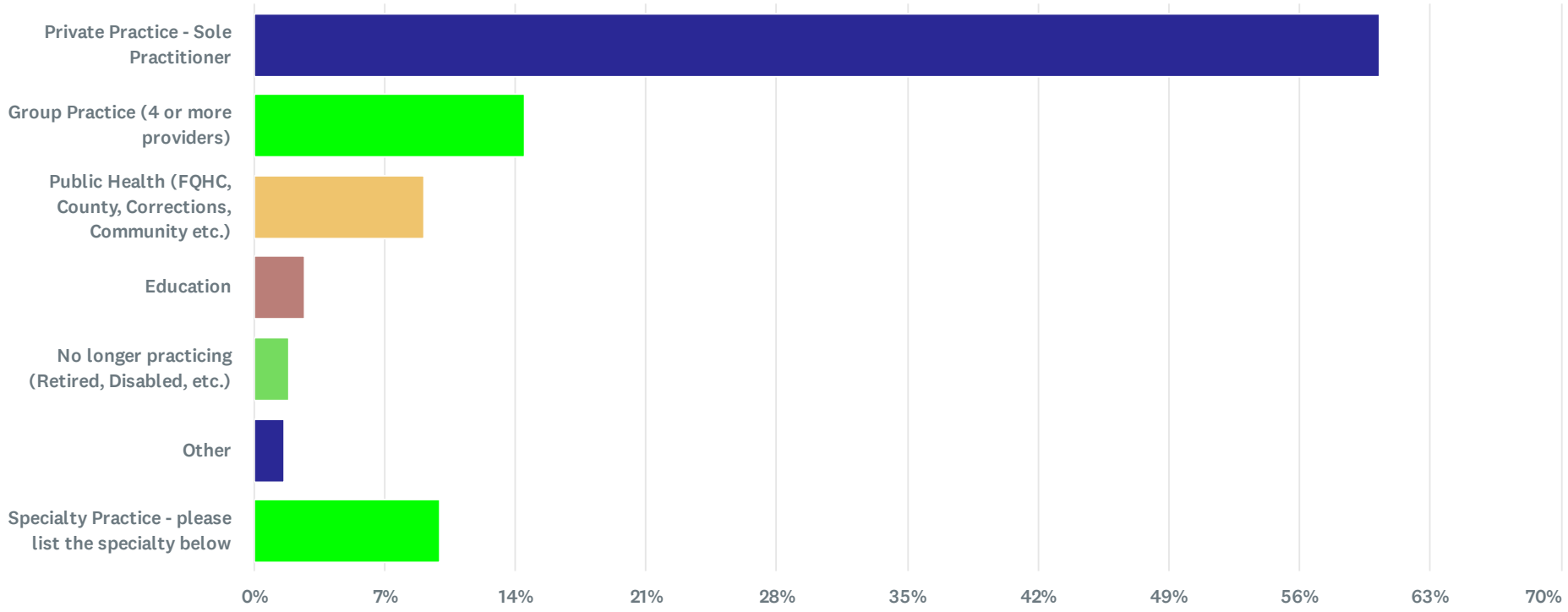
Are you a dentist, registered dental hygienist, dental therapist, or dental assistant?



Attachment #7

Q2 373 responses

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



Answer Choices	Percentage	Responses
Private Practice - Sole Practitioner	60.32%	225
Group Practice (4 or more providers)	14.48%	54
Public Health (FQHC, County, Corrections, Community etc.)	9.12%	34
Total		**373**

Attachment #7

Answer Choices	Percentage	Responses
Education	2.68%	10
No longer practicing (Retired, Disabled, etc.)	1.88%	7
Other	1.61%	6
Specialty Practice - please list the specialty below	9.92%	37
Total		**373**

2026 Dental Assisting Survey

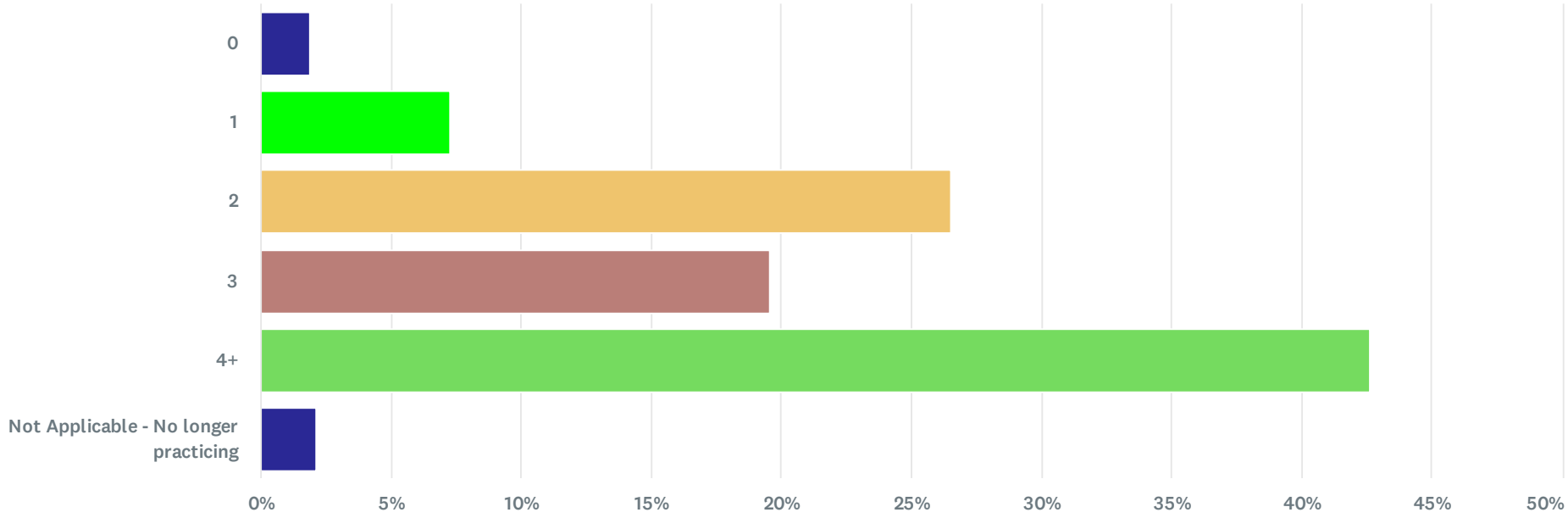
Summary of Responses by Survey Question

Specialty Practice - please list the specialty below

- Pediatric Dentistry (9)
- Oral Surgery (6)
- Periodontics (5)
- General/Private Practice (5)
- Orthodontics (4)
- Endodontics (2)
- Prosthodontics (2)
- Corporate/Multi-office (1)
- Public/Tribal/Community Health (1)
- Permanente Dental Group (1)

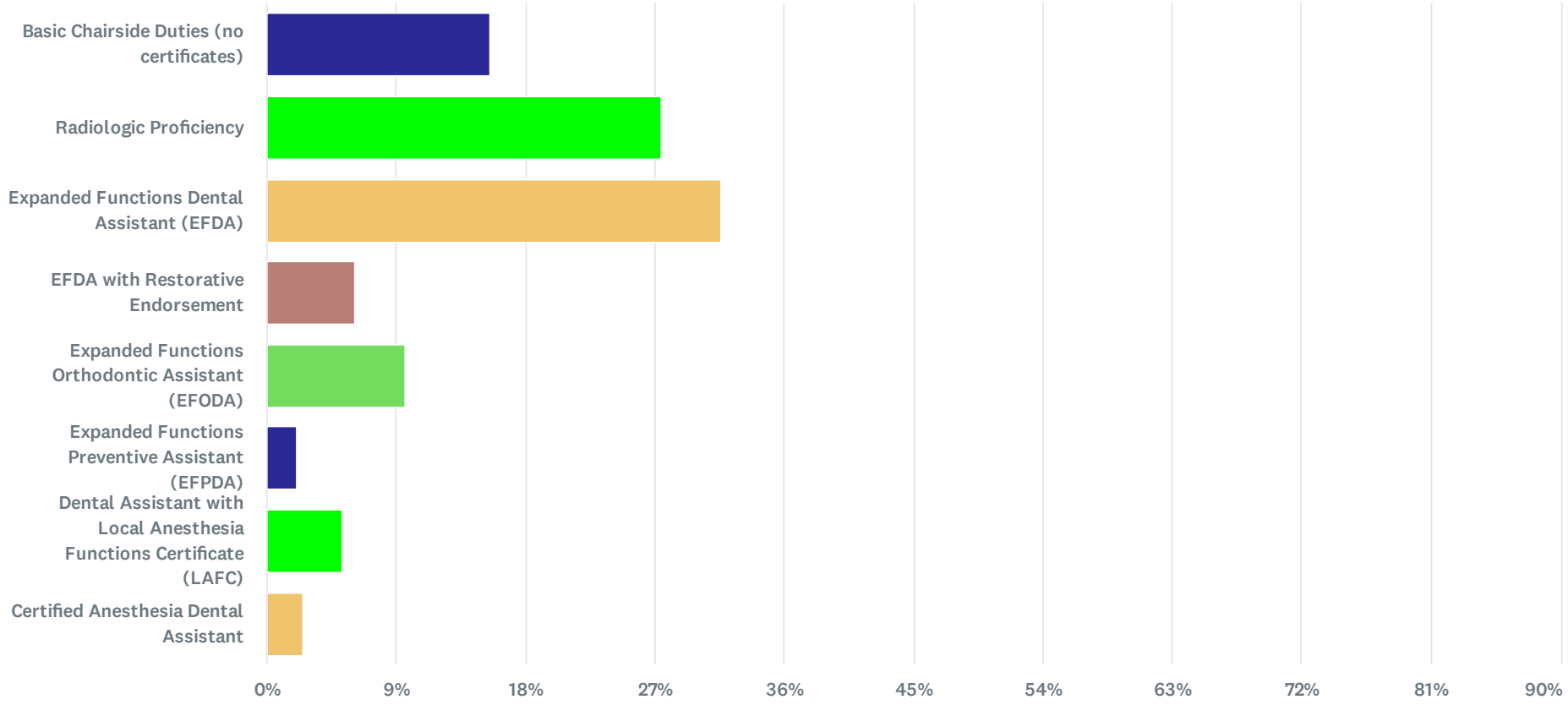
Q3 373 responses

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



Q4 366 responses

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



Answer Choices	Percentage	Responses
Basic Chairside Duties (no certificates)	15.48%	157
Total		**1014**

Attachment #7

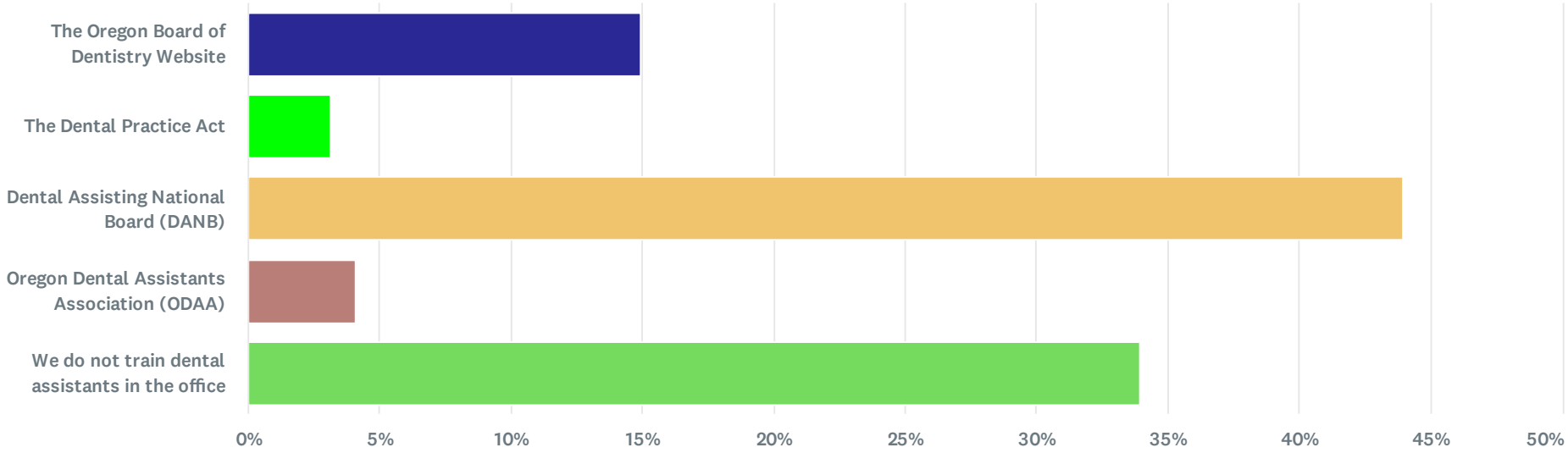
Answer Choices	Percentage	Responses
Radiologic Proficiency	27.42%	278
Expanded Functions Dental Assistant (EFDA)	31.56%	320
EFDA with Restorative Endorsement	6.11%	62
Expanded Functions Orthodontic Assistant (EFODA)	9.66%	98
Expanded Functions Preventive Assistant (EFPDA)	2.07%	21
Dental Assistant with Local Anesthesia Functions Certificate (LAFC)	5.23%	53
Certified Anesthesia Dental Assistant	2.47%	25
Total		**1014**

Other (please specify)

- CDA certification (4)
- DAANCE / anesthesia certification (3)
- Sealant certification (3)
- Education/no assistant employed (2)
- Phlebotomy / IV therapy (2)
- Nitrous oxide / local anesthesia (1)
- No additional suggestion / N/A (1)
- I am the dentist (1)
- Does not apply (1)
- Bad temps from non-accredited programs. These programs need to be shut down. (1)
- What else could possibly show up here? Scaling (1)

Q5 321 responses

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



Answer Choices	Percentage	Responses
The Oregon Board of Dentistry Website	14.95%	48
The Dental Practice Act	3.12%	10
Dental Assisting National Board (DANB)	43.93%	141
Oregon Dental Assistants Association (ODAA)	4.05%	13
We do not train dental assistants in the office	33.96%	109
Total		**321**

Attachment #7

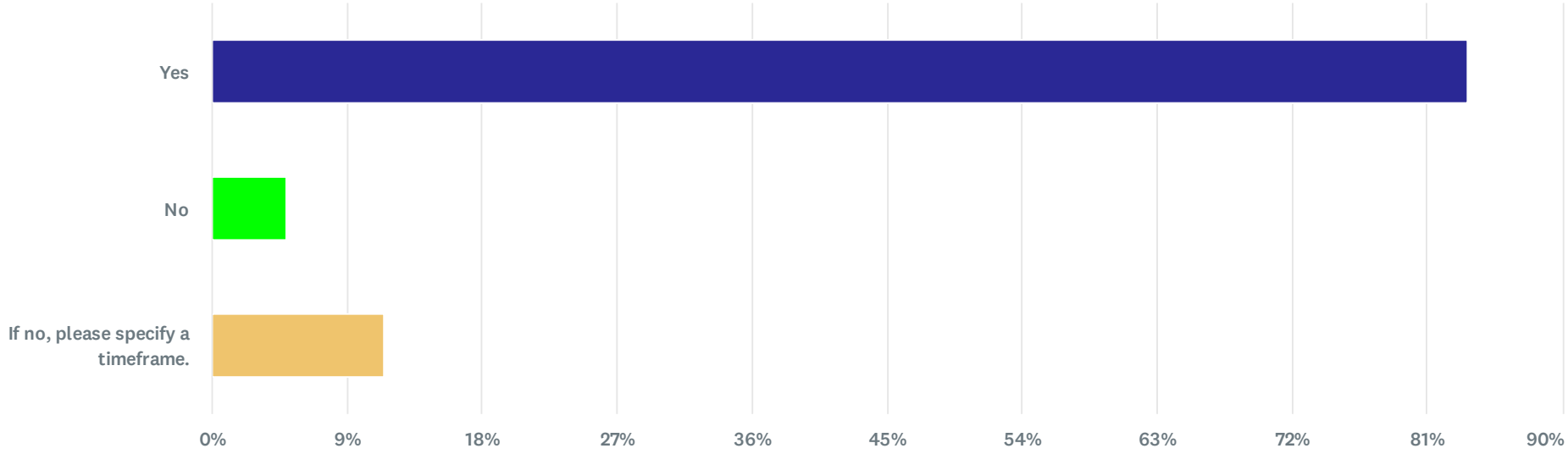
Other (please specify)

- Continuing education / accountability concern (13)
- Dentist/office-led on-the-job training (11)
- Professional organizations/resources (9)
- Formal dental assisting program / externship (7)
- No additional suggestion / N/A (1)
- No training materials/resources (1)
- Question/design feedback or multiple sources (1)
- The company I work for provides the training material I need. (1)
- National classes (1)
- Material we've made ourselves (1)
- They need to have an EFDA prior to hiring. (1)
- We train on our own (1)
- No Assistant employed. (1)
- We train without any training materials. (1)
- On the job training (1)
- We have developed our own. (1)
- Don’t know (1)
- AAO (1)
- We have someone who oversees the assistants and makes sure they have all the requirements needed. (1)
- Create my own (1)
- Any additional trainings that the drs need to update our technologies and surgeries are taught by our main dr. (1)
- . (1)
- This only allows you to select one option we use several of the above. (1)
- Internal (1)
- Dr does the training (1)
- Advantage Dental or Smile Generation took care of the initial training (1)
- More than one of the above (1)

- Don’t know. (1)
- Internal training protocols (1)
- Internal training materials (1)
- Personal train (1)

Q6 367 responses

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?



Answer Choices	Percentage	Responses
Yes	83.65%	307
No	4.90%	18
If no, please specify a timeframe.	11.44%	42
Total		**367**

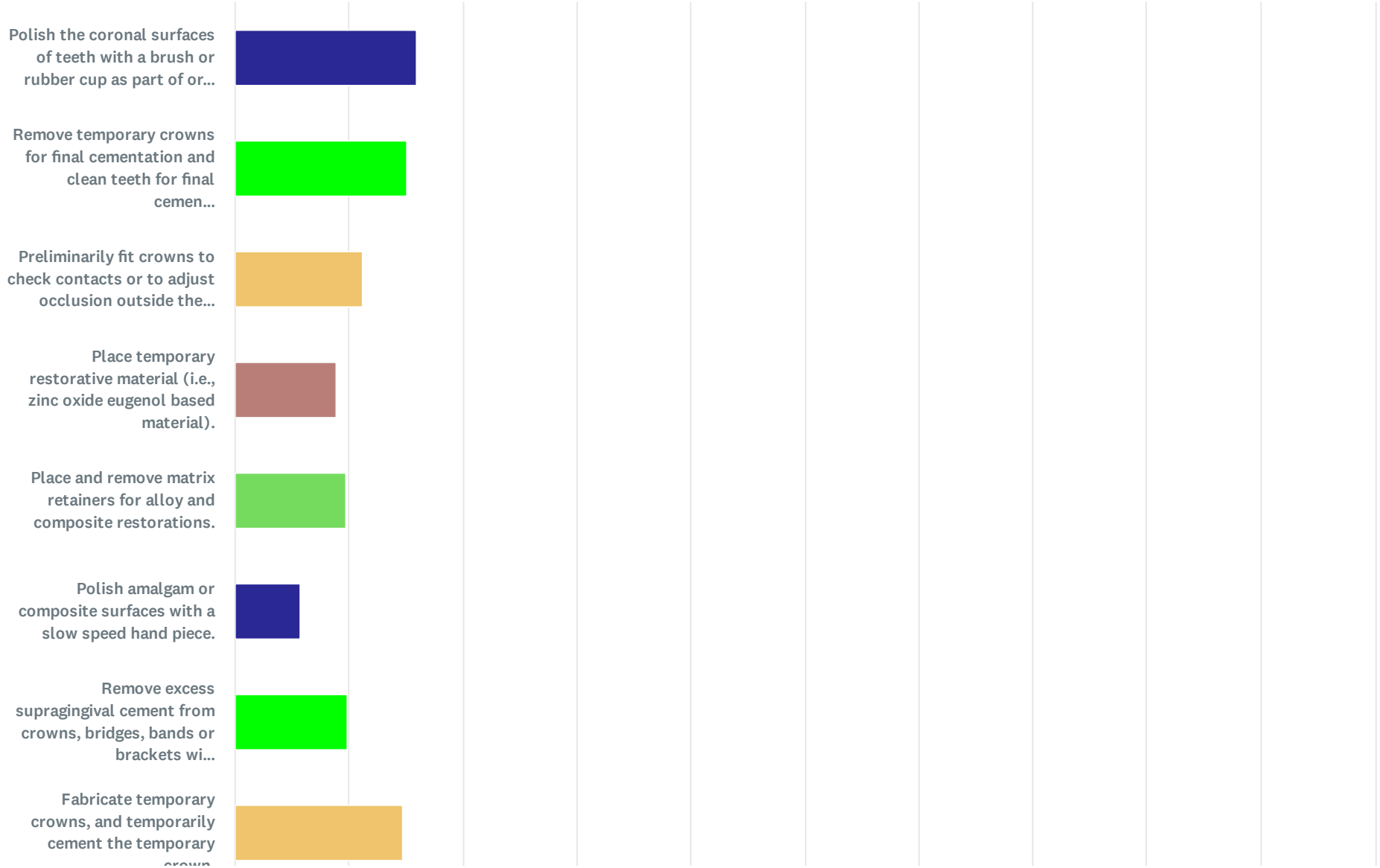
Attachment #7

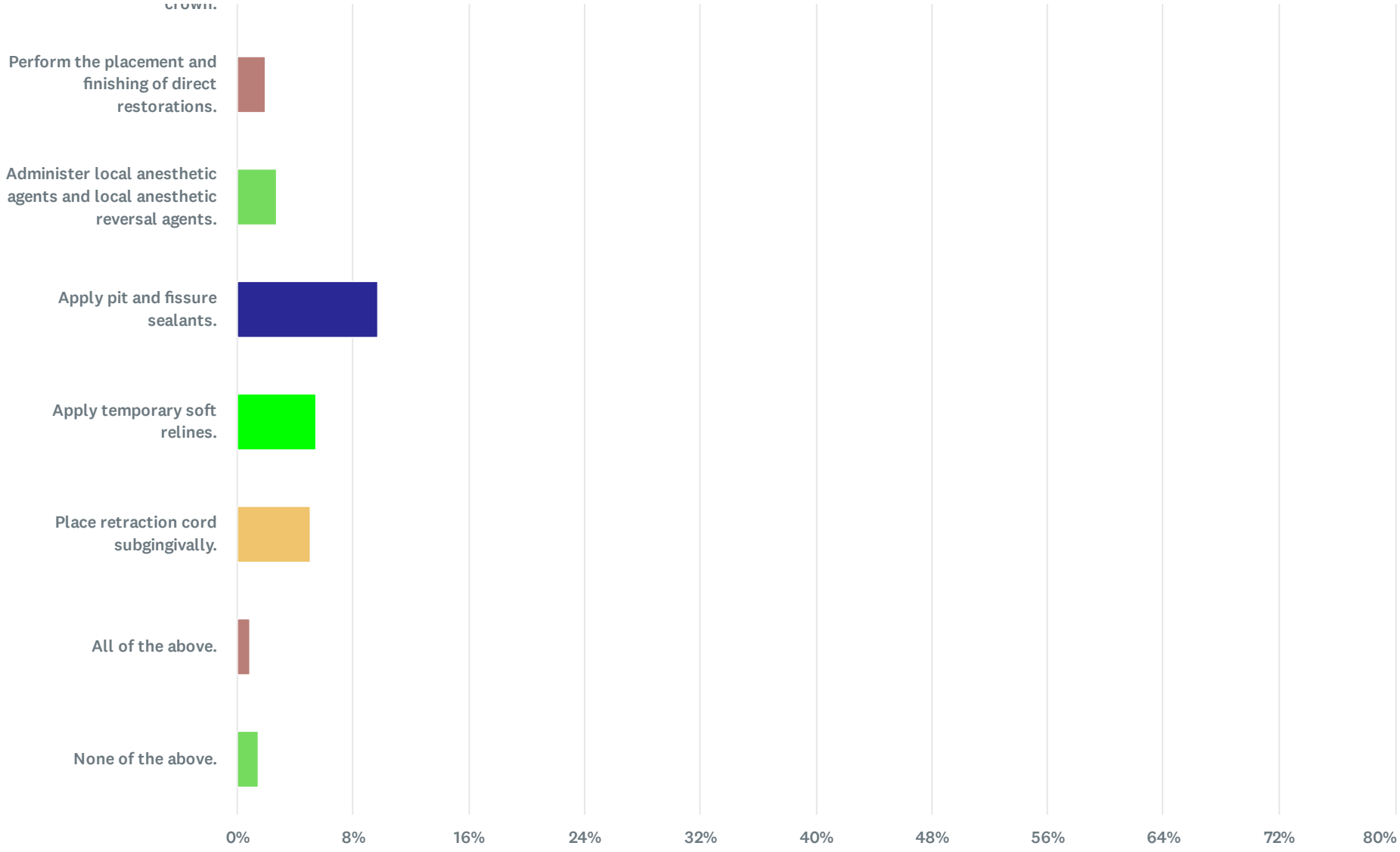
If no, please specify a timeframe.

- Approximately 12 months (14)
- Approximately 6–9 months (8)
- Timeframe should depend on experience/opportunities (5)
- 12–18 months (3)
- Approximately 2 years (1)
- Require formal education rather than time-based pathway (1)
- 12 (1)
- Yes but only if they are getting the hours and hands on experience they need daily. (1)
- Individuals learn at different rates. There should be no specified time limit. (1)
- I'm not sure since I don't train assistants in the office (1)
- 22-28 months (1)
- A year (1)
- I don't know an appropriate time frame (1)
- For EFDA it should be longer as they should really have a strong base before being trusted to have expanded duties (1)
- We don't do on the job training. (1)
- I don't have any knowledge of this. (1)

Q7 362 responses

Which EFDA duties do you perform, or you allow/supervise assistant(s) to perform once certified in Oregon? (Check all that apply)

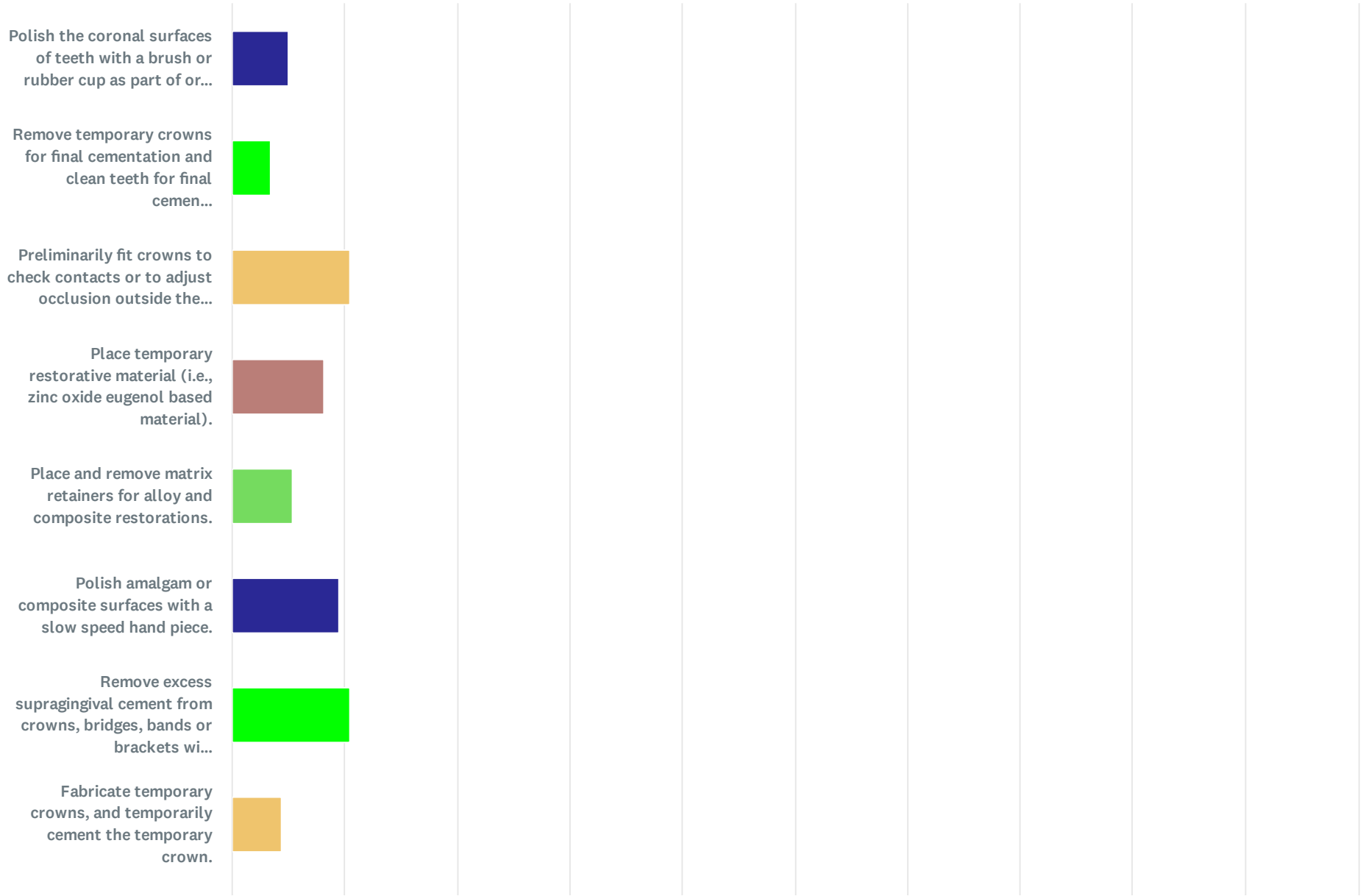




Attachment #7

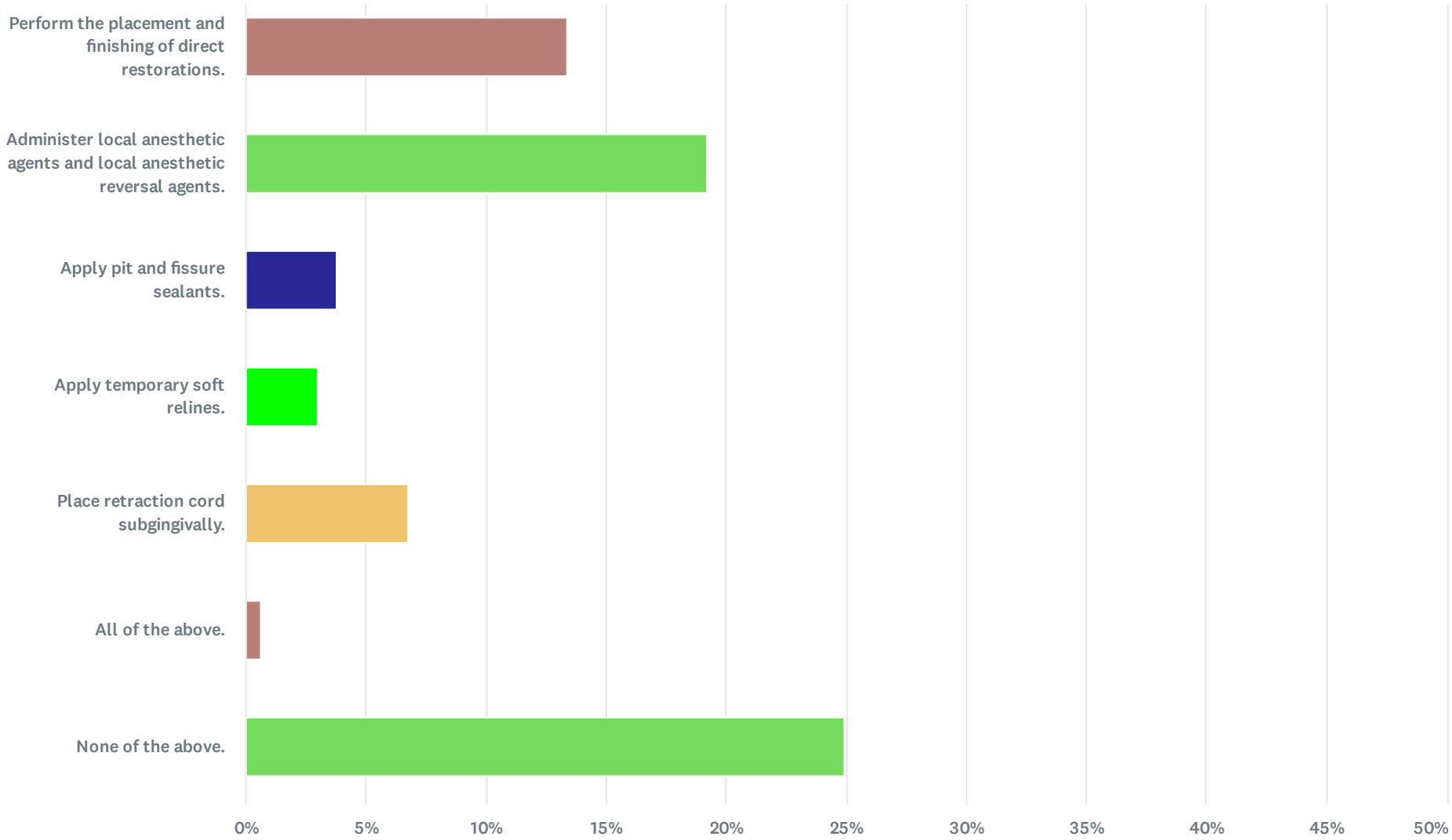
Q8 330 responses

Which EFDA duties (if any) would you remove? (Check all that apply)



Attachment #7

2026 Dental Assisting Survey



Attachment #7

Q9 What duties would you like to see added to the expanded functions list?

Answered: 126 Skipped: 249

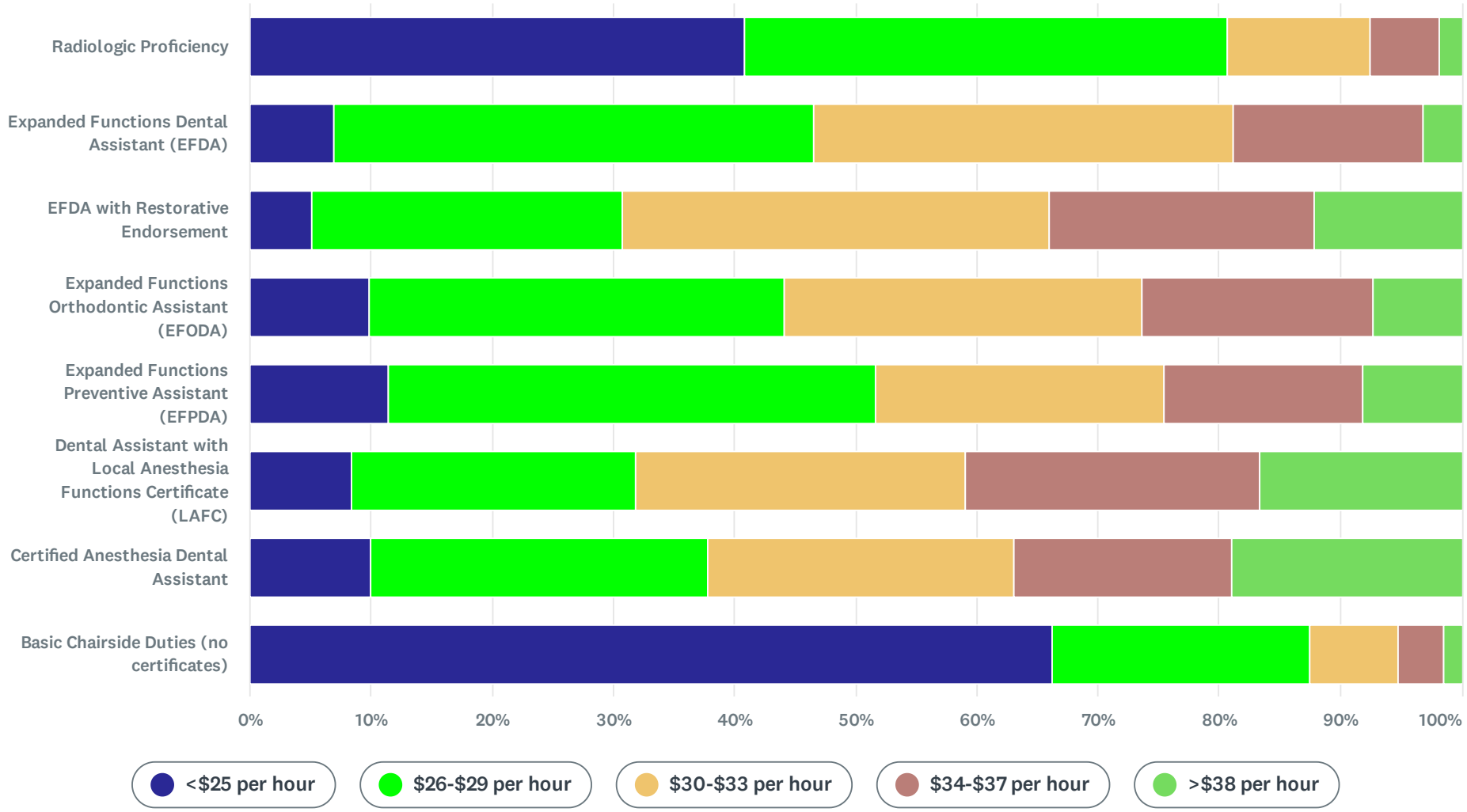
What duties would you like to see added to the expanded functions list?

- No additional suggestion / N/A (30)
- Scaling / debridement / coronal polishing (22)
- Nitrous oxide administration/monitoring (12)
- Standardized training/CE/licensure rather than new duty (11)
- Impressions / scans / digital impressions (10)
- Local anesthesia / anesthesia-related functions (7)
- Restorative functions / expanded restorative duties (6)
- No additional duties suggested (5)
- Implant-related functions (3)
- Radiography-related functions (1)
- Rubber dam placement (1)
- Adult prophy (1)
- The ability to use lasers (1)
- ???? (1)
- Do a full prophylaxis on all patients above the gum line. (1)
- PBM with diode lasers. If the tanning salon employees can operate red light PBM why not DA (1)
- deliver and adjust NGs. (1)
- Teeth Whitening, fabricating night guards, retainers and bleaching trays. more lab work including dentures. (1)
- No Assistant employed. (1)
- Removing supragingival calculus deposits (1)
- Placing Curadont (1)
- Probing (1)
- I can't think of any. (1)
- Curodont application (1)
- Use of ultrasonic for the purpose of removing calculus and staining (1)
- Help dental hygienists (1)
- Adjusting dentures and partials (1)

- Supragingival calculus removal in pediatric patients. (1)

Q10 354 responses

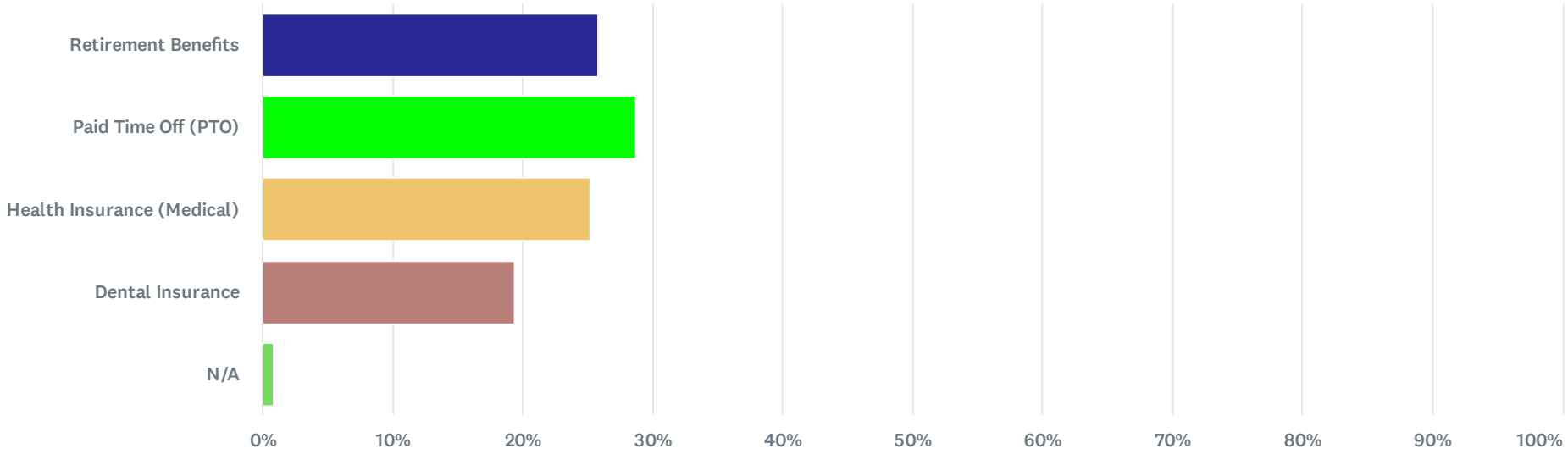
How much does your office pay each type of dental assistant?



Attachment #7

Q11 361 responses

Please select any other type(s) of compensation/benefits that your office provides. (Check all that apply)



Answer Choices	Percentage	Responses
Retirement Benefits	25.81%	304
Paid Time Off (PTO)	28.69%	338
Health Insurance (Medical)	25.21%	297
Dental Insurance	19.44%	229
N/A	0.85%	10
Total		**1178**

Attachment #7

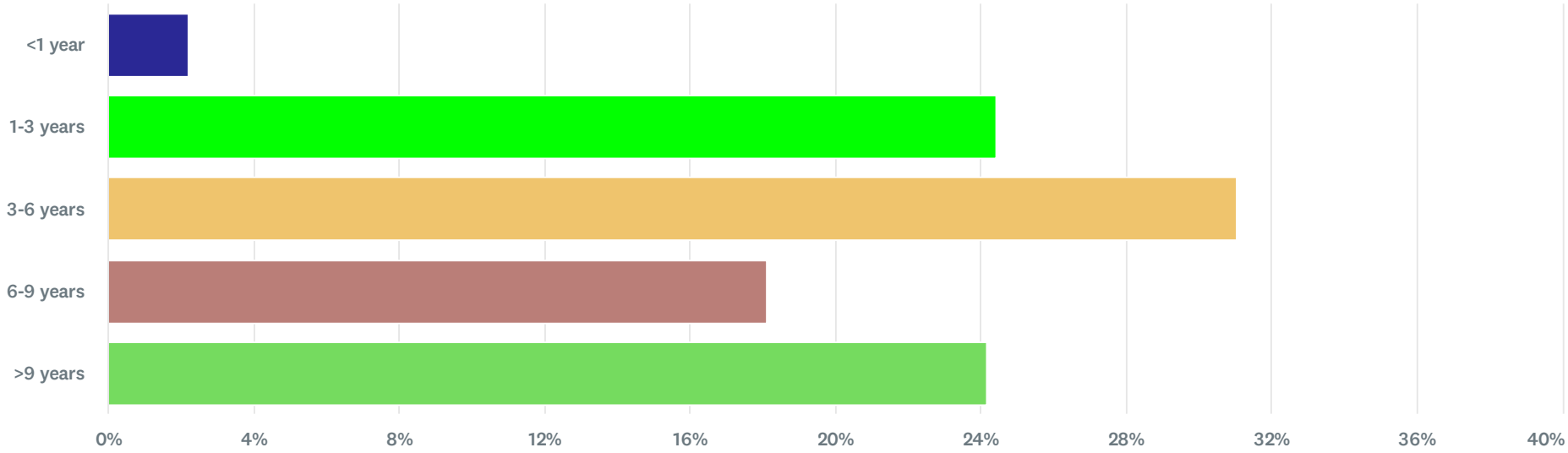
Other (please specify)

- Bonuses / incentive pay (9)
- Dental care / treatment benefits (8)
- Health savings/FSA contributions (3)
- Education / dues / professional development (2)
- Paid time off / holidays / sick leave (2)
- Wellness / optical / other health benefits (2)
- Life insurance (1)
- Tribal Dental for members (1)
- office lead pd $90k/y with 5 wks vaca plus $12k ins., efda is $44k/hr (1)
- Eye insurance (1)
- Uniform allowance (1)
- Disability, life, and vision insurance (1)
- they provide all of the above but unfortunately keep everyone under 30 hours besides the managers and Doctors. So all assistants don't qualify for Any benefits:((1)
- No Assistant employed. (1)
- In-house dental benefit for employee and family. Uniforms, CE. (1)
- Commission (1)
- Flex days (1)
- Free dental minus the cost of the lab (1)
- Unsure, as I am not full time with my office. (1)
- Vision (1)
- uniform allowance (1)
- Short term disability (1)
- Uniform stipend, CE money (1)
- Pediatric dental services for family for free, (1)
- Paid classes/CEs (1)
- CE monies, loupes (1)

- Dental services (1)

Q12 364 responses

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



Q13 In your experience, what affects the retention of dental assistants in the office?

Answered: 307 Skipped: 68

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

- Pay / compensation (134)
- Office culture / respect / morale (41)
- Management / dentist leadership / communication (17)
- Benefits / PTO (16)
- Career growth / training / advancement (14)
- Work-life balance / schedule / flexibility (10)
- Relocation / life changes (7)
- Staffing / teamwork (6)
- Workload / stress / burnout / physical demands (3)
- No additional suggestion / N/A (1)
- How employees are treated (1)
- Non-expanded function dental assistants are getting hired and are allowed to do all the duties of an EFDA and are being paid $18 an hour (1)
- Lying about their competency and then being offended when we show them the right way. in other words: accountability (1)
- Supportive and fun staff. (1)
- An excellent work environment (1)
- Experience (1)
- Personal Issues (1)
- They move away, they find other jobs (1)
- Capacity to with stand multitasking and fast paced environment. handling work load (1)
- Job satisfaction patient behavior (1)
- Only had one assistant ever! I'm a 3 year old startup. (1)
- Atmosphere of the office and relationships with colleagues (1)
- Relationship dynamics (1)
- Most recent applicants do not have the work ethic required to succeed in a professional place of business. They're late to interview, work, dress inappropriately, wear long nails, call in short notice, etc (1)
- Amount of work they are expected to perform (1)
- Personal fit and connection. (1)

- No Assistant employed (1)
- Fulfillment. The ability to use skills and have some autonomy. (1)
- They leave either for a higher $/hr at a neighboring office or when they can't meet office expectations (computer skills, showing up on time, etc) (1)
- Life situation, Long term goals (1)
- Office environment. (1)
- If you get raises (1)
- good work environment (1)
- treating them well in a friendly environment (1)
- Life changes (1)
- how much they are paid (1)
- Maternity, leaving area (1)
- Attendance, willingness to perform duties, office friendships/relationships (1)
- Work environment. - No drama (1)
- Unable to give raises (1)
- A specific staff member that may be overbearing (1)
- Work environment (1)
- having a say in who joins the practice and control of their future. (1)
- Individual motivations and factors vary widely (1)
- We train pre dental students as dental assistants (1)
- Job satisfaction. (1)
- keep job interesting with slowly expanding duties. (1)
- The dynamic of the drs and assistants (1)
- They’re getting paid a reasonably amount (1)
- Number of patients expected to see every hour (1)
- Poor work environment (1)
- Ergonomics (1)
- Pace of work. Change in profession (1)
- gossip (1)

- Other dental assistants and chronic concerns not being addressed (1)
- Lack of ability (1)
- Living on the border to Washington, which has zero rules for certification, we lose assistants who haven't received radiology as they can just take xrays without the hassle working in Wa (1)
- Enjoying who they work with. Autonomy, me listening to them in their ideas or changes they perceive need being done than talking about it and coming to a conclusion. (1)
- Workplace atmosphere (1)
- Well recognized, wellpaid (1)
- Over worked under paid (1)
- Happiness (1)
- Competency (1)
- Sense of belonging. (1)
- Inability to obtain certifications. (1)
- Delegation and say thank you daily (1)
- $$$ (1)

Q14 If less than 3 years what do you believe is the reason(s) for dental assistants leaving your office?

Answered: 224 Skipped: 151

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

- Pay / compensation (64)
- Office culture / respect / morale (21)
- Career growth / training / advancement (13)
- Relocation / life changes (13)
- Management / dentist leadership / communication (12)
- Work-life balance / schedule / flexibility (8)
- No additional suggestion / N/A (7)
- Workload / stress / burnout / physical demands (6)
- Benefits / PTO (5)
- Staffing / teamwork (2)
- I worked in offices that have low retention for the reasons listed above as well (1)
- Lack of structure (1)
- Life changes (1)
- We do not employ assistants in my office (1)
- Location (1)
- We let them go because not the right fit. (1)
- Office compatibility. Continued education that may affect employment goals (1)
- Not happy with work (1)
- Personal Issues (1)
- They move away or find other jobs (1)
- N/A. (I work in education) (1)
- patient load (1)
- Not meeting performance expectations (1)
- Termination due to inability meet job duty expectations. (1)
- Not the right fit (1)
- Leaving town. (1)
- No Assistant employed. (1)

- They can't keep up with the pace or the needs of a specialty office. We struggle with people being adequately trained - especially with interpersonal skills, computer skills, etc. (1)
- Having a baby (1)
- Lifestyle changes or cultural fit issues (1)
- they want to be paid more (1)
- Desire to leave rural practice setting. (1)
- Same (1)
- Personality not a fit (1)
- drama (1)
- We find they are not a good fit. (1)
- Dental assistants are primarily women and they move for marriage or have babies and stay home (1)
- They work so hard, know so much and are treated like crap. (1)
- Hygienist (1)
- Inability to get along with others in the workplace (1)
- Friend working in another clinic with an opening. (1)
- Being overwhelmed, not feeling “heard.” Generation problem for sure (1)
- Life changes (1)
- A specific staff member that may be overbearing (1)
- Environment (1)
- No consistent reason thus far for my office (1)
- they arent a good fit. (1)
- Having a baby, poor/unprofessional behavior (1)
- Over worked and underpaid (1)
- same as above (1)
- Hygienist everytime (1)
- Physical/health limitations (1)
- The work is too hard or not worth their effort. (1)
- We don't have any. (1)
- contention with other staff (1)

- Lack of experience (1)
- Finding a new job (1)
- Pace and style of practice (1)
- Our rural location (1)
- Other dental assistants and chronic concerns not being addressed (1)
- Not a good fit or same as above (1)
- Poor fit (1)
- Not a good fit , personality conflicts (1)
- Too quickly paced (1)
- Being overwhelmed with busy work days. (1)
- They can’t perform (1)
- most stay at least 3 years (1)
- Please see their resume. They keep changing the office nearly once every 1-2 yrs. (1)
- Personality conflict (1)
- Mostly has been due to personal life choices causing challenges with being reliable or consistent. Assistants that have stayed longer than 3 years typically have a more stable personal life. (1)
- location, (1)
- Public health is hard (1)
- I’ve only owned the office just over 3 years, so that’s a tricky question that could produce weird results. I think my current staff will be here for the long haul. I had to fire s couple of people that were not the right fit for our office. (1)
- The lack of support from the other assistants. (1)
- Unable to pass radiology certification test (1)
- Hard on body.. (1)
- Too many new tasks for them- such as scaling or local anesthetic (1)
- Employee in-fighting (1)
- Not being able to obtain all of the certifications. They are hired as sterilization technicians and we want to train them to be assistants but many of them fail the exams even though they demonstrate a high level of knowledge and skills (where allowed) in the clinic. It is WAY too difficult to become certified, especially in radiology where and EFODA only takes 2 kinds of xrays (pano and ceph). (1)
- One is just starting to be trained (1)

- They don’t leave (1)

Q15 What are your ideas to increase the number of dental assistants in the workforce?

Answered: 271 Skipped: 104

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

- Expand/access training and education programs (96)
- Increase pay / compensation (91)
- Professionalize role / licensure / CE / career ladder (21)
- Improve office culture / respect / management (16)
- No additional suggestion / N/A (7)
- Broaden scope / expanded functions (5)
- Benefits / work-life balance / schedules (4)
- Recruitment / career awareness / outreach (3)
- Reduce workload / housekeeping / add support staff (3)
- Lower barriers/costs to entry (2)
- The need for a float dental assistant is needed (1)
- Team bonding (1)
- Encourage possible observation, ask about interest in all areas of Dentistry (1)
- Please No promises of Supra gingival scaling. No matter how good the polish it's never complete. (1)
- Great! We need more...and dental hygienists (1)
- Make the job feel more like a profession than just a job. Being a valued member of a team. (1)
- Train ing opportunities. (1)
- Keeping the ones we have is the most important. (1)
- No Assistant employed. (1)
- None. (1)
- Train more, start interest early (1)
- Allow assistants to do supragingival scaling (1)
- Good (1)
- Development opportunities (1)
- Allow assistants to scale. More job opportunities that way. (1)
- Allow dental assistants to be trained to clean teeth. it would be a game changer for their career and income, and absolutely resolve the fact we have a national shortage of hygienists. (1)

- ?? (1)
- Not overwhelm them with hygiene tasks. Also don’t risk them as additional liability such as scaling. (1)
- Make the exams cheaper to take. (1)
- Stop over working them. (1)
- Encourage (1)

Oregon Board of Dentistry

Dental Assistant Log In

This is a new application and renewal portal. The Online Application and Renewal Process requires the completion of a one-time registration before you can login. This will provide you with your username **(the email address used during registration)** and a password for log in.

Active License: Please login with your current username (the email address used during registration) and password. **If you hold an active Oregon license and you wish to apply for a different licensure type, please email Information@obd.oregon.gov.**

Inactive License: If you held an Oregon license that is no longer active (resigned, retired, expired, etc.), and you wish to reapply for an active license or a new type of license, please **email Information@obd.oregon.gov.**

New users/Applicants: Please **Click Here** or click on the button below "Click here to Register" for one-time registration, enter all required information and click on button "Submit Registrationâ€□. You will receive a temporary password by email, which you will use to access the portal. You will be prompted to change your password before you can log in.

Please contact the Board Office if you have any questions or experience any issues with the registration or renewal process.

Email: information@obd.oregon.gov
Phone: 971-673-3200

User Name (Email)

Password

Forgot password?

Log In

Click here to Register

Attachment #8

Personal Information

First Name* Test

Middle Name

Last Name* test

Date of Birth* 07/15/2000

Email Address*

Phone Number* (___) ___-____

Mailing Address

Street Line 1*

Street Line 2

City* State* -- Select -- Zip*

Work Address Same as Mailing Address

Street Line 1*

Street Line 2

City* State* -- Select -- Zip*

Attachment #8

Certifications

What certification(s) do you currently hold?

- [ ] Basic Chairside or Sterilization Tech
- [ ] Expanded Functions Dental Assistant (EFDA)
- [ ] Local Anesthesia Functions Certificate (LAFC)
- [ ] Expanded Function Preventive Dental Assistants (EFPDA)
- [ ] Radiologic Proficiency
- [ ] EFDA with Restorative Functions Certificate
- [ ] Expanded Functions — Orthodontic Assistant (EFODA)
- [ ] Expanded Functions — Certified Anesthesia Dental Assistant

Certifications are optional. You may leave all unchecked.

Attachment #8

Close

UNFINISHED BUSINESS & RULES

From: Dan Ta
To: ROBINSON Haley * OBD
Subject: Re: June 12 OBD Board Meeting
Date: Tuesday, June 30, 2026 12:52:02 PM

Thanks again for taking the time to meet with me today. I appreciated the opportunity to discuss the EFODA certification rules and to better understand the Board's intent. To ensure I accurately captured our discussion, I wanted to summarize my understanding below as well as submit my request for written guidance on the rules. If I've misunderstood anything or if any of the points below are inconsistent with the Board's interpretation, please let me know.

My understanding is that:

- OAR 818-042-0110(2)(a) provides a pathway for dental assistants who complete a CODA-accredited dental assisting program to obtain EFODA certification without the need to complete the dental proficiency determination ("check off list").
- OAR 818-042-0110(2)(b) provides a pathway for dental assistants who pass the required DANB (or equivalent) exam. Upon receiving notice of successfully passing the examination, the assistant may begin performing EFODA duties while working toward demonstrating proficiency. The 6-month period begins upon notification of passing the examination, during which the assistant must demonstrate proficiency and submit the required check off list.
- During that 6-month period, assistants may perform EFODA duties under indirect supervision.
- OAR 818-042-0120 is intended to apply only to applicants seeking certification by credential based on qualifications obtained outside of Oregon, and the Board is considering refinements to the rule language to better reflect that intent.

As we also discussed, I wanted to put our request for written guidance in writing. We believe it would be very helpful for licensees if the Board could issue guidance confirming that:

1. An assistant who has successfully passed the examination under OAR 818-042-0110(2)(b) may perform EFODA duties under *indirect supervision* while completing the 6-month proficiency period; and
2. The 6-month period begins upon the assistant's receipt of notice that they have successfully passed the required exam.

We believe this guidance would help provide clarity for Oregon orthodontists and their staff as they work to comply with the rule. Thank you again for your time. We appreciate the Board's willingness to engage on these questions and look forward to hearing from you. Have a wonderful holiday weekend!

-Dan

Dan Ta
Legal and Advocacy Staff Counsel
American Association of Orthodontists

818-042-0050

Taking of X-Rays — Exposing of Radiographic Images

(1) Taking of X-Rays and exposing radiographic images for a dental assistant consists of the following activities:

(i) placing films/sensors,

(ii) adjusting equipment preparatory to exposing films/sensors, and

(iii) exposing the films and creating the images;

~~*(2) A licensee may authorize a dental assistant who has completed a course of instruction approved by the Oregon Board of Dentistry, and who has passed the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry to place films/sensors, adjust equipment preparatory to exposing films/sensors, and expose the films and create the images under the indirect supervision of a dentist, dental therapist, dental hygienist, or dental assistant who holds an Oregon Radiologic Proficiency Certificate. The dental assistant must submit within six months, certification by an Oregon licensed dentist, dental therapist or dental hygienist that the assistant is proficient to take radiographic images.*~~

~~*(1)*~~ **(2)** A Licensee may authorize the following persons to ~~*place films/sensors, adjust equipment preparatory to exposing films/sensors, and expose the films and create the images*~~ perform the activities in subsection (1) under general supervision:

(a) A dental assistant certified by the Board in radiologic proficiency; or

(b) A radiologic technologist licensed by the Oregon Board of Medical Imaging and certified by the Oregon Board of Dentistry (OBD) who has completed ten (10) clock hours in a Board approved dental radiology course.

(3) To obtain a certificate in radiologic proficiency, a dental assistant must:

(a) Successfully complete a course of instruction approved by the Oregon Board of Dentistry, and pass the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, or comparable exam administered by any other testing entity authorized by the Board, or

(b) Obtain other comparable requirements approved by the Oregon Board of Dentistry; and

(c) After completion of the requirements in (2)(a) or (b), submit certification by an Oregon licensed dentist, dental therapist or dental hygienist that the assistant is proficient to take radiographic images.

(4) A dental assistant may perform the activities in subsection (1) under indirect supervision for the six months following completion of the requirements in (2)(a) or (b).

(5) A dental assistant may perform the activities in subsection (1) under direct supervision after completion of the requirements in subsection (2)(a) or (b) if a certificate in radiologic proficiency was not obtained within six months after completion of the requirements in subsection (2)(a) or (b).

(3) A dental therapist may not order a computerized tomography scan**.**

818-042-0080

Certification — Expanded Function Dental Assistant (EFDA)

The Board may certify a dental assistant as an expanded function assistant **if the assistant submits a completed application, pays the fee and provides evidence of:**

(1)~~*By credential in accordance with*~~ **Satisfaction of the credential requirements in** OAR 818-042-0120, or

~~*(2) If the assistant submits a completed application, pays the fee and provides evidence of;*~~

(2) Certification of Radiologic Proficiency (OAR 818-042-0060) and satisfactory completion of a course of instruction in a program accredited by the Commission on Dental Accreditation; or

(3) Certification of Radiologic Proficiency (OAR 818-042-0060) and

~~*(b) Certification of Radiologic Proficiency (OAR 818-042-0060); and passage of the Oregon Expanded Functions with Infection Control examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board, or prior passage of the Certified Dental Assistant examination or Infection Control Examination and passage of the Oregon Expanded Functions General Dental Assisting exam, or equivalent successor examinations, administered by DANB or any other testing entity authorized by the Board; and certification by an Oregon licensed dentist that the applicant has successfully removed supra-gingival excess cement from four (4) crowns and/or fixed partial dentures (bridges) with hand instruments; placed temporary restorative material in three (3) teeth; preliminarily fitted four (4) crowns to check contacts or to adjust occlusion outside the mouth; removed four (4) temporary crowns for final cementation and cleaned teeth for final cementation; fabricated four (4) temporary crowns and/or fixed partial dentures (bridges) and temporarily cemented the crowns and/or fixed partial dentures (bridges); polished the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis in six (6) patients; placed matrix bands on four (4) teeth prepared for Class II restorations. The dental assistant must submit within six months' certification by a licensed dentist that the dental assistant is proficient to perform all the expanded function duties in subsection (b). If no expanded function certificate is issued within the six months, the dental assistant is no longer able to continue to perform expanded function duties until EFDA certification is achieved.*~~

(a) Successful passage of the following examination requirement:

(i) Oregon Expanded Functions with Infection Control examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board, or

(ii) Certified Dental Assistant examination or Infection Control Examination and passage of the Oregon Expanded Functions General Dental Assisting exam, or equivalent successor examinations, administered by DANB or any other testing entity authorized by the Board; and

(b) Certification by an Oregon licensed dentist that the applicant has successfully:

(i) removed supra-gingival excess cement from four (4) crowns and/or fixed partial dentures (bridges) with hand instruments;

(ii) placed temporary restorative material in three (3) teeth;

(iii) preliminarily fitted four (4) crowns to check contacts or to adjust occlusion outside the mouth;

(iv) removed four (4) temporary crowns for final cementation and cleaned teeth for final cementation;

(v) fabricated four (4) temporary crowns and/or fixed partial dentures (bridges) and temporarily cemented the crowns and/or fixed partial dentures (bridges);

(vi) polished the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis in six (6) patients; and

(vii) placed matrix bands on four (4) teeth prepared for Class II restorations.

(c) A dental assistant may perform the activities in (3)(b) under indirect supervision for six months after passage of a required examination in subsection (3)(a). If the expanded function certificate is not obtained within the six months, the dental assistant is no longer able to continue to perform expanded function duties under indirect supervision.

(d) A dental assistant may perform the activities in subsection (3)(b) under direct supervision after passage of a required examination in subsection (3)(a) if the expanded function certificate was not obtained within six months after completion of the requirements in subsection (3)(a).

818-042-0110

Certification — Expanded Function Orthodontic Dental Assistant (EFODA)

The Board may certify a dental assistant as an expanded function orthodontic assistant **if the assistant submits a completed application, pays the fee and provides evidence of:**

(1) ~~*By credential in accordance with*~~ **Satisfaction of the credential requirements in** OAR 818-042-0120, or

~~*(2) If the assistant submits a completed application, pays the fee and provides evidence of;*~~

(~~*a*~~**2**) Completion of a course of instruction in a program in dental assisting accredited by the American Dental Association Commission on Dental Accreditation; or

(~~*b*~~**3**) **Completion of the following requirements:**

(a) Successful passage of the following examination requirement:

(i) Oregon Orthodontic Expanded Functions with Infection Control examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board, or

(ii) Certified Dental Assistant, Certified Orthodontic Assistant or Infection Control Examination administered by DANB and passage of the Oregon Expanded Functions Orthodontic Assisting exam, or equivalent successor examinations, administered by DANB, or any other testing entity authorized by the Board; and

(b) Certification by an Oregon licensed dentist that the applicant has successfully:

(i) placed and ligated orthodontic wires on ten (10) patients and

(ii) removed bands/brackets and remaining adhesive using an ultrasonic, hand scaler or a slow speed hand piece from teeth on four (4) patients.

~~*The dental assistant must submit within six months' certification by a licensed dentist that the dental assistant is proficient to perform all the expanded function duties in subsection (b). If no expanded function orthodontic certificate is issued within the six months, the dental assistant is no longer able to continue to perform expanded orthodontic function duties until EFODA certification is achieved.*~~

(c) A dental assistant may perform the activities in (3)(b) under indirect supervision for six months after passage of a required examination in subsection (3)(a). If the expanded function orthodontic certificate is not obtained within the six months, the dental assistant is no longer able to continue to perform expanded function duties under indirect supervision.

(d) A dental assistant may perform the activities in subsection (3)(b) under direct supervision after passage of a required examination in subsection (3)(a) if the

expanded function orthodontic certificate was not obtained within six months after completion of the requirements in subsection (3)(a).

818-042-0113

Certification — Expanded Function Preventive Dental Assistants (EFPDA)

The Board may certify a dental assistant as an expanded function preventive dental assistant **if the assistant submits a completed application, pays the fee and provides evidence of:**

(1) ~~*By credential in accordance with*~~ **Satisfaction of the credential requirements in** OAR 818-042-0120, or

~~*(2) If the assistant submits a completed application, pays the fee and provides evidence of;*~~

(~~a~~**2**) Certification of Radiologic Proficiency (OAR 818-042-0060) and satisfactory completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association; or

(3) **Completion of the following requirements:**

(a) Certification of Radiologic Proficiency (OAR 818-042-0060); and

(b) Passage of one of following examination:

(i) Oregon Expanded Functions with Infection Control examination; or

(ii) Coronal Polishing with Infection Control examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board, or

(iii) Infection Control Examination and passage of the Oregon Expanded Functions General Dental Assisting exam or Coronal Polishing exam, or equivalent successor examinations, administered by DANB, or any other testing entity authorized by the Board; and

(c) Certification by an Oregon licensed dentist that the applicant has successfully polished the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains on six (6) patients.

(d) A dental assistant may perform the activities in (3)(c) under indirect supervision for six months after passage of a required examination in subsection (3)(b). If the expanded function preventive certificate is not obtained within the six months, the dental assistant is no longer able to continue to perform expanded function duties under indirect supervision.

(d) A dental assistant may perform the activities in subsection (3)(c) under direct supervision after passage of a required examination in subsection (3)(b) if the expanded function preventive certificate was not obtained within six months after completion of the requirements in subsection (3)(b).

~~*(d) The dental assistant must submit within six months' certification by a licensed dentist that the dental assistant is proficient to perform all the expanded function preventive duties in subsection (b). If no expanded function preventive certificate is issued within the six months, the dental assistant is no longer able to continue to perform expanded function preventive duties until EFPDA certification is achieved.*~~

Discussion: Should the rule be modified to say the Board may.**participate in the Health Professionals' Services Program (HPSP) since the Board is not actively participating?**

818-013-0005
Participation in Health Professionals' Services Program

(1) Effective July 1, 2010, the Board participates in the Health Professionals' Services Program (HPSP).

(a) The Board establishes procedures to process cases of licensees preparatory to transfer to HPSP.

(b) The procedures will be confidential, non-disciplinary, and voluntary.

(c) The Executive Director will have overall management responsibilities for the procedures. The Executive Director will designate Board staff to serve as Diversion Coordinator(s) who will manage and conduct investigations and report to the Board.

(d) The Diversion Coordinator(s) will investigate information related to addiction to, dependence upon, or abuse of alcohol, drugs, or mind altering substances or mental health disorders, by licensees and provide licensees with resources for evaluations, if appropriate.

(2) Only licensees of the Board who meet the referral criteria may be referred by the Board to the HPSP.

(a) The Board may refer a licensee to the HPSP in lieu of public discipline.

(b) In the event a licensee declines to submit to an evaluation or declines referral to HPSP, the Diversion Coordinator(s) will present the matter to the Board for decision and the Board's action may jeopardize the confidential nature of licensee's status as a candidate for, or enrollment in, HPSP.

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**.

Chapter 818

Division 26
ANESTHESIA

818-026-0030
Requirements for Anesthesia Permits

(1) A permit holder who administers sedation shall assure that drugs, drug dosages, and/or techniques used to produce sedation shall carry a margin of safety wide enough to prevent unintended deeper levels of sedation.

(2) No licensee shall induce central nervous system sedation or general anesthesia without first having obtained a permit under these rules for the level of anesthesia being induced.

(3) A licensee may be granted a permit to administer sedation or general anesthesia with documentation of training/education and/or competency in the permit category for which the licensee is applying by any one the following:

(a) Initial training/education in the permit category for which the applicant is applying shall be completed no more than two years immediately prior to application for sedation or general anesthesia permit; or

(b) If greater than two years but less than five years since completion of initial training/education, an applicant must document completion of all continuing education that would have been required for that anesthesia/permit category during that five year period following initial training; or

(c) If greater than two years but less than five years since completion of initial training/education, immediately prior to application for sedation or general anesthesia permit, current competency or experience must be documented by completion of a comprehensive review course approved by the Board in the permit category to which the applicant is applying and must consist of at least one-half (50%) of the hours required by rule for Nitrous Oxide, Minimal Sedation, Moderate Sedation and General Anesthesia Permits. Deep Sedation and General Anesthesia Permits will require at least 120 hours of general anesthesia training.

(d) An applicant for sedation or general anesthesia permit whose completion of initial training/education is greater than five years immediately prior to application, may be granted a sedation or general anesthesia permit by submitting documentation of the requested permit level from another state or jurisdiction where the applicant is also licensed to practice dentistry or dental hygiene, and provides documentation of the completion of at least 25 cases in the requested level of sedation or general anesthesia in the 12 months immediately preceding application; or

(e) Demonstration of current competency to the satisfaction of the Board that the applicant possesses adequate sedation or general anesthesia skill to safely deliver sedation or general anesthesia services to the public.

(4) A licensee holding a nitrous or minimal sedation permit, shall at all times maintain a current BLS for Healthcare Providers certificate or its equivalent.

(5) A licensee holding an anesthesia permit for moderate sedation, deep sedation or general anesthesia at all times maintains a current BLS for Healthcare Providers certificate or its equivalent, and a current Advanced Cardiac Life Support (ACLS) Certificate or Pediatric Advanced Life Support (PALS) Certificate, whichever is appropriate for the patient being sedated. If a licensee permit holder sedates only patients under the age of 12, only PALS is required. If a licensee permit holder sedates only patients age 12 and older, only ACLS is required. If a licensee permit holder sedates patients younger than 12 years of age as well as older than 12 years of age, both ACLS and PALS are required. For licensees with a moderate sedation permit only, successful completion of the American Dental Association's course "Recognition and Management of Complications during Minimal and Moderate Sedation" at least every two years may be substituted for ACLS, but not for PALS.

(6) Advanced Cardiac Life Support (ACLS) and or Pediatric Advanced Life Support (PALS) do not serve as a substitute for Healthcare Provider Basic Life Support (BLS).

(7) When a dentist utilizes a single oral agent to achieve anxiolysis only, no anesthesia permit is required. **The dentist shall follow all rules and requirement listed under ORS minimal sedation 818-026-0050 except for obtaining or renewing the minimal sedation permit. The dentist will provide Initial training and continuing education certificates upon written request of the Board.**

(8) The applicant for an anesthesia permit must pay the appropriate permit fee, submit a completed Board-approved application and consent to an office evaluation.

(9) Permits shall be issued to coincide with the applicant's licensing period.

Statutory/Other Authority: ORS 679 & 680
Statutes/Other Implemented: ORS 679.250
History:
OBD 2-2019, amend filed 10/29/2019, effective 01/01/2020
OBD 2-2018, amend filed 10/04/2018, effective 01/01/2019
OBD 2-2016, f. 11-2-16, cert. ef. 3-1-17
OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12
OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10
OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08

OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05
OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05
OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05
OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03
OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98

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

818-026-0050
Minimal Sedation Permit

Minimal sedation and nitrous oxide sedation.

(1) The Board shall issue a Minimal Sedation Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and

(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or

(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and

(h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.

(3) Before inducing minimal sedation, a dentist permit holder who induces minimal sedation shall:

(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for minimal sedation;

(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;

(c) Certify that the patient is an appropriate candidate for minimal sedation; and

(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.

(4) No permit holder shall have more than one person under minimal sedation or nitrous oxide sedation at the same time.

(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental assistant, when directed by a dentist permit holder, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist permit holder under the direct supervision of a dentist permit holder.

(6) A patient under minimal sedation shall be visually monitored at all times, including recovery phase. The record must include documentation of all medications administered with dosages, time intervals and route of administration. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.

(7) Persons serving as anesthesia monitors for minimal sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS), or its equivalent, shall be trained and competent in monitoring patient vital signs, in the use of monitoring and emergency equipment appropriate for the level of sedation utilized. ("competent" means displaying special skill or knowledge derived from training and experience.)

(8) The patient shall be monitored as follows:

(a) Color of mucosa, skin or blood must be evaluated continually. Patients must have continuous monitoring using pulse oximetry. The patient's response to verbal stimuli, blood pressure, heart rate, pulse oximetry and respiration shall be monitored and documented every fifteen minutes, if they can reasonably be obtained.

(b) A discharge entry shall be made by the dentist permit holder in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.

(9) The dentist permit holder shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

(a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

(b) The patient is alert and oriented to person, place and time as appropriate to age and preoperative psychological status;

(c) The patient can talk and respond coherently to verbal questioning;

(d) The patient can sit up unaided;

(e) The patient can ambulate with minimal assistance; and

(f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

(g) A dentist permit holder shall not release a patient who has undergone minimal sedation except to the care of a responsible third party.

(10) The permit holder shall make a discharge entry in the patient's record indicating the patient's condition upon discharge.

(11) Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide documentation of a current BLS for Healthcare Providers certificate or its equivalent. In addition, Minimal Sedation Permit holders must also complete four (4) hours of continuing education in one or more of the following areas every two years: sedation, physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or pharmacology of drugs and agents used in sedation. Training taken to maintain current BLS for Healthcare Providers certificate, or its

equivalent, may not be counted toward this requirement. Continuing education hours may be counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.

Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.250(7) & 679.250(10)
History:
OBD 2-2024, amend filed 10/28/2024, effective 01/01/2025
OBD 1-2024, amend filed 03/08/2024, effective 05/01/2024
OBD 1-2021, amend filed 11/08/2021, effective 01/01/2022
OBD 2-2019, amend filed 10/29/2019, effective 01/01/2020
OBD 2-2018, amend filed 10/04/2018, effective 01/01/2019
OBD 2-2016, f. 11-2-16, cert. ef. 3-1-17
OBD 4-2015, f. 9-8-15, cert. ef. 1-1-16
OBD 1-2014, f. 7-2-14, cert. ef. 8-1-14
OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10
OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05
OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05
OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03
OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99

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

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.

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.

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.

DRAFT statement on the use of AI

Artificial/Augmented Intelligence (AI) is rapidly evolving and becoming increasingly integrated into dentistry. AI tools range from administrative applications that assist with documentation and communication to advanced technologies that may support diagnosis, treatment planning, imaging analysis, and other aspects of patient care.

AI has the potential to improve efficiency, enhance clinical decision-making, reduce administrative burdens, and allow dental professionals to devote more time to patient care. As these technologies continue to develop, dental professionals should understand both their potential benefits and their limitations.

Regardless of how AI is introduced or used in a dental practice, the Oregon Board of Dentistry will continue to hold its licensees responsible for the care they provide. Licensees are expected to use AI and other technologies responsibly, ethically, and in a manner consistent with applicable laws and professional standards.

Dental professionals who use AI should have a basic understanding of the technology, including its capabilities and limitations, and should appropriately evaluate AI-generated information before relying on it in patient care. AI should support (not replace) a licensee's independent clinical judgment and professional responsibility.

The OBD encourages licensees to remain informed about emerging AI technologies relevant to dentistry and to incorporate these tools thoughtfully, with patient safety, privacy, and quality of care remaining paramount.

CORRESPONDENCE

Board Inquiry:

I wanted to check in and see if hygienists in Oregon without a Restorative Function Permit can apply Curodont?

Dr. Smorra Response:

I am going to have the full Board weigh in on this question at the next Board meeting on August 21, 2026.

Prior to submitting this into the public informational packet, can you clarify for the Board these questions:

1. What are the clinical indications in which this product will be utilized?
2. What are the specific procedural steps that will be performed when using this product?
3. What CDT codes will be utilized?
4. Provide the manufacturers package insert for the specific product you are referencing.

Under the current DPA, under general supervision, a Registered Dental Hygienist (RDH) may administer, dispense, and prescribe antimicrobial agents, fluorides, and varnishes in the performance of dental hygiene functions.

The Board recently underwent multiple days of strategic planning to create goals for the next few years. One goal is for the Board to discuss future rule changes regarding the placement of resin infiltration products, scaffolding products, peptides, and other miscellaneous remineralization techniques. As biomimetic and regenerative dentistry has rapidly evolved the DPA rules may also need to evolve.

The ADA has also been discussing changes to code D2991 “Application of hydroxyapatite regeneration medicament – per tooth" which they currently list with other restorative codes. RDH’s who hold a Restorative Functions Endorsement (RFE) can place restorations as described under 818-035-0072. Additionally, consult with the American Dental Association to review any official statements regarding this products and coding requirements. It is also worth reviewing the ADA guide titled “D1355 – Guide to Reporting Caries Preventive Medicament Application. Finally, check with individual insurance plans to determine coverage for your patients.

Below are some excerpts from the Dental Practice Act for your review and interpretation:

ORS 679.010

... "(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"...

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;

(3) Extract any tooth;

(4) Perform intraoral adjustment of fixed and removable prosthesis or appliances.

(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 indirect supervision.

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

(11) Act in violation of Board statute or rules.

818-035-0030
Additional Functions of Dental Hygienists

(1) In addition to functions set forth in ORS 679.010, a dental hygienist may perform the following functions under the general supervision of a licensed dentist:

(a) Make preliminary intra-oral and extra-oral examinations and record findings;

(b) Place periodontal dressings;

(c) Remove periodontal dressings or direct a dental assistant to remove periodontal dressings;

(d) Perform all functions delegable to dental assistants and expanded function dental assistants providing that the dental hygienist is appropriately trained;

(e) Administer and dispense antimicrobial solutions or other antimicrobial agents in the performance of dental hygiene functions.

(f) Prescribe, administer and dispense fluoride, fluoride varnish, antimicrobial solutions for mouth rinsing or other non-systemic antimicrobial agents.

(g) Use high-speed handpieces to polish restorations and to remove cement and adhesive material.

(h) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.

(i) Perform all aspects of teeth whitening procedures.

(2) A dental hygienist may perform the following functions at the locations and for the persons described in ORS 680.205(1) and (2) without the supervision of a dentist:

(a) Determine the need for and appropriateness of sealants or fluoride; and

(b) Apply sealants or fluoride.

(3) In addition to functions set forth in ORS 679.010, a dental hygienist may perform the following functions under the indirect supervision of a licensed dentist:

(a) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist 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.

(b) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist 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.

(4) Perform extraoral adjustment of fixed and removable prosthesis or appliances.

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 Western Regional Examining Board's Restorative Examination or other equivalent examinations approved by the Board within the last five years; or

(b) If successful passage of the Western Regional Examining Board's 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.

818-001-0002 Definitions

As used in OAR chapter 818:

... “(7) "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.”...

Division 42

DENTAL ASSISTING

818-042-0040

Prohibited Acts

No licensee may authorize any dental assistant to perform the following acts:

(1) Diagnose or plan treatment.

(2) Cut hard or soft tissue.

(3) Any Expanded Function duty (OAR 818-042-0070 and OAR 818-042-0090) or Expanded Orthodontic Function duty (OAR 818-042-0100) or Restorative Functions (OAR 818-042-0095 or Expanded Preventive Duty (OAR 818-042-0113 and OAR 818-042-0114) or Expanded Function Anesthesia (OAR 818-042-0115) without holding the appropriate certification.

(4) Correct or attempt to correct the malposition or malocclusion of teeth except as provided by OAR 818-042-0100.

(5) Adjust or attempt to adjust any orthodontic wire, fixed or removable appliance or other structure while it is in the patient’s mouth.

(6) Administer any drug except as allowed under the indirect supervision of a Licensee, such as fluoride, topical anesthetic,desensitizing agents, topical tooth whitening agents, over the counter medications per package instructions or drugs administered pursuant to OAR 818-026-0050(5), OAR 818-026-0060(12), OAR 818-026-0065(12), OAR 818-026-0070(12) and as provided in OAR 818-042-0070, OAR 818-042-0090 and OAR 818-042-0115.

(7) Prescribe any drug.

(8) Place periodontal packs.

(9) Start nitrous oxide.

(10) Remove stains or deposits except as provided in OAR 818-042-0070.

(11) Use ultrasonic equipment intra-orally except as provided in OAR 818-042-0100.

(12) Use a high-speed handpiece or any device that is operated by a high-speed handpiece intra-orally except as provided in OAR 818-042-0095, and only for the purpose of adjusting occlusion, contouring, and polishing restorations on the tooth or teeth that are being restored.

(13) Use lasers, except laser-curing lights.

(14) Use air abrasion or air polishing.

(15) Remove teeth or parts of tooth structure.

(16) Cement or bond any fixed prosthesis or orthodontic appliance including bands, brackets, retainers, tooth moving devices, or orthopedic appliances except as provided in OAR 818-042-0100.

(17) Condense and carve permanent restorative material except as provided in OAR 818-042-0095.

(18) Place any type of retraction material subgingivally except as provided in OAR 818-042-0090.

(19) Apply denture relines except as provided in OAR 818-042-0090(2).

(20) Expose radiographs without holding a current Certificate of Radiologic Proficiency issued by the Board (OAR 818-042-0050 and OAR 818-042-0060) except while taking a course of instruction approved by the Oregon Health Authority, Oregon Public Health Division, Office of Environmental Public Health, Radiation Protection Services, or the Oregon Board of Dentistry.

(21) Use the behavior management techniques known as Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.

(22) Perform periodontal assessment.

(23) Place or remove healing caps or healing abutments, except under indirect supervision.

(24) Place implant impression copings, except under indirect supervision.

(25) Any act in violation of Board statute or rules.

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 Western Regional Examining Board's Restorative Examination or other equivalent examinations approved by the Board within the last five years, or (b) If successful passage of the Western Regional Examining Board's 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.

Response for Board review and discussion:

Thank you so much for your quick response. Please see my answers below, organized by number:

1. Curodont should be considered for patients with early enamel demineralization or incipient, non-cavitated carious lesions, including white spot lesions. It can be used on smooth, interproximal, and occlusal surfaces when the tooth structure is still intact and the lesion has not progressed to cavitation.
2. Please see attached for the steps (CRFP IFU Document)
3. D2991
4. Please see the attached Box Drug Facts, Box Image, and MSDS sheet.

If there is any additional information I can provide, please let me know.

I look forward to hearing what the ODB decides regarding Curodont permissions for hygienists. Thank you and have a wonderful day.

1x UNIT A AND 1x UNIT B MUST BE USED TOGETHER AND FOR 1 LESION.

Sodium fluoride 0.05% /
Anticavity fluoride treatment rinse.
Contains 10 units A and 10 units B
10 x 0.0085 fl. oz. (10 x 0.25ml)

FOR PROFESSIONAL USE ONLY
IMPORTANT: READ DIRECTIONS FOR PROPER USE

ᵛVARDIS
PROFESSIONAL
SWITZERLAND

SAME FORMULATION
NEW AND ENHANCED APPLICATION PROTOCOL

CURODONT™ REPAIR
FLUORIDE PLUS

Drug Facts

Active ingredients — Purpose

Sodium fluoride 0.05% (0.02% w/v fluoride ion)........Anticavity

Use

• Aids in the prevention of dental cavities.

Warnings

For Topical Use Only
For Professional Office Use Only

Do not use
• at home or for unsupervised consumer use

Keep out of reach of children. If more than used for rinsing is accidentally swallowed, get medical help or contact a Poison Control Center right away.

Directions

See package insert for specific instructions for product application. Adults and children: Do not swallow the rinse. Do not eat or drink for 30 minutes after application.Children under 6 years of age: under supervision of a dentist or doctor.

Product Preparation
• From the Curodont Repair Fluoride Plus box, retrieve one **UNIT A** and peel off the cover.
• From the pouch, retrieve one **UNIT B.** Put the remaining unopened **UNIT B** droppers back in the pouch for future use. Do not replace **UNIT B** with any other liquid.
• Squeeze out the contents of **UNIT B** into the **UNIT A** receptacle to fully immerse the sponge. Minimal liquid inadvertently left over in **UNIT B** is acceptable.
• **UNIT A** and **UNIT B** must always be used together. Each saturated sponge is intended to be used in a single patient and to treat **one lesion**.
One lesion defined as:
• One interproximal site with one or both surface(s) involved
• One occlusal or smooth surface
• One demineralized white spot lesion
• While letting the sponge absorb the liquid (for at least 2 minutes), proceed with preparing the treatment site.

Patient preparation
• Perform oral prophylaxis, including removal of the salivary pellicle using your preferred method [pumice/prophy paste (with or without fluoride)/air polisher]. Rinse and dry.
• Etch using 35% phosphoric acid for not more than 20 seconds. For interproximal sites, use unwaxed dental floss to apply the etchant, if needed. Rinse and dry.
• Once the sponge is fully saturated and soft, use basic aids such as cotton rolls, saliva ejector, dry aids, etc. at the treatment site. (Rubber dam is not necessary).

Application
• Use cotton pliers/a hemostat to pick up the saturated sponge from one of its corners.
• Press the sponge on/near the lesion surface until the formula is deposited (approx. 5 seconds).
• For interproximal sites, press the saturated sponge starting from the lingual embrasure and then the buccal embrasure. Separators or wedges are not needed.
• Instruct the patient not to eat, drink, spit or rinse for 30 minutes after application. Provide routine oral hygiene instructions. Discharge. Dispose the used sponge and dropper.

Other information

• Store at room temperature in a dry, cool place
• Single use only
• TAMPER EVIDENT: Do not use if safety packaging seal is broken or missing.

Inactive ingredients

anhydrous citric acid, chlorhexidine gluconate, hypromellose, oligopeptide-104, sodium hydroxide, trehalose dihydrate, tromethamine, water

Questions? Comments?

Call 1-800-217-0064 or write vVardis Inc., at 651 N. Broad St., Middletown, DE 19709

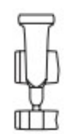
SAME FORMULATION
NEW AND ENHANCED APPLICATION PROTOCOL

THIS PACK CONTAINS

UNIT A

10 UNITS

UNIT B



10 UNITS

1x UNIT A AND 1x UNIT B
MUST BE USED TOGETHER AND FOR 1 LESION

SAME FORMULATION
NEW AND ENHANCED APPLICATION PROTOCOL

ᵛVARDIS
PROFESSIONAL
SWITZERLAND

7 649991 541357

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CURODONT™ REPAIR
FLUORIDE PLUS

Sodium fluoride 0.05% /
Anticavity fluoride treatment rinse.
Contains 10 units A and 10 units B
10 x 0.0085 fl. oz. (10 x 0.25ml)

FOR PROFESSIONAL USE ONLY
IMPORTANT: READ DIRECTIONS FOR PROPER USE

VVARDIS.COM

To onboard your clinic, scan below QR code and register in less than 30 seconds:

Pink = Unvarnished
40 x 55 mm

Manufactured for
credentis ag
Gubelstrasse 24
6300 Zug
Switzerland

Drug Facts

Active ingredients — Purpose

Sodium fluoride 0.05% (0.02% w/v fluoride ion).....Anticavity

Use

- Aids in the prevention of dental cavities.
  - Anticavity dental rinse
  - Enamel mineralizer
  - Repairs white spots

Warnings

For Topical Use Only
For Profession Office Use Only

Do not use

- at home or for unsupervised consumer use

Keep out of reach of children. If more than used for rinsing is accidentally swallowed, get medical help or contact a Poison Control Center right away.

Directions

- See package insert for specific instructions for product activation
- From the Curodont Repair Fluoride Plus box, retrieve one UNIT A and peel off the cover.
- From the pouch, retrieve one UNIT B. Keep the remaining unused UNIT B in the pouch for future use. Do not replace UNIT B with water, saline, or any other liquid. UNIT A and UNIT B are intended to always be used together.
- Pour the entire contents of UNIT B into the UNIT A receptacle containing the sponge, letting it absorb the liquid for at least 5 minutes to fully activate the proprietary formulation. Meanwhile, proceed with preparing the treatment site. Each set of UNIT A and UNIT B is intended to treat one initial lesion in a single patient.
- Perform oral prophylaxis on the teeth to be treated, including removal of the salivary pellicle using your preferred method (pumice/prophy paste/air polisher/2% sodium hypochlorite). Rinse and dry.

Drug Facts *(continued)*

- Etch using 35 % phosphoric acid for 20 seconds. For interproximal sites, use unwaxed dental floss to apply the etchant, if needed. Rinse.
- After ensuring that the sponge in UNIT A is fully soaked and soft, isolate the treatment site using basic aids such as cotton rolls, saliva ejector, dry aids, etc. Rubber dam is not necessary.
- Use cotton pliers to firmly grip the saturated sponge in UNIT A from one of its corners.
- Press the sponge on the lesion surface until the formula is deposited and the sponge starts to appear dry. Use one saturated sponge per lesion. One 'lesion' is defined as one lesion on occlusal/buccal/lingual surfaces or one interproximal site with lesions on one or both adjacent surfaces.
- For interproximal sites, press the saturated sponge starting from the lingual embrasure, moving to the buccal and, for any residual formula, the occlusal. Separators or wedges are not needed.
- Wait for 5 minutes before asking the patient to expectorate residues, if any. Dispose the used UNIT A and UNIT B.
- Instruct the patient not to rinse, eat or drink for 30 minutes.

Other information

- Store at room temperature in a dry, cool place
- Single use only
- TAMPER EVIDENT: Do not use if safety packaging seal is broken or missing.

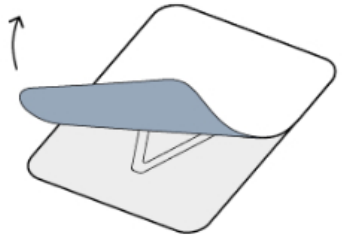
Inactive ingredients

anhydrous citric acid, chlorhexidine gluconate, hypromellose, oligopeptide-104, sodium hydroxide, trehalose dihydrate, tromethamine, water

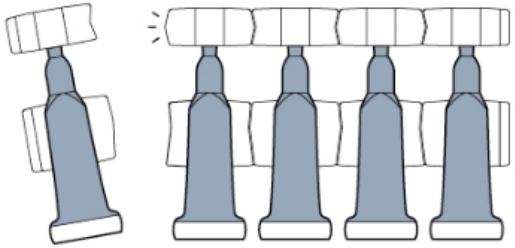
Questions? Comments?

Call 1-800-217-0064 or write vVardis Inc., at 651 N. Broad St., Middletown, DE 19709

Product Preparation

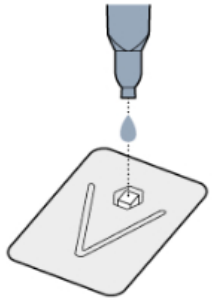


Carefully peel the cover off **UNIT A** to expose the sponge.



Retrieve one **UNIT B** dropper. Put the remaining unopened dropper(s) back in the pouch.

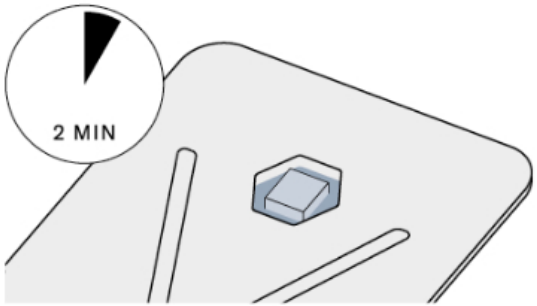
Immerse the sponge fully with **UNIT B** liquid* and let it soak for at least 2 minutes. Do not replace **UNIT B** with any other liquid.



*Minimal liquid left over in the dropper inadvertently is acceptable.

Patient Preparation

While the sponge is soaking proceed with preparing the treatment site:

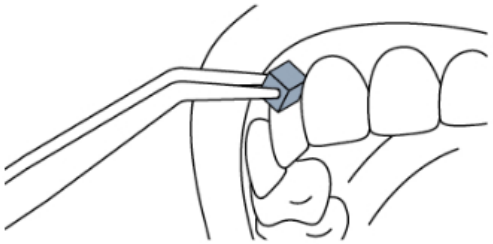


- Clean the treatment site using one of your preferred methods, i.e.:
  - Pumice
  - Prophy paste (with or without fluoride)
  - Air Polisher

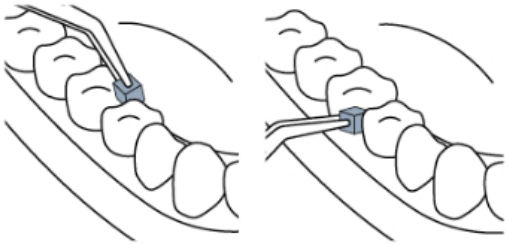
- Rinse and dry.
- Etch using 35 % phosphoric acid for not more than 20 seconds. Rinse and dry.
- Once the sponge is fully saturated and soft, place cotton rolls around the treatment site.

Application

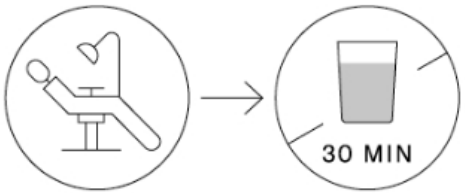
- Use cotton pliers/hemostat to pick up the soft saturated sponge.
- Press it on/near the lesion for 5 seconds.
- Use one sponge per lesion.



For interproximal application, apply from the lingual embrasure followed by the buccal embrasure.



- Instruct the patient not to eat, drink, spit or rinse for 30 minutes after application.
- Provide routine oral hygiene instructions.
- Discharge.
- Dispose the used sponge and dropper.



Safety Data Sheet

according to 29 CFR 1910.1200(g)

1. Identification

Product identifier

Curodont Repair Fluoride Plus

Recommended use of the chemical and restrictions on use

Use of the substance/mixture

mouthwash

Uses advised against

Any non-intended use.

Details of the supplier of the safety data sheet

Company name:	vVARDIS AG
Street:	Sihlbruggstrasse 109
Place:	CH-6340 Baar
Telephone:	+41415014230
Internet:	https://eu.vvardis.com/
Responsible Department:	spc@vvardis.com

Emergency phone number: +41415014230 (9:00-17:00, Mo.-Fr.)

2. Hazard(s) identification

Classification of the chemical

29 CFR Part 1910.1200

Serious eye damage/eye irritation: Eye Irrit. 2A

Label elements

29 CFR Part 1910.1200

Signal word: Warning

Pictograms:

Hazard statements

Causes serious eye irritation

Precautionary statements

If medical advice is needed, have product container or label at hand.
Keep out of reach of children.
Read label before use.
Wash hands thoroughly after handling.
If in eyes: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do.
Continue rinsing.
If eye irritation persists: Get medical advice/attention.

Hazards not otherwise classified

The components in this formulation (>0,1%) do not meet the criteria for classification as PBT or vPvB.

3. Composition/information on ingredients

Mixtures

Hazardous components

CAS No	Components	Quantity

18472-51-0	D-gluconic acid, compound with N,N''-bis(4-chlorophenyl) -3,12-diimino-2,4,11,13-tetraazatetradecanediamidine (2:1)	ca. 1 %

4. First-aid measures

Description of first aid measures

General information

In case of accident or unwellness, seek medical advice immediately (show directions for use or safety data sheet if possible).

After inhalation

In case of accident by inhalation: remove casualty to fresh air and keep at rest. In case of respiratory tract irritation, consult a physician.

After contact with skin

Gently wash with plenty of soap and water. In case of skin irritation, seek medical treatment.

After contact with eyes

Rinse cautiously with water for several minutes. In case of troubles or persistent symptoms, consult an ophthalmologist.

After ingestion

Rinse mouth thoroughly with water. Let water be drunken in little sips (dilution effect). Do NOT induce vomiting. In all cases of doubt, or when symptoms persist, seek medical advice.

Most important symptoms and effects, both acute and delayed

No information available.

Indication of any immediate medical attention and special treatment needed

Treat symptomatically.

5. Fire-fighting measures

Extinguishing media

Suitable extinguishing media

Carbon dioxide (CO2) Dry extinguishing powder. alcohol resistant foam. Atomized water.

Unsuitable extinguishing media

High power water jet.

Specific hazards arising from the chemical

Can be released in case of fire: Carbon monoxide, Carbon dioxide (CO2).

Special protective equipment and precautions for fire-fighters

In case of fire: Wear self-contained breathing apparatus.

Additional information

Collect contaminated fire extinguishing water separately. Do not allow entering drains or surface water. Co-ordinate fire-fighting measures to the fire surroundings.

6. Accidental release measures

Personal precautions, protective equipment and emergency procedures

General advice

See protective measures under point 7 and 8.

For non-emergency personnel

Wear personal protection equipment (refer to section 8).

For emergency responders

No special measures are necessary.

Environmental precautions

Discharge into the environment must be avoided.

Methods and material for containment and cleaning up

For containment

Absorb with liquid-binding material (e.g. sand, diatomaceous earth, acid- or universal binding agents).
Treat the recovered material as prescribed in the section on waste disposal.

For cleaning up

Clean contaminated objects and areas thoroughly observing environmental regulations.

Reference to other sections

Safe handling: see section 7
Personal protection equipment: see section 8
Disposal: see section 13

7. Handling and storage

Precautions for safe handling

Advice on safe handling

Wear suitable protective clothing. (See section 8.)

Advice on protection against fire and explosion

Usual measures for fire prevention.

Advice on general occupational hygiene

Always close containers tightly after the removal of product. Do not eat, drink, smoke or sneeze at the workplace. Wash hands before breaks and after work.

Further information on handling

General protection and hygiene measures: See section 8.

Conditions for safe storage, including any incompatibilities

Requirements for storage rooms and vessels

Keep container tightly closed in a cool, well-ventilated place.

Hints on joint storage

Do not store together with: Explosives. Oxidizing solids. Oxidizing liquids. Radioactive substances. Infectious substances. Food and animal feedingstuff.

Further information on storage conditions

Keep the packing dry and well sealed to prevent contamination and absorbtion of humidity.
Recommended storage temperature: 20°C
Protect against: frost. UV-radiation/sunlight. heat. Humidity

8. Exposure controls/personal protection

Control parameters

Exposure limits

CAS No.	Substance	ppm	mg/m³	f/cc	Category	Origin
-	Fluorides (as F)	-	2.5		TWA (8 h)	PEL
7681-49-4	Sodium fluoride (as F)	-	2.5		TWA (8 h)	REL

Additional advice on limit values

The following constituents are the only constituents of the product which have a PEL, TLV or other recommended exposure limit. At this time, the other constituents have no known exposure limits.

Exposure controls

Appropriate engineering controls

Technical measures and the application of suitable work processes have priority over personal protection equipment.

Provide adequate ventilation.

Individual protection measures, such as personal protective equipment

Eye/face protection

Wear safety glasses; chemical goggles (if splashing is possible). Standards: EN 166 or 29 CFR 1910.133

Hand protection

Wear suitable gloves.
Suitable material:
FKM (fluororubber). - Thickness of the glove material 0,4 mm
Breakthrough time >= 8 h
Butyl rubber. - Thickness of the glove material 0,5 mm
Breakthrough time >= 8 h
CR (polychloroprenes, Chloroprene rubber). - Thickness of the glove material 0,5 mm
Breakthrough time >= 8 h
NBR (Nitrile rubber). - Thickness of the glove material 0,35 mm
Breakthrough time >= 8 h
PVC (Polyvinyl chloride). - Thickness of the glove material 0,5 mm
Breakthrough time >= 8 h
For special purposes, it is recommended to check the resistance to chemicals of the protective gloves mentioned above together with the supplier of these gloves.
The selected protective gloves should satisfy the specifications of standards like EN 374.
Before using check leak tightness / impermeability. In the case of wanting to use the gloves again, clean them before taking off and air them well.

Skin protection

Suitable protective clothing: Lab apron.

Respiratory protection

With correct and proper use, and under normal conditions, breathing protection is not required.
Respiratory protection necessary at:
Exceeding exposure limit values
Suitable respiratory protective equipment: half-mask with filter EN 149 or 29 CFR 1910.134 .
The filter class must be suitable for the maximum contaminant concentration (gas/vapour/aerosol/particulates) that may arise when handling the product. If the concentration is exceeded, self-contained breathing apparatus must be used.

Environmental exposure controls

No special precautionary measures are necessary.

9. Physical and chemical properties

Information on basic physical and chemical properties

Physical state:	liquid
Color:	clear
Odor:	characteristic

Changes in the physical state

Melting point/freezing point:	not determined
Boiling point or initial boiling point and boiling range:	not determined

Sublimation point:	not determined
Softening point:	not determined
Pour point:	not determined
Flash point:	not determined

Explosive properties
none

Lower explosion limits:	not determined
Upper explosion limits:	not determined
Auto-ignition temperature:	not determined

Self-ignition temperature

Gas:	not determined
Decomposition temperature:	not determined

Oxidizing properties
none

pH-Value (at 20 °C):	7,48
Viscosity / dynamic:	not determined
Viscosity / kinematic:	not determined
Flow time:	not determined
Water solubility:	not determined

Solubility in other solvents
not determined

Partition coefficient n-octanol/water:	SECTION 12: Ecological information
Vapor pressure:	not determined
Density (at 20 °C):	0,9990 g/cm³
Relative vapour density:	not determined

Other information

Information with regard to physical hazard classes

Sustaining combustion:	Not sustaining combustion

Other safety characteristics

Solvent separation test:	not determined
Solvent content:	not determined
Solid content:	not determined
Evaporation rate:	not determined

Further Information

10. Stability and reactivity

Reactivity
No information available.

Chemical stability
Stability: Stable
The product is chemically stable under recommended conditions of storage, use and temperature.

Possibility of hazardous reactions
Hazardous reactions: Will not occur
No information available.

Conditions to avoid

Protect against: UV-radiation/sunlight. heat.

Incompatible materials

Materials to avoid: Oxidising agent, strong. Reducing agents, strong.

Hazardous decomposition products

Can be released in case of fire: Carbon monoxide, Carbon dioxide (CO2).

11. Toxicological information

Information on toxicological effects

Route(s) of Entry

Ingestion: May be harmful if swallowed. Inhalation: May be harmful if inhaled. Skin contact: May cause irritation. Eye contact: May cause irritation.

Toxicocinetics, metabolism and distribution

No data available.

Acute toxicity

Based on available data, the classification criteria are not met.

CAS No	Components				
	Exposure route	Dose	Species	Source	Method
18472-51-0	D-gluconic acid, compound with N,N''-bis(4-chlorophenyl)-3,12-diimino-2,4,11,13-tetraazatetradecanediamidine (2:1)				
	oral	LD50 2270 mg/kg	Rat	ECHA Dossier	OECD Guideline 401
	dermal	LD50 > 5000 mg/kg	Rabbit	ECHA Dossier	EPA - Proposed Guidelines for Tox

Irritation and corrosivity

Causes serious eye irritation

Skin corrosion/irritation: Based on available data, the classification criteria are not met.

Sensitizing effects

Based on available data, the classification criteria are not met.

Carcinogenic/mutagenic/toxic effects for reproduction

Based on available data, the classification criteria are not met.

Specific target organ toxicity (STOT) - single exposure

Based on available data, the classification criteria are not met.

Specific target organ toxicity (STOT) - repeated exposure

Based on available data, the classification criteria are not met.

Carcinogenicity (OSHA): No ingredient of this mixture is listed.

Carcinogenicity (IARC): Fluorides (CAS 16984-48-8) inorganic, used in drinking-water is listed in group 3.

Carcinogenicity (NTP): No ingredient of this mixture is listed.

Aspiration hazard

Based on available data, the classification criteria are not met.

Specific effects in experiment on an animal

No data available.

Information on other hazards

Endocrine disrupting properties

No data available.

12. Ecological information

Ecotoxicity

The product has not been tested.

CAS No	Components						
	Aquatic toxicity	Dose		[h] | [d]	Species	Source	Method
18472-51-0	D-gluconic acid, compound with N,N''-bis(4-chlorophenyl)-3,12-diimino-2,4,11,13-tetraazatetradecanediamidine (2:1)						
	Acute fish toxicity	LC50 mg/l	2,08	96 h	Danio rerio	ECHA Dossier	OECD Guideline 203
	Acute algae toxicity	ErC50 mg/l	0,081	72 h	Desmodesmus subspicatus	ECHA Dossier	OECD Guideline 201
	Acute crustacea toxicity	EC50 mg/l	0,087	48 h	Daphnia magna	ECHA Dossier	OECD Guideline 202
	Crustacea toxicity	NOEC mg/l	0,0206	21 d	Daphnia magna	ECHA Dossier	OECD Guideline 211
	Acute bacteria toxicity	(EC50	25 mg/l)	3 h	activated sludge of a predominantly domestic sewage	ECHA Dossier	OECD Guideline 209

Persistence and degradability

The product has not been tested.

CAS No	Components			
	Method	Value	d	Source
	Evaluation			
18472-51-0	D-gluconic acid, compound with N,N''-bis(4-chlorophenyl)-3,12-diimino-2,4,11,13-tetraazatetradecanediamidine (2:1)			
	OECD 301A / ISO 7827 / EEC 92/69 annex V, C.4-A	71	28	ECHA Dossier
	Readily biodegradable (according to OECD criteria).			

Bioaccumulative potential

No indication of bioaccumulation potential.

Partition coefficient n-octanol/water

CAS No	Components	Log Pow
18472-51-0	D-gluconic acid, compound with N,N''-bis(4-chlorophenyl) -3,12-diimino-2,4,11,13-tetraazatetradecanediamidine (2:1)	-1,81

BCF

CAS No	Components	BCF	Species	Source
18472-51-0	D-gluconic acid, compound with N,N''-bis(4-chlorophenyl) -3,12-diimino-2,4,11,13-tetraazatetrade canediamidine (2:1)	42	Leuciscus idus melanotus	Ecotoxicol. Environ.

Mobility in soil

No data available.

Endocrine disrupting properties

This product does not contain a substance that has endocrine disrupting properties with respect to non-target organisms as no components meets the criteria.

The aforementioned statement applies to substances contained in the product with a minimum content of 0.1%.

Other adverse effects

No data available.

Further information

Do not allow to enter into surface water or drains.

13. Disposal considerations

Waste treatment methods

Disposal recommendations

Observe in addition any national regulations! Consult the local waste disposal expert about waste disposal.
Non-contaminated packages may be recycled.

RCRA Hazardous wastes (Resource Conservation and Recovery Act)

None

Contaminated packaging

Handle contaminated packages in the same way as the substance itself.

14. Transport information

US DOT 49 CFR 172.101

Proper shipping name:	Not a hazardous material with respect to these transport regulations. && Not controlled under DOT

Marine transport (IMDG)

UN number or ID number:	No dangerous good in sense of this transport regulation.
UN proper shipping name:	No dangerous good in sense of this transport regulation.
Transport hazard class(es):	No dangerous good in sense of this transport regulation.
Packing group:	No dangerous good in sense of this transport regulation.

Air transport (ICAO-TI/IATA-DGR)

UN number or ID number:	No dangerous good in sense of this transport regulation.
UN proper shipping name:	No dangerous good in sense of this transport regulation.
Transport hazard class(es):	No dangerous good in sense of this transport regulation.
Packing group:	No dangerous good in sense of this transport regulation.

Environmental hazards

ENVIRONMENTALLY HAZARDOUS: No

Special precautions for user

See section 8.

Transport in bulk according to Annex II of MARPOL 73/78 and the IBC Code

not relevant

15. Regulatory information

U.S. Regulations

National Inventory TSCA

All components are listed in the TSCA 8 (b) inventory as "active" or exempted.

National regulatory information

SARA Section 304 CERCLA:
Sodium fluoride (7681-49-4): Reportable quantity = 1,000 (454) lbs. (kg)
SARA Section 311/312 Hazards:
D-gluconic acid, compound with N,N''-bis(4-chlorophenyl)-3,12-diimino-2,4,11,13
-tetraazatetradecanediamidine (2:1) (18472-51-0): Immediate (acute) health hazard
Sodium fluoride (7681-49-4): Immediate (acute) health hazard

State Regulations

Safe Drinking Water and Toxic Enforcement Act of 1986 (Proposition 65, State of California)

This product can not expose you to chemicals known to the State of California to cause cancer, birth defects or other reproductive harm.

Additional information

This preparation is hazardous in the sense of regulation 29 CFR Part 1910.1200.

16. Other information

Hazardous Materials Information Label (HMIS)

Health:	1
Flammability:	0
Physical Hazard:	0
Personal Protection:	A

NFPA Hazard Ratings

Health:	1
Flammability:	0
Reactivity:	0
Unique Hazard:	-

Changes

Revision date:	03/31/2022
Revision No:	1,0

Rev. 1.0; Initial release: 31.03.2022

Abbreviations and acronyms

ACGIH:American Conference of Governmental Industrial Hygienists
ASTM: American Society for Testing and Materials.
ATE: acute toxicity estimate
BCF: Bio concentration factor
ECHA: European Chemicals Agency
CAS: Chemical Abstracts Service
CFR: Code of Federal Regulations
DOT: Department of Transportation
d: days
EC50: Half maximal effective concentration
EN: European Norm
EPA: Environmental Protection Agency
GHS: Globally Harmonized System of Classification and Labelling of Chemicals
h: hours
HMIS: Hazardous Materials Identification System
IARC: INTERNATIONAL AGENCY FOR RESEARCH ON CANCER
IBC: Intermediate Bulk Container
IMDG: International Maritime Code for Dangerous Goods
IATA: International Air Transport Association
IATA-DGR: Dangerous Goods Regulations by the "International Air Transport Association" (IATA)
ICAO: International Civil Aviation Organization
ICAO-TI: Technical Instructions by the "International Civil Aviation Organization" (ICAO)
GHS: Globally Harmonized System of Classification and Labelling of Chemicals
LOAEL: Lowest observed adverse effect level
LOAEC: Lowest observed adverse effect concentration
LC50: Lethal concentration, 50 percent
LD50: Lethal dose, 50 percent
MARPOL: marine pollution
NOAEL: No observed adverse effect level
NOAEC: No observed adverse effect concentration
NTP: National Toxicology Program
N/A: not applicable
NFPA: National Fire Protection Association

UN: United Nations
OECD: Organisation for Economic Co-operation and Development
OSHA: Occupational Safety and Health Administration
PBT: Persistent bioaccumulative toxic
RTECS: Registry of Toxic Effects of Chemical Substances
REACH: Registration, Evaluation, Authorisation and Restriction of Chemicals
SARA: Superfund Amendments and Reauthorization Act
STEL: short-term exposure limits
TSCA: Toxic Substances Control Act
TWA: time weighted average
VOC: Volatile Organic Compounds

Other data

Classification according 29 CFR Part 1910.1200: - Classification procedure:
Health hazards: Calculation method.
Environmental hazards: Calculation method.
Physical hazards: On basis of test data and / or calculated and / or estimated.

The above information describes exclusively the safety requirements of the product and is based on our present-day knowledge. The information is intended to give you advice about the safe handling of the product named in this safety data sheet, for storage, processing, transport and disposal. The information cannot be transferred to other products. In the case of mixing the product with other products or in the case of processing, the information on this safety data sheet is not necessarily valid for the new made-up material.

(The data for the hazardous ingredients were taken respectively from the last version of the sub-contractor's safety data sheet.)

Proposed Scope-of-Practice Change for Oregon Dental Hygienists

Authorization to Apply Noninvasive Enamel Remineralization and Repair Materials

Submitted to the Oregon Board of Dentistry

Purpose of the Proposal

I respectfully request that the Oregon Board of Dentistry amend or clarify Oregon's dental hygiene scope-of-practice rules to permit all licensed Oregon dental hygienists—not only those holding a Restorative Functions Endorsement—to apply noninvasive therapeutic materials intended to remineralize or repair enamel.

This authority would be limited to procedures that do not involve the cutting, drilling, preparation, excavation, or irreversible removal of natural tooth structure.

Proposed Scope

A licensed dental hygienist should be permitted, under the appropriate level of supervision and pursuant to a dentist's diagnosis and treatment plan, to apply a professionally indicated material that is designed to:

- Promote the remineralization of demineralized enamel;
- Arrest, stabilize, or repair an incipient or noncavitated enamel lesion;
- Strengthen enamel against further demineralization;
- Occlude dentinal tubules or subsurface lesions through a noninvasive procedure;
- Protect enamel following the identification of an early carious lesion; or
- Provide another Board-approved noninvasive therapeutic benefit to enamel.

The proposed authority would not permit a dental hygienist without a Restorative Functions Endorsement to:

- Remove, cut, drill, prepare, or excavate natural tooth structure;
- Treat a cavitated lesion that requires mechanical tooth preparation;
- Place or finish a traditional direct restoration;
- Independently diagnose dental caries;
- Independently develop a restorative treatment plan; or
- Perform any procedure that otherwise requires a restorative, expanded-practice, or other specialized endorsement.

Suggested Regulatory Language

The following language could be added to OAR 818-035-0030, “Additional Functions of Dental Hygienists,” or another section identified by the Board:

Noninvasive enamel remineralization and repair materials

A licensed dental hygienist may, under the general supervision of a licensed dentist and pursuant to a dentist’s diagnosis and treatment plan, apply professionally administered materials intended to remineralize, arrest, stabilize, strengthen, or noninvasively repair enamel.

The dental hygienist must complete manufacturer-recommended or Board-approved training before applying the material.

A procedure performed under this section may not include the cutting, drilling, excavation, preparation, or irreversible removal of natural tooth structure.

Nothing in this section authorizes a dental hygienist to diagnose dental caries, prepare a tooth for a restoration, or place or finish a direct restoration unless the dental hygienist holds any endorsement otherwise required by law.

Rationale

1. These procedures are preventive and therapeutic, rather than conventionally restorative

Traditional restorative treatment generally requires the removal or preparation of tooth structure followed by the placement and finishing of a restorative material.

Noninvasive remineralization therapies are fundamentally different. They are applied topically or through another non-surgical technique and are intended to strengthen or repair enamel without the use of a handpiece, bur, excavator, or other instrument that removes natural tooth structure.

The defining boundary should therefore be the nature of the procedure—not whether the manufacturer describes the product as “repairing” enamel.

2. The proposal is consistent with the existing dental hygiene scope

Oregon dental hygienists are already authorized to provide preventive and therapeutic services, including the administration of fluoride and fluoride varnish. Expanding the rule to include additional noninvasive remineralization materials would be a logical extension of the hygienist’s existing role in caries prevention, risk reduction, patient education, and disease management.

The proposed change would not grant dental hygienists independent diagnostic authority. The dentist would remain responsible for diagnosis, treatment planning, and determining whether a lesion is appropriate for noninvasive treatment.

3. Earlier intervention may preserve healthy tooth structure

When early enamel lesions are identified before cavitation, noninvasive treatment may allow the dental team to intervene before conventional surgical-restorative treatment becomes necessary.

Authorizing trained dental hygienists to provide this care supports a minimally invasive philosophy in which clinicians preserve healthy tooth structure whenever clinically appropriate.

This proposal would establish a clear boundary: hygienists without restorative authorization could apply qualifying materials but could not remove or mechanically prepare tooth structure.

4. The change would improve access to timely care

Dental hygienists frequently identify demineralization and early enamel lesions during preventive visits. Under a dentist's diagnosis and treatment plan, allowing the hygienist to apply the prescribed material during the same appointment could reduce delays and eliminate the need for a separate restorative-chair appointment solely for a noninvasive application.

This is particularly important for patients who experience transportation barriers, limited appointment availability, financial constraints, dental anxiety, or difficulty returning for additional visits.

5. The change would preserve restorative capacity

Dentists' restorative schedules should be prioritized for procedures that require their specialized surgical and restorative expertise, including:

- Removal of infected or irreversibly damaged tooth structure;
- Preparation of cavitated lesions;
- Placement of complex restorations;
- Endodontic and surgical treatment;

Allowing dental hygienists to deliver dentist-prescribed, noninvasive enamel therapies would help reserve valuable restorative-chair time for patients who require operative care.

6. Appropriate safeguards can be maintained

The requested scope expansion can be implemented with clear safeguards:

- A dentist must diagnose the condition and authorize the treatment;
- The lesion must be appropriate for noninvasive management;
- The hygienist must follow the manufacturer's instructions;

- The hygienist must complete applicable product training;
- Informed consent must be obtained and documented;
- The product, tooth number, treated surface, indication, and clinical findings must be documented;
- The patient must receive appropriate follow-up and monitoring; and
- The hygienist may not remove or prepare natural tooth structure.

Requested Board Action

I respectfully request that the Oregon Board of Dentistry:

1. Review whether the current Dental Practice Act and administrative rules adequately distinguish noninvasive enamel remineralization from restorative treatment;
2. Confirm that applying a material without cutting, drilling, excavating, or preparing tooth structure does not constitute the placement of a direct restoration;
3. Amend OAR 818-035-0030, or another applicable rule, to expressly authorize licensed dental hygienists to apply dentist-prescribed noninvasive enamel remineralization and repair materials;
4. Establish reasonable education, documentation, supervision, and informed-consent requirements; and
5. Use technology-neutral language so the rule applies to current and future evidence-based remineralization materials rather than being limited to a specific brand or product.

Conclusion

Oregon dental hygienists are educated and licensed preventive oral healthcare professionals whose core responsibilities include disease prevention, patient education, fluoride therapy, risk reduction, and the preservation of oral health.

Permitting trained dental hygienists to apply dentist-prescribed, noninvasive enamel remineralization materials would enhance access to early intervention while maintaining clear professional boundaries. It would support the preservation of natural tooth structure, improve clinical efficiency, and allow dentists to dedicate more restorative-chair time to patients requiring operative treatment.

Most importantly, the proposed change would allow Oregon dental teams to provide timely, minimally invasive care while preserving the dentist's responsibility for diagnosis and treatment planning.

Thank you for your consideration of this proposed scope-of-practice clarification.

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Thank you for your consideration of this proposed scope-of-practice clarification.

Request for Licensure Requirements Exception – Dr. Zaid Badr

On June 30, 2026, the Board received an application for dental license without further examination for Zaid Badr.

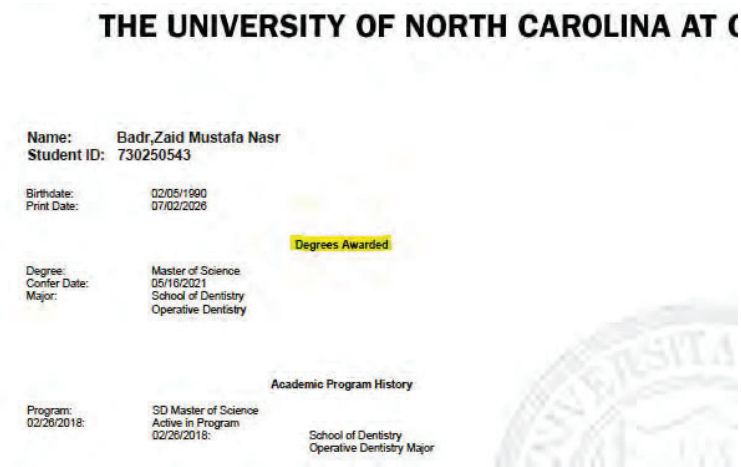
Dr. Badr completed his dental school education in 2015 at the University of Jordan, in Amman, Jordan. Dr. Badr. Completed a three year graduate program in Operative Dentistry from the University of North Carolina, School of Dentistry, in 2021.

Dr. Badr holds a temporary faculty dental license in Wisconsin and a dental license in Illinois. Dr. Badr has previously held an instructor license in North Carolina (exp. 2021) and a faculty license in Nebraska (exp. 2023).

Dr. Badr's application certifies he has completed 4440 clinical practice hours in the last five years at 1801 W Wisconsin Ave (Marquette University School of Dentistry).

Dr. Badr's application states he has completed the Board required 40 hours of Continuing Education in the two years prior to submitting his application to the Board.

Dr. Badr supplied proof of passing the clinical examinations in 2024 and 2025.



THE UNIVERSITY OF NORTH CAROLINA AT (

Name: Badr,Zaid Mustafa Nasr
Student ID: 730250543

Birthdate: 02/05/1990
Print Date: 07/02/2026

Degrees Awarded

Degree: Master of Science
Confer Date: 05/16/2021
Major: School of Dentistry
Operative Dentistry

Academic Program History

Program: SD Master of Science
02/26/2018: Active in Program
02/26/2018: School of Dentistry
Operative Dentistry Major

Pursuant to OAR 818-021-0011 the Board needs to decide if they will give exception to Dr. Badr's residency certification in operative dentistry as acceptable to the required completion of a postdoctoral General Dentistry Residency program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association.

Relevant Rule:

818-021-0011
Application for License to Practice Dentistry Without Further Examination

(1) The Oregon Board of Dentistry may grant a license without further examination to a dentist who holds a license to practice dentistry in another state or states if the dentist meets the requirements set forth in ORS 679.060 and 679.065 and submits to the Board satisfactory evidence of:

(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association; or

(b) Having graduated from a dental school located outside the United States or Canada, completion of a predoctoral dental education program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or completion of a postdoctoral General Dentistry Residency program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and

(c) Having passed the dental clinical examination conducted by a regional testing agency, by a state dental licensing authority, by a national testing agency or other Board-recognized testing agency; and

(d) Holding an active license to practice dentistry, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dentistry, without restrictions, and whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and

(e) Having conducted licensed clinical practice in Oregon, other states or in the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately preceding application. Licensed clinical practice could include hours devoted to teaching by dentists employed by a dental education program in a CODA accredited dental school, with verification from the dean or appropriate administration of the institution documenting the length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dentistry, and any adverse actions or restrictions; and

(f) Having completed 40 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.

(2) Applicants must pass the Board's Jurisprudence Examination.

(3) Prior to initial licensure, an applicant must complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).

(4) A dental license granted under this rule will be the same as the license held in another state; i.e., if the dentist holds a general dentistry license, the Oregon Board will issue a general (unlimited) dentistry license. If the dentist holds a license limited to the practice of a specialty, the Oregon Board will issue a license limited to the practice of that specialty. If the dentist holds more than one license, the Oregon Board will issue a dental license which is least restrictive.

Note: Illinois rule for application for licensure:

Ill. Admin. Code tit. 68, § 1220.100 - Application for Licensure

An applicant for a license to practice dentistry in Illinois shall file an application on forms supplied by the Division that shall include:

a) For graduates from a dental college or school in the United States or Canada, certification of successful completion of 60 semester hours or its equivalent of college pre-dental education, and graduation from a dental program specified in Section 1220.140.

b) For graduates from a dental college or school outside of the United States or Canada:

1) Certification of graduation from a dental college or school; and

2) Clinical Training

A) Certification from an approved dental college or school in the United States or Canada that the applicant has completed a minimum of 2 years of general dental clinical training at the school in which the applicant met the same level of scientific knowledge and clinical competence as all graduates from that school or college. The 2 years of general dental clinical training shall consist of:

i) 2850 clock hours completed in 2 academic years for full-time applicants; or

ii) 2850 clock hours completed in 4 years with a minimum of 700 hours per year for part-time applicants; or

B) In the alternative, certification, from the program director of an accredited advanced dental education program approved by the Division, of completion of no less than 2 academic years may be substituted for the 2 academic years of general dental clinical training. The accredited advanced dental education program must have sufficient clinical and didactic training. An advanced dental education clinical program in Prosthodontics, pediatric dentistry, periodontics, endodontics, orthodontics, and oral and maxillofacial surgery is acceptable under this Part;

In summary: does the Board find cause to approve Dr. Badr's request for exception to the licensure requirements for an applicant to have completed a postdoctoral General Dentistry Residency program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association?

From: Zaid Badr <zaidbadr@hotmail.com>
Sent: Friday, August 7, 2026 1:30 PM
To: MCNEAL Kathleen * OBD <Kathleen.McNeal@obd.oregon.gov>
Subject: Re: Oregon Dental License - application does not meet requirements

Hi Kathleen,

Thank you very much for taking the time to speak with me today regarding my concerns about my licensure application. As discussed, I am writing to formally request an appeal and further review of my eligibility under the pathway for licensure to practice dentistry without further examination.

I graduated from the University of Jordan, a dental school located outside the United States and Canada, following completion of a five-year predoctoral dental education program. I subsequently completed a three-year postgraduate residency in Operative Dentistry at the University of North Carolina Adams School of Dentistry in Chapel Hill, a CODA-accredited dental school.

In addition, I have:

* Passed the ADEX regional clinical examination;
* Maintained an active, unrestricted dental license in Illinois;
* Completed more than 3,500 hours of clinical practice;
* Held faculty appointments and provided dental education at CODA-accredited U.S. dental schools, including UNC, the University of Nebraska Medical Center, and Marquette University School of Dentistry;
* Completed 40 hours of continuing education consistent with the Board's requirements;
* Passed the Board's jurisprudence examination; and
* Completed the required one-hour pain management course.

Based on my review of the Application for License to Practice Dentistry Without Further Examination, I believe I have satisfied the applicable requirements and respectfully request reconsideration of the provision concerning graduates of dental schools outside the United States or Canada.

Specifically, Section B provides for:

"or completion of a postdoctoral General Dentistry Residency program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association."

My postgraduate training consisted of three years of full-time residency education in Operative Dentistry at the UNC Adams School of Dentistry. I understand that the Board may need to determine whether this program satisfies its interpretation of a "postdoctoral

general dentistry residency program." However, the language of the application does not specifically state "General Practice Residency", or identify a particular CODA-recognized program category. The language does not also require a US DDS or DMD degrees with the postgraduate residency program. Rather, it refers more broadly to a "general dentistry residency program" completed at a CODA-accredited dental school.

Operative Dentistry is fundamentally grounded in the diagnosis, treatment planning, restoration, and clinical management of the dentition and represents a core area of general dental practice. Given the duration, clinical nature, and setting of my three-year residency, I respectfully request that the Board evaluate the substance and curriculum of my postgraduate training in determining whether it satisfies this requirement, rather than relying solely on the title of the program. Also, please find a letter from the American Board of General Dentistry approving my training as General Dentistry Residency. In addition, at the time of application, the ADA recognizes Operative Dentistry as an area of General Dentistry.

Here is also a brief description of what Operative Dentistry program is at UNC.

"Operative dentists provide general dental care with a focus on conservative restorative dentistry."

Source:
https://dentistry.unc.edu/clinic/operative-dentistry/

I would be very happy to provide the complete residency curriculum, documentation of clinical hours and procedures, program descriptions, letters from UNC, or any additional information that would assist the Board in evaluating the scope and equivalency of my training.

I greatly appreciate your time and consideration of my appeal.

Warm regards,
Zaid Badr

From: Zaid Badr <zaidbadr@hotmail.com>
Sent: Tuesday, 04 August 2026 15:59:19
To: MCNEAL Kathleen * OBD <Kathleen.McNeal@obd.oregon.gov>
Subject: Re: Oregon Dental License - application does not meet requirements

Hi Kathleen,

Thank you for your email.

The ADA recognizes Operative Dentistry as interest area in general dentistry and my school (UNC) is CODA accredited. It is also a 3-year program.

https://editions.mydigitalpublication.com/article/ADA+Recognizes+Operative+Dentistry+as+Interest+Area+in+General+Dentistry+/2630226/354796/article.html

I have moved to Oregon already, and in a previous communication with you, I have inquired if my program is approved and you replied:

"Rather than assure you that you meet the requirement for licensure with your 'postgraduate 3-year residency', I am sharing the rule and asking you - why do you think you do not meet the criteria for licensure via this pathway?"

I asked again, you didn't reply and that's why I took your first answer as no issue with the program and moved with my wife.
This is going to lead to significant loss of financial resources.

I kindly ask that the Board re-evaluates my case given that I have years of experience teaching general dentistry and meet the requirements (general dentistry/CODA-accredited institution).

Respectfully,
Zaid Badr

From: MCNEAL Kathleen * OBD <Kathleen.McNeal@obd.oregon.gov>
Sent: Tuesday, August 4, 2026 3:18:32 PM
To: zaidbadr@hotmail.com <zaidbadr@hotmail.com>
Subject: Oregon Dental License - application does not meet requirements

Hello Dr. Badr,

The Oregon Board of Dentistry (OBD) is in receipt of your application for Dental Licensure Without Further Examination (LWOFE) in the State of Oregon. Your application cannot be accepted, because you do not appear to meet the requirements for Dental LWOFE. Please review the requirements as stated in OAR 818-021-0011:

818-021-0011
Application for License to Practice Dentistry Without Further Examination

(1) The Oregon Board of Dentistry may grant a license without further examination to a dentist who holds a license to practice dentistry in another state or states if the dentist meets the requirements set forth in ORS 679.060 and 679.065 and submits to the Board satisfactory evidence of:

(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association; or

(b) Having graduated from a dental school located outside the United States or Canada, completion of a predoctoral dental education program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or completion of a postdoctoral General Dentistry Residency program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and

(c) Having passed the dental clinical examination conducted by a regional testing agency, by a state dental licensing authority, by a national testing agency or other Board-recognized testing agency; and

(d) Holding an active license to practice dentistry, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dentistry, without restrictions, and whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and

(e) Having conducted licensed clinical practice in Oregon, other states or in the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately preceding application. Licensed clinical practice could include hours devoted to teaching by dentists employed by a dental education program in a CODA accredited dental school, with verification from the dean or appropriate administration of the institution documenting the length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dentistry, and any adverse actions or restrictions; and

(f) Having completed 40 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.

(2) Applicants must pass the Board's Jurisprudence Examination.

(3) Prior to initial licensure, an applicant must complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).

(4) A dental license granted under this rule will be the same as the license held in another state; i.e., if the dentist holds a general dentistry license, the Oregon Board will issue a general (unlimited) dentistry license. If the dentist holds a license limited to the practice of a specialty, the Oregon Board will issue a license limited to the practice of that specialty. If the dentist holds more than one license, the Oregon Board will issue a dental license which is least restrictive.

- The three year residency you completed at the University of North Carolina is not a General Dentistry residency.

After reviewing the application materials you submitted, we cannot determine that these requirements were met. If you have any questions, please contact me at Kathleen.McNeal@obd.oregon.gov or (971) 673-3200.

Sincerely,

Kathleen McNeal
Licensing Manager
Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, OR 97201
Telephone: 971-673-3200
www.oregon.gov/dentistry

Need to login to your licensee portal? CLICK HERE

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

UNC | ADAMS SCHOOL OF DENTISTRY

THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL
ADAMS SCHOOL OF DENTISTRY

919-537-3737

Koury Oral Health Sciences Building
Campus Box 7450
385 South Columbia Street | Chapel Hill, NC 27599-7450
dentistry.unc.edu

Chapel Hill, April 15, 2025

RE: Dr. Zaid Badr

From: Dr. Bert Vasconcellos, Professor and Graduate Program Director.

To whom it may concern,

This letter is to certify that Dr. Zaid Badr successfully completed a three-year, full-time clinical residency program in operative dentistry at the University of North Carolina at Chapel Hill, Adams School of Dentistry, from July 1, 2018, to June 30, 2021.

This residency program is a full-time commitment, requiring 40 hours per week of advanced dental training. While the program is structured over a three-year period (156 weeks), we have accounted for two weeks per year of national holidays and scheduled breaks. Therefore, the total training period is approximately 150 weeks. Based on this structure, Dr. Badr completed approximately 6,000 hours of advanced education (40 hours/week × 150 weeks = 6,000 hours).

The completion of this program represents an advanced level of expertise that extends well beyond the clinical competency required for a U.S. DDS degree. The residency provides specialized training in complex restorative and esthetic dentistry, evidence-based treatment planning, digital dentistry applications, and the restoration of dental implants. Additionally, Dr. Badr has developed expertise in managing direct and indirect restorations, advanced restorative cases, and implant-supported prostheses, equipping him with a high level of proficiency in both conventional and modern treatment approaches.

Dr. Badr has demonstrated exceptional skill, professionalism, and dedication throughout the program, successfully fulfilling all requirements necessary for completion. Please feel free to contact our office should you require any additional information.

Sincerely,

Bert Vasconcellos, DDS, MS, PhD
Dr. Clifford M. Sturdevant Distinguished Professor
Director of the Graduate Program in Operative Dentistry & Biomaterials
Director of the Operative Dentistry Predoctoral Program
University of North Carolina – Chapel Hill
Adams School of Dentistry
Division of Operative Dentistry & Biomaterials
Department of Restorative Sciences
bert_vasconcellos@unc.edu

From: Zaid Badr <zaidbadr@hotmail.com>
Sent: Friday, August 7, 2026 8:31 PM
To: MCNEAL Kathleen * OBD <Kathleen.McNeal@obd.oregon.gov>
Subject: Re: Oregon Dental License - application does not meet requirements

Hi Kathleen,

I have also found current evidence on the official ADA website that can be found in here:

https://www.ada.org/resources/careers/practicing-dentistry

Under "What is an interest area in general dentistry?"

Third paragraph:

"Operative Dentistry, Cariology and Biomaterials has met the Criteria and is formally recognized by the American Dental Association. Operative Dentistry, Cariology and Biomaterials is that branch of general dentistry concerned with the advanced knowledge, expertise and clinical skills in operative dentistry, restorative dental materials, educational theory, techniques, and teaching skills. It includes scientific research and knowledge in the areas of cariology and advanced scientific clinical training in restorative materials and biomaterials."

Sincerely,
Zaid

Practicing dentistry

Whether you are exploring dentistry or an established professional looking for new opportunities, the ADA has resources for you.

Starting your dental career

Congratulations! You've worked hard to earn your dental degree. Now it's time to choose your own path. There are so many ways to practice der in a variety of settings, that sometimes it can be stressful to decide what's right for you.

Explore the variety of ways to use your dental degree, including nonclinical career options. If you qualify and are interested in an academic caree applying for CDEL's Teaching and Leadership Scholarship.

Check out the information and resources here, which may help you with your decision. Additionally, the American Dental Education Association provide helpful information.

How does licensure work?

What is an interest area in general dentistry?

An interest area in general dentistry is a well-defined body of evidence-based scientific and clinical knowledge underlying general dentistry, but i focused, complex and distinct field identified by advanced knowledge, techniques and procedures.

Today's rapidly emerging technologies and science are providing more sophisticated and complex solutions to problems encountered in general

The advances are changing and enhancing the dental practice environment. Interest areas in general dentistry must meet the specified Criteria f Recognition of Interest Areas in General Dentistry (PDF) in order to be formally recognized by the American Dental Association.

Operative Dentistry, Cariology and Biomaterials has met the *Criteria* and is formally recognized by the American Dental Association. Operative De Cariology and Biomaterials is that branch of general dentistry concerned with the advanced knowledge, expertise and clinical skills in operative d restorative dental materials, educational theory, techniques, and teaching skills. It includes scientific research and knowledge in the areas of cario advanced scientific clinical training in restorative materials and biomaterials.

For more information about interest areas in general dentistry, contact the ADA Council on Dental Education and Licensure at CDEL@ada.org or

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What are the recognized specialties within dentistry?

Read the article

Using your degree in different ways can offer fresh challenges and rewards.

Landing page

Job listings

Looking for your next opportunity? Visit the ADA job board.

Service

For future dentist

Are you a high-school or college student hoping to become a dentist? Find resources here.

Landing page

Clinical Career Pathways

Solo Owner

Small Group Practice

Business Support Organizations (DSO/DMO/DPO) – Near Term / Non-Ownership

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Business Support Organizations (DSO/DMO/DPO) – Longer Term / Ownership Path

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Co-op Model

Medical-Dental Model

Traveling Dentist

Federally Qualified Health Center (FQHC)

Department of Veterans Affairs

Federal Dentists: Dept. of Defense (Armed Forces)

Federal Dentists: Commissioned Corp

Faculty

Getting hired

Starting a new job search? Here are tools and perspectives to help you succeed.

Where should I practice?

What do hiring organizations look for in a new associate?

Where can I find more information?

Where can I find current job opportunities?

Also of Interest

ADA News

Join the ADA

ADA Policy on Teledentistry

OTHER ISSUES

Oregon Board of Dentistry
Strategic Plan
2026-2029

Final Report
As of August 21, 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
Michelle Aldrich, DMD
Sharity Ludwig, RDH
Kristen Simmons, RDH
Olesya Salathe, DMD
Ginny Jorgensen
Kieshawn Lewis

Staff Members

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

Oregon Board of Dentistry

Organizational & External Influences Analysis

This organizational and external analysis covers the internal factors that will influence the ability to respond to operational needs as well as the external factors that may drive change. The Oregon Board of Dentistry analyzed the social, technological, economic, legal/regulatory, and environmental factors that might affect the practice of dentistry and the OBD's oversight. In addition, the current organizational status was analyzed primarily through staff interviews.

The most significant Strengths, Weaknesses, Opportunities, and Threats that affect the OBD are:

STRENGTHS	WEAKNESSES / IMPROVEMENT AREAS
• 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	• Team and board succession planning processes • Lack of clarity of requirements for each type of license • 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 • Board member turnover creates loss of continuity and historical knowledge
OPPORTUNITIES	**THREATS**
• 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	• 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 especially OHP • Cost and profit pressures influencing standard of care • Dental practice desire for additional scope to be delegated to Registered Dental Hygienists & Assistants • Continued cost pressures on OBD budget and resulting pressure to increase fees

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

1c) Assign DAWSAC to review and clarify rules to enable simple guidelines to be created.

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.

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, hygienist, and assistant professionals to improve the workforce shortage through questions in the annual or separate survey sent by OBD

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

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

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

2b) Communicate consumer information regarding Tooth Gem & Whitening Kiosks for clarity, awareness, and intent to improve consumer safety

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

Oregon Board of Dentistry Strategic Plan 2026-2029

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

MISSION-CRITICAL PRIORITIES				
A. Future of Dental Regulation	B. Emerging Dental Practice Challenges	C. Community & Access to Care	D. Workplace Environment	E. Technology and Processes
GOALS				
• Clarify and Communicate rules for Dental Assistants; increase visibility and accountability	• Address workforce shortage of Registered Dental Hygienists, Dental Assisstants, and Dental Therapists	• Strengthen Community Engagement and support improved communication with Dental Providers	• Ensure OBD staff and Board Member talent & continuity	• Improve efficiency leveraging technology resulting in decreased staff time per case, fewer calls, and number of cases
• Improve Board communication, scope of practice enforcement, and education	• Support provider wellness, specifically addressing emergent provider challenges	• Communicate clarification of full scope of services by licensee types	• Organizational practices & skills are state of the art and current with technology (within budgetary limitations)	• Establish rules governing Artificial Intelligence within Dental Practices Act (DPA)
• Determine OBD position on Dental Compact & related actions needed	• Foster mutual respect & collaboration among dental professionals including the Board		• Ensure all committed Affirmative Action Plan Deliverables are completed	
ACTION ITEMS				
• Create or provide access to a Dental Assistant Registry within OBD	• Research recommendations of Oregon dentistry, hygienist, and assistant professionals to improve workforce shortage through questions in the annual or separate survey sent by OBD	• Increase ease of community access to OBD Services & Information as committed in Affirmative Action Plan	• Responsibility cross-training completed	• Explore implementation of standard patient records portal
• Create ability for Dentists to voluntarily register and diclosed employed Dental Assistants	• Encourage associations to promote dental professional paths in high schools, community colleges, 4-year colleges through website, newsletters, and other communication pathways	• Create easier access to information on OBD email communications and website; provide summarization of important topics; highlight access to minutes & video recordings	• Validate needed Committees, determine appropriate meeting frequency, establish proactive Committee leadership	• Increase Licensee understanding of complaint process
• Assign DAWSAC to review and clarify rules to enable simple guidelines to be created	• Publish newsletter articles / website content to address mental health & addiction challenges; lead by Communication Committee	• Gather demographic information, store in InLumon, when new licensees apply, in support of understanding equity in investigation outcomes	• Invest in continuing education to support changing industry & technology landscape	• Implement InLumon updates to increase automation & reduce data entry
• Address use of AI via OARs or assign to committee to create policy	• Promote wellness tools & resources including continuing education; leverage best practices from other states	• Communicate Best Practices for addressing complaints within a dental practice, to lower formal OBD complaints filed	• In support of Affirmative Action Plan, reinforce State policies, provide training & development to the Board and Staff as needed	• Complete Website improvements for clarity of overall content and navigation + licensing processes
• Review budget annually and deteremine actions for budget to keep pace with needed staffing / oversight	• Implement a 1-hour Continuing Education requirement focused on mental health & addiction challenges and solutions	• Document & communicate scope of each license including expanded practices and scope; better enable provider interpretation & implementation choice		• Create a statement of position on Artificial Intelligence within the DPA that aligns with regulatory oversight of OBD
• Explore Dental Compact progress across other states; provide informational updates to Board for consideration including how funding would work	• Board to advance collaborative teamwork through development of Board behavioral norms in alignment with OBD values	• Communicate consumer information regarding Tooth Gem & Whitening Kiosks for clarity, awareness, and intent to improve consumer safety		

Oregon Board of Dentistry 2026-2029 Strategic Plan

Summary Priorities, Goals, and Roadmap

Strategic Priorities	Goals	2026-2027	2027-2028	2028-2029
Future of Dental Regulation	• Clarify and Communicate rules for Dental Assistants; increase visibility and accountability	• Assign DAWSAC to review and clarify rules to enable simple guidelines to be created	• Create or provide access to a Dental Assistant Registry within OBD;	• Explore Dental Compact progress across other states; provide informational updates to Board for considerations including how funding would work
	• Improve Board communication, scope of practice enforcement, and education	• Review budget annually and deteremine actions for budget to keep pace with needed staffing / oversight	• Create ability for Dentists to voluntarily register and disclose employed Dental Assistants	
	• Determine OBD position on Dental Compact & related actions needed	• Address use of AI via OARs or assign to committee to create policy		
Emerging Dental Practice Challenges	• Address workforce shortage of Registered Dental Hygienists, Dental Assisstants, and Dental Therapists	• Research recommendations of Oregon dentistry, hygienist, and assistant professionals to improve workforce shortage through questions in the annual or separate survey sent by OBD	• Encourage associations to promote dental professional paths in high schools, community colleges, 4-year colleges through website, newsletters, and other communication pathways	• Implement a 1-hour Continuing Education requirement focused on mental health & addiction challenges and solutions
	• Support provider wellness, specifically addressing emergent provider challenges	• Publish newsletter articles / website content to address mental health & addiction challenges; led by Communication Committee	• Promote wellness tools & resources including continuing education; leverage best practices from other states	
	• Foster mutual respect & collaboration among dental professionals including the Board	• Board to advance collaborative teamwork through development of Board behavioral norms in alignment with OBD values		
Community & Access to Care	• Strengthen Community Engagement and support improved communication with Dental Providers	• Create easier access to information on OBD email communications and website; provide summarization of important topics; highlight access to minutes & video recordings	• Document & communicate clarity about scope of each license including expanded practices and scope; better enable provider interpretation & implementation choice	• Increase ease of community access to OBD Services & Information as committed in AAP
	• Communicate clarification of full scope of services by licensee types	• Communicate consumer information regarding Tooth Gem & Whitening Kiosks for clarity, awareness, and intent to improve consumer safety	• Communicate Best Practices for addressing complaints within a dental practice, to lower formal OBD complaints filed	
		• Gather demographic information, store in InLumon, when new licensees apply, in support of understanding equity in investigation outcomes		
Workplace Environment	• Ensure OBD staff and Board Member talent & continuity	• Responsibility cross-training completed	• Invest in continuing education to support changing industry & technology landscape	• In support of Affirmative Action Plan, reinforce State policies, provide training & development to the Board and Staff as needed
	• Organizational practices & skills are state of the art and current with technology (within budgetary limitations)	• Validate needed Committees, determine appropriate meeting frequency, establish proactive Committee leadership		
	• Ensure all committed Affirmative Action Plan Deliverables are completed			
Technology & Processes	• Improve efficiency leveraging technology resulting in decreased staff time per case, fewer calls, and number of cases	• Increase Licensee understanding of complaint process	• Implement InLumon updates to increase automation & reduce data entry	• Explore implementation of standard patient records portal
	• Establish rules governing Artificial Intelligence within Dental Practices Act (DPA)	• Complete Website improvements for clarity of overall content and navigation + licensing processes		
		• Create a statement of position on Artificial Intelligence within the DPA that aligns with regulatory oversight of OBD		

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Oregon Wellness Program
Annual Report for 2025 Activities
Presented to the Oregon State Board of Dentistry
January 31, 2026

The purpose of this document is to respond to the requirements of the agreement between The Foundation for Medical Excellence (TFME) and the Oregon State Board of Dentistry (OBD) concerning the Oregon Wellness Program (OWP).

Introduction and OWP Overview

The OWP is a key element of a board-based effort by the health care community and Oregon health care policy leaders to promote the wellbeing of health care professionals through education, coordinated counseling services, and research. The community believes that supporting provider wellbeing improves career retention of health care professionals and therefore improves public access to health care services.

As a state-wide mental health counseling program, the OWP is dedicated to confidentially serving the urgent mental health and counseling needs of Oregon's health care professionals. It provides services to clients who self-refer (not referred by employers or family or friends) and does not offer services to evaluate or treat ongoing medical issues, drug or alcohol abuse disorders or practice competency concerns. These are in the purview of the relevant licensing boards.

OWP services are 100% confidential and free of charge to the client. No insurance is billed. The client is eligible for up to three, one-hour counseling sessions.

Services are provided by a mental health care team of 32 professionals ranging from MSWs, PMHNPs, Psych Ds, PhDs to MD/DO Psychiatrists. All services are currently offered via telehealth. To participate in the program, the mental health care team member must be recommended by their professional colleagues, have experience in treating fellow health care professionals, be in good standing with their professional board, be in private practice, have in-force professional liability insurance, commit to see clients within three (3) business days of initial client contact and accept a standard one-hour fee for services with no supplemental billings.

OWP and OBD – A Shared Vision

As we all keenly recognize, Oregon healthcare professionals continue to face myriad perils in the workforce. Weaknesses in our healthcare system were cracked open during the pandemic, and many of those challenges linger. Limited capacity and staffing issues in hospitals, nursing homes, and clinics, scarce resources, and more recent changes to federal policies jeopardize Medicare and Medicaid funding and further increase health care costs, recently ICE has been showing up in local hospitals and clinics; all of these issues come to a head when frontline staff show up to work.

With all of the overwhelm healthcare workers face, the OWP, with the continued support of the OBD, provides something very specific to our providers: space for confidential, timely, and complimentary care by a team of mental health providers with healthcare backgrounds and sensitivity to the unique challenges they face.

As Sara Klebanowski, a RN in Marion County (and OWP user) explains it:

> "I have been an emergency room nurse for 15 years. Throughout that time, I have experienced hardship, anxiety, depression and uneasiness regarding my job. Daily, I am met with pressures of working fast, efficient, and precise. I am expected to be kind and patient to those who do not share those qualities. **I am expected to be an emotional chameleon** during that 12-hour shift…OWP services has provided me with a healthy outlet to work through the hardships of being an ER nurse, deal with my personal life in a healthier manner, and come to work with a better outlook and understanding. **I am a more self-aware person overall, and I know this program has prolonged my longevity as a nurse but has made me a better one.** I have gained coping skills, I have improved my communication skills with patients and co-workers, and I have more self-love. I owe the OWP for providing me with free counseling and making my mind healthier so I can care for others."

The OWP provides a proven, meaningful reprieve for healthcare professionals who are struggling *now*.

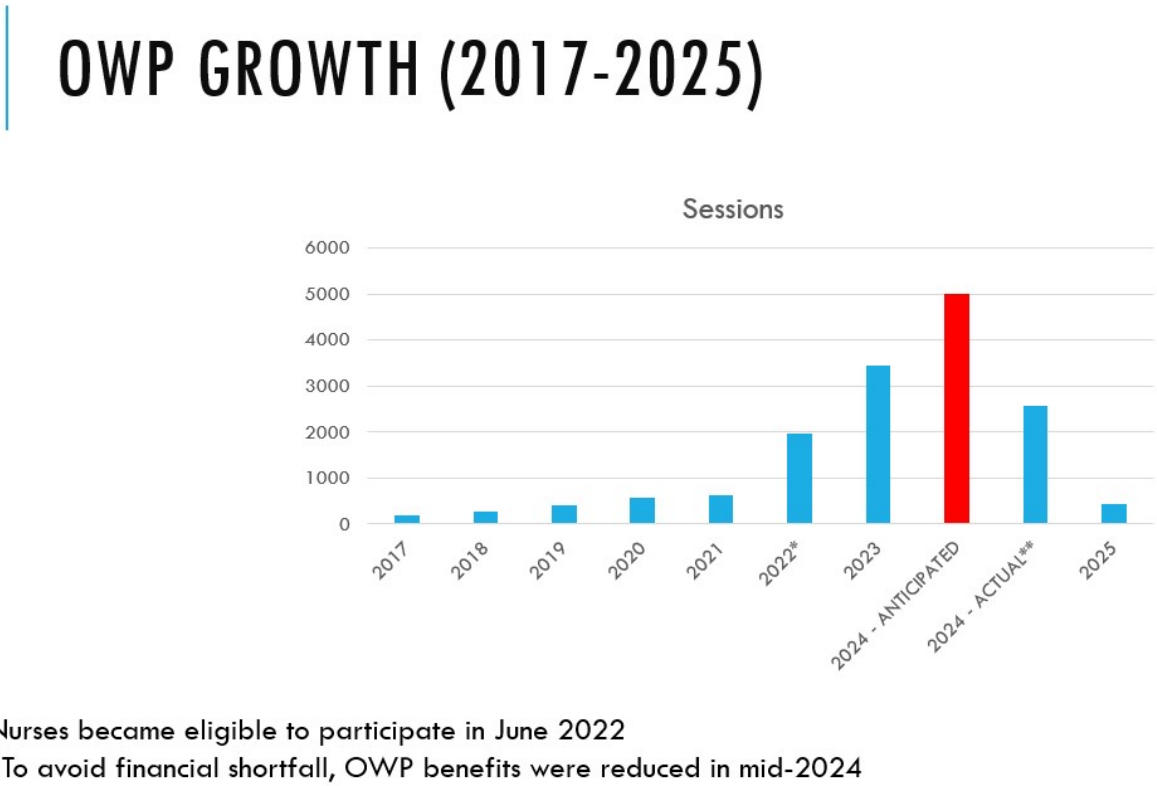
Of course, this isn't easy. In 2025, the OWP settled into a "new normal" following the mid-2024 decision to reduce program benefits from a renewable annual benefit of (8) sessions to a one-time benefit of (3) sessions to avoid financial overwhelm. After years of steadily gaining clients and recognition, the projected spike in utilization in 2024 had threatened to overwhelm the program's finances. The steep increase in demand for OWP services came at a time of financial stagnation for the program and required OWP leaders to make hard choices regarding program benefits.

Although stabilizing OWP's finances with the 3-session limit does have its practical downsides, it has also given the program the financial breathing room to serve *even more* Oregon healthcare workers and intensify our outreach. To this end, in fall 2025 we reached out to healthcare providers outside of Oregon's major healthcare systems, including smaller regional clinics, mobile and street medicine organizations, school districts, and corrections facilities. Looking forward, OWP will prioritize connecting with health care administrators and human resource managers who can help connect even more healthcare professionals with our services.

As a result of this decrease in session benefits, 2025 OWP session utilization declined accordingly (see "Program Utilization" below). The strategic reduction in services, bolstered by the emergency gap funding, allowed the OWP to stabilize the program's financial obligations and will maximize the number of clients able to access its services in 2026 and beyond. Our mental health providers encourage OWP clients to consider continuing their care using insurance benefits or out-of-pocket funds. Additionally, OWP's Executive Committee has set aside $20,400 in emergency session funding for OWP mental health providers to use at their professional discretion in circumstances where a client in need requires more care than the limited OWP sessions could provide.

We thank the OBD for continuing to see the value in the OWP and support these necessary changes to ensure the program's longevity.

Program Utilization

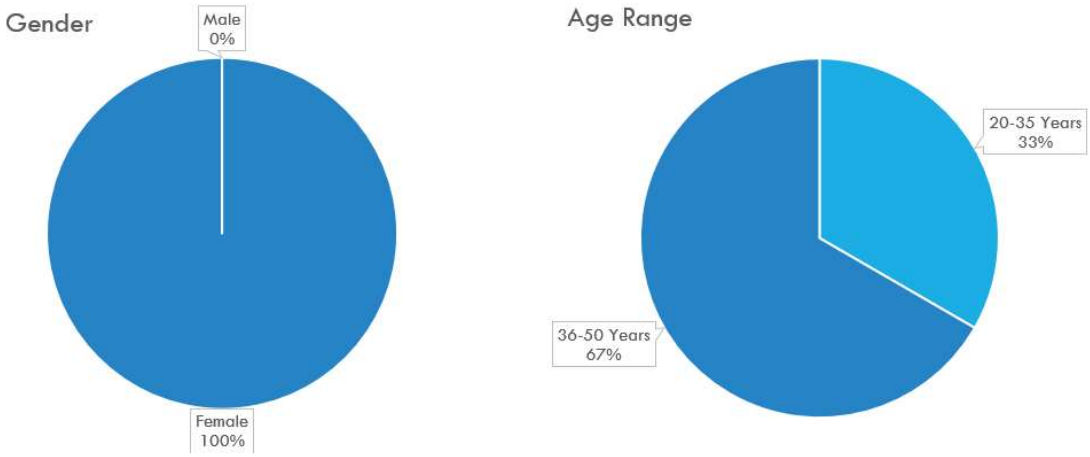


Between January and December 2025, OWP mental health care professionals provided **431 one-hour counseling sessions** to **182 clients**. The program served **3 OBD clients** and provided those clients **8 hours of counseling**. This compares to 16 OBD clients and 93 hours of counseling in the same 12 months of 2024. A dedicated team of 32 mental health professionals uphold the OWP's standards of confidential services offered within 3 working days of a client's request.

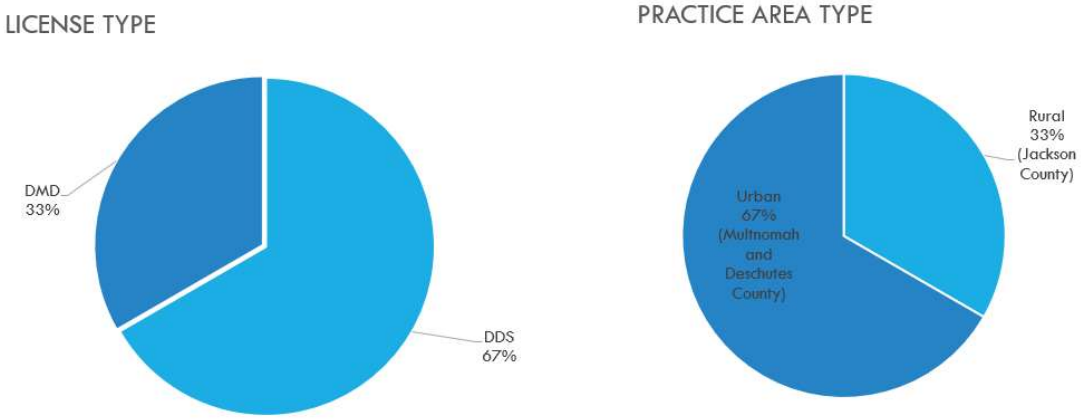
The first table (above) depicts program growth since the inception of OWP as a coordinated state-wide effort. The notable decline in utilization between 2023 and 2026 was expected and reflects the mid-2024 decision to a) reduce complimentary sessions to 3 (from 8) and b) make the OWP benefit a one-time benefit (previously, complimentary sessions were renewed year-to-year if client desired).

The tables (below) show the breakdown of clients by gender, age, license type, practice location and employer affiliation.

2025 OWP OBD CLIENT DEMOGRAPHICS – GENDER AND AGE



2025 OWP OBD CLIENT DEMOGRAPHICS – LICENSE AND LOCATION

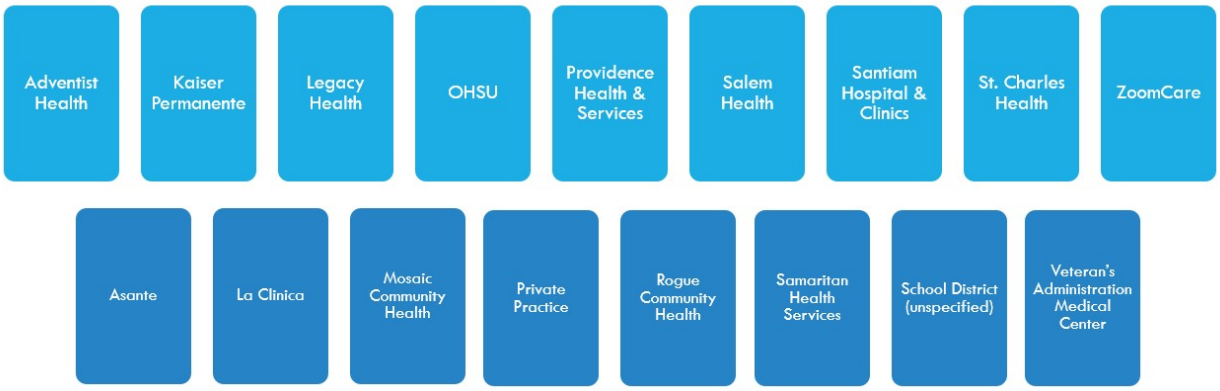


COUNTIES REPRESENTED BY OWP 2025 CLIENTS

WESTERN OREGON	CENTRAL OREGON	EASTERN OREGON
BENTON	DESCHUTES	UMATILLA
CLACKAMAS	JACKSON	
CLARK (WA)	JEFFERSON	
CLATSOP	JOSEPHINE	
COLUMBIA		
LANE		
MARION		
MULTNOMAH		
WASHINGTON		
YAMHILL		

OWP CLIENT DEMOGRAPHICS – ORGANIZATIONAL AFFILIATION

OVER **17** HEALTHCARE ORGANIZATIONS REPRESENTED



Program Financials (2025)

We have included copies of the latest TFME Statement of Financial Position and a display of OWP dedicated accounts. The reports are prepared by Susan Matlack Jones and Associates, LLC, a Portland Oregon firm that specializes in financial accounting for not-for-profit organizations.

In OWP's early 2025 report to the OBD, we warned of the significant funding gap between what the OBD could provide via licensing fees, the continued dwindling of health system contributions, and the potential cost of caring for OBD licensees. At that time, OWP outlined the 3-part strategy we had implemented to address the significant funding gap between what the

OBD could provide via licensing fees and the potential cost of care for OBD licensees in 2024. As a reminder, this strategy included:

1) Retaining the Mid-2024 Reduction in OWP Service Benefits
2) Utilizing One-time Emergency Funds to Bridge Gap
3) Renewing Request for Legislative Funding in 2025

We are pleased to report that at the end of 2025, OWP financials reflected that the reduction-in-services strategy accomplished what it set out to do – stabilize OWP expenses. OWP's overall expenses in 2025 were **$159,000** – *$459,000 less* than in 2024!

The cost savings went even further, thanks to the one-time, mid-2024 bridge funds from CareOregon, the EOCCO, and a grant from PacificSource Foundation. In 2025, the OWP did not have to lean on licensee funding, which means vested licensee funds from the OBD will last longer and go farther, dollar-for-dollar.

Finally, during the 2025 full legislative session, our lobbyist team advocated for $1.6 million in the 2025-2027 biennium budget. State dollars would have stabilized funding and allowed the program to reinstate its original offerings of up to (8) complimentary sessions per client, renewable year-to-year. Sadly, and despite the admirable teamwork of organizations that represent Oregon's healthcare professionals (OMA, ONA, ODA, and the Hospital Association of Oregon), and the advocacy work of many OWP clients themselves, the bid was ultimately unsuccessful.

Thankfully, due to the continued support from the licensing boards and the remaining OWP emergency funding, the OWP is currently in a strong position to maintain its reduced offerings of (3) sessions per client at least through 2027.

In early 2026, TFME will usher in a new President and CEO, Dr. John Kitzhaber, former Governor of Oregon and longtime advocate of progressive health policy in Oregon. We are optimistic that his leadership can help guide the OWP to a more formalized relationship with the State and ease the reliance on licensee dollars to primarily fund the program.

Funding Request and Budget

The OWP respectfully request the commitment of $40,000 for the support of OBD licensee use of OWP services in 2026. These funds will only be utilized to support OBD licensees and will provide 166 hours of counseling services (166 sessions at $200/session plus 20% for administration including communications/billing/insurance/accounting).

Oregon
Tina Kotek, Governor

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Oregon Board of Dentistry
Affirmative Action Plan
2027–2029 Biennium

At the Oregon Board of Dentistry (OBD), we are committed to equal opportunity and providing a workplace free of discrimination and harassment based on race, color, sex, marital status, sexual orientation, religion, national origin, age, mental or physical disability, or any reason prohibited by state or federal law. We are also committed to the right of any employee to work and advance on the basis of merit, ability, and potential. We believe that all of us at the OBD are responsible for creating and contributing to an inclusive and professional work environment. To help ensure the effective implementation of our policy statements and the success of our 2027-2029 biennium goals, the OBD will work with our DAS CHRO Human Resources Partner and our Board to monitor implementation and ongoing effectiveness, adjusting as necessary. We are dedicated to finding new ways to foster staff and board diversity and promote an inclusive and professional work environment.

I am pleased to share the OBD's Affirmative Action plan for the 2027-2029 Biennium. This report was finalized in conjunction with the compilation of the OBD's 2027-2029 Agency Request Budget in the summer of 2026.

Haley Robinson

Haley Robinson
Executive Director

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Affirmative Action Plan
2027 – 2029 Biennium

AGENCY MISSION

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.

AGENCY FUNCTION

The Oregon Board of Dentistry (OBD) is comprised of a ten member board and seven staff members. The Board Members are selected by the Governor and confirmed by the Senate. The staff members are state employees who were hired through the state of Oregon's HR employment system. The OBD utilizes DAS HR support for all recruitment efforts. The authority and responsibilities of the Oregon Board of Dentistry (OBD) are contained in Oregon Revised Statutes Chapter 679 (Dentists & Dental Therapists), Chapter 680.010 to 680.205 (Dental Hygienists), and Oregon Administrative Rules, Chapter 818. These statutes charge the OBD with the responsibility to regulate the practice of dentistry, dental therapy and dental hygiene by enforcing the standards of practice established in statute and rule. The primary program activities are Licensing, Enforcement, Monitoring and Administration.

AGENCY REPRESENTATIVES

Agency Director
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971-673-3200

Governor's Policy Advisor
Kristina Narayan
Office of Governor Tina
Kotek 503-378-6727

Affirmative Action Representative
Haley Robinson, Executive Director
1500 SW 1st Ave., Suite #770
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971-673-320

The OBD ensures that it creates and maintains a diverse and inclusive environment and organizational culture throughout the agency in keeping with the Office of Cultural Change (OCC) and The Governor's Office's (GO) policies. The BOLI and appropriate policies are posted in the office kitchen/break room. All staff are regularly updated on HR policies and information when distributed to the executive director.

The OBD's Policy Statement on affirmative action is:

> *"The Oregon Board of Dentistry affirms and supports the Governor's Affirmative Action Plan and is dedicated to creating a work environment which will attract and retain employees who represent the broadest possible spectrum of society including women, minorities and people with disabilities."*

This policy applies to all Oregon Board of Dentistry employees and Board members and encompasses every aspect of employment, including recruitment, hiring, promotion, compensation, benefits, professional development, discipline, separation from employment, and all other terms and conditions of employment. It also guides the equitable and accessible delivery of the Board's programs and services.

The Oregon Board of Dentistry is committed to building and sustaining a workplace where diversity is valued, inclusion is intentional, and every employee has the opportunity to contribute and succeed. We are dedicated to providing equal employment opportunities and fostering an environment free from discrimination, harassment, and retaliation. Employment decisions are based on merit, qualifications, and business needs, while respecting the dignity and unique perspectives of every individual, regardless of race, color, national origin, ethnicity, religion, sex, sexual orientation, gender identity or expression, age, disability, veteran status, etc.

The OBD will also ensure that it provides an environment for all applicants and employees that is free from sexual harassment and intimidation, creating a professional workplace environment regardless of an individual's race, color, religion, gender, sexual orientation, national origin, age, or disability.

The OBD supports the spirit and letter of equal employment opportunity laws, rules and regulations, affirmative action concepts, and the right of all persons to work and advance based on merit, ability, and potential. OBD will not discriminate, nor tolerate discrimination, against any applicant or employee because of physical or mental disability in regard to any position for which the applicant for employment is qualified.

The OBD is an autonomous agency, created by an act of the legislature in 1887, but it receives Human Resource services through an interagency agreement with the Oregon Medical Board's HR staff and overall support as a client agency of the Department of Administrative Services (DAS)
The OBD's 2026-2029 Strategic plan aligns with our agency's goals based on the State of

Oregon's 2027-2029 Affirmative Action Plan. The OBD's DEI Plan, and this AAP, are all working in concert for the agency.

While the OBD was created by state laws, we seek to ensure that the OBD builds an organization that uses the concepts of diversity, equity, and inclusion (DEI), such as problem-solving, innovation, and organizational development, to create a workplace that is stronger, better functioning, and more dynamic, and that can deliver the best possible service to the people of Oregon.

2025-2027 PROGRESS REPORT

During the 2025-27 biennium, the OBD has continued to work toward meeting its affirmative action, diversity, equity, inclusion, and altruistic goals. It is embedded in our work, our managers and we believe we are adhering to all policies applicable and also working in the full spirit of its intent. The Board members turned over due to the term limits on Board members. We welcomed eight new Board members since 2022. These eight were chosen by the Governor and confirmed by the Senate.

All the basic tasks and mission of the Board to license regulate and protect the public were accomplished. The OBD fulfilled its goal of initiating and completing strategic planning.

Employees are urged to cross-train whenever possible so that they may take advantage of those opportunities when they occur. The OBD's Executive Director promotes and encourages professional development training. OBD Staff have annually attended the DEI Conference and found great value in it.

2027-2029 OBJECTIVES

In the 2027-29 biennium, OBD will pursue the following strategies as the foundation of its Affirmative Action Plan:

Strategy 1 – Advance Equitable Access to Board Services
Objective: Ensure OBD programs, communications, and regulatory services are accessible, inclusive, and responsive to the diverse communities we serve.
Actions:

- Review public-facing communications annually using plain language and accessibility best practices.
- Continue improving language access resources for applicants, licensees, complainants, and members of the public.
- Seek feedback from stakeholders, including Tribal governments, professional associations, educational institutions, and community organizations, to improve agency services.
- Evaluate agency forms, publications, and website content for accessibility and ease of use.

Strategy 2 – Advance Community Engagement

Objective: Strengthen partnerships and engagement with Oregon's diverse communities to promote equitable access to Board services, increase transparency, and ensure a broad range of perspectives informs the Board's work.

Actions:

- Build and maintain collaborative relationships with professional associations, educational institutions, Tribal governments, community organizations, and workforce partners that reflect the diversity of Oregon.
- Engage with dental, dental hygiene, and dental therapy education programs to increase awareness of Board resources, regulatory processes, and career opportunities in public service.
- Review outreach, communication, and engagement practices annually to identify opportunities to improve accessibility, inclusivity, and meaningful participation.
- Provide ongoing education for Board members and staff on affirmative action, diversity, equity, inclusion, and belonging (DEIB) principles and their role in advancing an inclusive workplace and equitable public service.

Strategy 3 - Foster an Inclusive Workplace Culture Through Learning and Continuous Improvement

Objective: Promote a workplace culture that values DEIB by providing opportunities for continuous learning, encouraging respectful collaboration, and integrating inclusive practices into the Board's daily operations.

Actions:

- Encourage and support participation in professional development opportunities related to diversity, equity, inclusion, belonging, accessibility, cultural responsiveness, and respectful workplace practices, including training offered by the Department of Administrative Services (DAS), the Office of Cultural Change (OCC), and other statewide partners.
- Incorporate DEIB principles into employee and Board member onboarding, ongoing professional development, and leadership discussions.
- Foster an environment where employees and Board members are encouraged to share diverse perspectives, engage in respectful dialogue, and contribute to continuous organizational improvement.

Strategy 4 – Strengthen Accountability and Respectful Workplace Practices

Objective: Promote a culture of professionalism, accountability, and mutual respect by ensuring employment practices, workplace expectations, and agency operations reflect the principles of equal opportunity, accessibility, fairness, and compliance with state and federal laws.

Actions:

- Provide annual training for Board members and staff on respectful workplace practices, affirmative action responsibilities, and the prevention of discrimination, harassment, and retaliation.
- Promote leadership accountability by incorporating affirmative action and respectful workplace responsibilities into management performance expectations, consistent with Oregon law.

- Encourage employees and Board members to raise concerns through established reporting processes and ensure concerns are addressed promptly, fairly, and in accordance with applicable policies.

Complaint Options:

An individual who has interviewed for employment or has any complaint or grievance, may file a complaint with the Executive Director, Operations Manager or the Board President.

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Executive Director, Haley Robinson
Haley.Robinson@obd.oregon.gov

In addition, a person may go directly to DAS-CHRO for guidance and help if they choose to as well. All reported incidents will be investigated promptly, thoroughly, impartially, and discreetly in compliance with DAS Policy. Formal appeals/complaints may also be filed with the state's Affirmative Action Office; the Bureau of Labor and Industries; the Equal Employment Opportunity Commission (909 First Avenue, Ste. 400, Seattle, WA 98104-1061); or the United States Department of Labor, Office of Civil Rights.

The OBD adheres to policies and practice in effect by DAS. Subject Investigations of Human Resource Management Practices, Number 10.25.01, effective date 2/1/2019.

Succession Plan:

The OBD has a Succession Plan, which was reviewed, accepted and on file with DAS and available upon request.

Contracting:

The OBD has current contracts for IT and licensing process system. Due the small size of the agency, it has utilized DAS for support and service when conducting any procurement or contracting needs or work. During 2025-2027 no contracts or new procurement was undertaken by the OBD and none are planned for the 2027-2029 Biennium.

OBD Diversity, Equity & Inclusion Statement

OBD is committed to establishing, monitoring, and maintaining a diverse workforce, reflective of the population in the State of Oregon, where all employees are valued, treated fairly, and given opportunities to develop, thrive and feel that they truly belong. This is a commitment to an active program that provides equal opportunities for all persons regardless of race, color, religion, sex, sexual orientation, national origin, marital status, age, or disability. Every employee plays a part in our diverse workforce and inclusive work environment by being respectful and supportive, and by acting with integrity and respect to one another. Each person's skills, talents, knowledge, experiences, and personalities broaden the range of perspectives and approaches to conducting the work we do at OBD.

OBD can best promote excellence by recruiting, retaining, and accommodating a diverse group

of staff in an environment of respect that is supportive of their workplace success. This climate of diversity, inclusion and excellence is critical to successfully attaining our mission of contributing leadership and resources to increase the skills, knowledge and career opportunities of Oregonians.

The OBD is an equal-opportunity employer that is committed to a proactive role in the recruitment and selection process. The OBD will use diverse recruitment strategies to identify and attract candidates and establish interview panels that represent protected-class groups.

The OBD is committed to providing broad and culturally enriched training, career growth and developmental opportunities to all employees on an equal basis, enabling them to further advance and promote their knowledge, skills, and abilities and their value of diversity

The Affirmative Action Policy and Diversity & Inclusion Statement will appear on OBD's webpage. Additionally, OBD's plan will be provided to all new employees, posted in the employees' common area, and linked in OBD's newsletter. All OBD employees, with a higher emphasis of responsibility placed on management employees, are responsible for the implementation of the Affirmative Action Policy and Diversity & Inclusion in the workplace. Employees and Board members are expected to ensure that they are aware of the Affirmative Action Policy and Diversity, Equity & Inclusion statement and follow the policy and statement guidelines as it pertains to their work, especially during the hiring process.

An individual who has interviewed for employment, who believes they were denied employment based on any of the aforementioned discriminatory factors, may file a complaint with the Executive Director on behalf of the Board. All reported incidents will be investigated promptly, thoroughly, impartially, and discreetly. The investigator will notify the complainant in writing of the results of the investigation. Formal appeals/complaints may also be filed with the state's Affirmative Action Office; the Bureau of Labor and Industries; the Equal Employment Opportunity Commission (909 First Avenue, Ste. 400, Seattle, WA 98104-1061); or the United States Department of Labor, Office of Civil Rights.

Leadership Evaluation Report:

The OBD's Executive Director ensures that ORS 659A.012 is adhered to. It states that agencies are required to include in the evaluation of all management personnel the manager's or supervisor's effectiveness in achieving affirmative action objectives as a key consideration of the manager's or supervisor's performance. The OBD has two staff that meet management criteria: the Executive Director and the Operations Manager.

The Executive Director has been held accountable by the Board with an annual performance review since 2015. The previous Executive Director was honored to be assessed in a 360-degree performance Evaluation in March 2024. The current Executive Director will be assessed in a 360-degree performance evaluation when it is due. The questions and comments related to affirmative action and diversity were all positive and in alignment with the Governor's expectations. These included feedback on how the director fosters and

promotes an inclusive workplace environment (95% rated effective/very effective). The Executive Director has individual goals as well as directives from the Governor's Office, OBD Strategic Plan and shifting agency priorities. They include and are not limited to the following:

- Provide leadership in implementing the Board's Affirmative Action Plan and advancing initiatives that promote diversity, equity, inclusion, and belonging (DEIB), and equal employment opportunity, consistent with applicable laws, statewide policies, and guidance from the Governor's Office, the Department of Administrative Services (DAS), and the Office of Cultural Change (OCC).
- Foster a workplace culture that values respect, collaboration, accessibility, and professional growth, while ensuring all employees have equitable opportunities to contribute, develop, and succeed.
- Meet regularly with agency leadership and Human Resources to review workforce trends, affirmative action goals, recruitment and retention efforts, and opportunities for continuous improvement.
- Ensure affirmative action, equal opportunity, accessibility, and inclusive leadership responsibilities are incorporated into agency planning, management practices, and organizational decision-making.
- Include implementation of affirmative action objectives and support for an inclusive workplace as performance expectations for management employees, consistent with ORS 659A.012, which requires state agencies to evaluate managers on their effectiveness in achieving affirmative action objectives.
- Hold managers accountable for supporting equitable employment practices, fostering respectful workplaces, and advancing the goals and objectives outlined in the Board's Affirmative Action Plan through annual performance evaluations.
- Collaborate with Human Resources to ensure recruitment, hiring, promotion, and retention practices are conducted in accordance with State of Oregon policies, applicable laws, and principles of equal employment opportunity.
- Encourage and support participation in professional development opportunities related to affirmative action, accessibility, inclusive leadership, cultural responsiveness, and respectful workplace practices to strengthen organizational capacity and continuous learning.
- Ensure the Board's Affirmative Action Policy Statement and Affirmative Action Plan remain readily accessible to employees and the public through the agency website and other appropriate communication channels.
- Respond promptly and appropriately to reports of discrimination, harassment, retaliation, or other workplace concerns, ensuring concerns are addressed fairly, consistently, and in accordance with applicable laws, DAS policies, and agency procedures.

Actions management personnel are implementing from the Strategic Plan to advance the AAP.

Monitoring work and progress on the OBD's 2026-2029 Strategic plan which includes this priority, goal & work: STRATEGIC PRIORITY C Community Interaction and 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. Protecting the community has always been at the center of the Oregon Board of Dentistry Mission. Fairness and equity are imbedded in the OBD Values. The OBD believes it can do more to address the systemic inequities that have existed and ensure more fully that our mission and values apply to everyone.

- Enhance outreach and communication efforts to improve awareness of Board programs, services, and regulatory resources among Oregon's diverse communities.
- Promote equitable and accessible access to Board services, information, and regulatory processes through continuous evaluation and improvement of agency practices.
- Support fair, consistent, and impartial regulatory processes by monitoring investigation practices and promoting equitable decision-making.
- Increase understanding among licensees, patients, stakeholders, and the public of the Board's mission, regulatory responsibilities, and role in protecting the health, safety, and welfare of all Oregonians.

Work done to support AAP work and in alignment with this goal:

- Strengthened engagement with the dental therapy community by establishing the Dental Therapy Rules Oversight Committee (DTRO) as a standing advisory committee to support ongoing stakeholder collaboration and informed rule development.
- Expanded opportunities for meaningful engagement with the dental assisting community by actively seeking and incorporating feedback on legislative proposals, rulemaking, and other issues affecting the profession. As one of Oregon's most diverse oral healthcare professions, the perspectives of dental assistants contribute valuable insight to the Board's policy development and decision-making.
- Continued implementation of the Dental Assisting, Workforce, and Scope Advisory Committee (DAWSAC) through regular meetings that promote collaboration, transparency, and stakeholder participation.
- Reinforced the Board's commitment to government-to-government relationships by providing the OBD Tribal Relationship and Cooperation Policy to all Board members and staff for review and acknowledgment.
- Strengthened relationships with Oregon's nine federally recognized Tribal governments by extending annual invitations to participate in Board and committee meetings, providing meeting notices, and including opportunities for Tribal representatives to share input and perspectives during regular Board meetings.

- Adopted rules supporting continuing education in cultural responsiveness and culturally responsive care, helping licensees provide high-quality, patient-centered care to Oregon's diverse communities.
- Updated Board rules to align with Oregon Health Authority requirements regarding the use of qualified healthcare interpreters, improving language access and supporting equitable communication with patients and the public.
- Continued to monitor progress toward affirmative action, accessibility, and DEIB objectives by evaluating agency initiatives, stakeholder engagement efforts, and opportunities for continuous improvement.

Next Steps & more work to do:

- Continue aligning the Board's Affirmative Action Plan, strategic priorities, and agency initiatives with guidance from the Governor's Office, the Department of Administrative Services (DAS), the Office of Cultural Change (OCC), and other applicable statewide policies to advance equitable employment practices and equitable public service.
- Enhance language access by refining processes that enable individuals to communicate with the Board and submit complaints in their preferred language, utilizing available interpretation and translation resources to improve accessibility and meaningful participation.
- Evaluate regulatory processes and available data to identify opportunities to promote consistency, transparency, and equitable outcomes across the Board's licensing, complaint, and enforcement functions, while maintaining the Board's commitment to impartial decision-making and public protection.
- Strengthen relationships with stakeholders, including Tribal governments, educational institutions, professional associations, community organizations, licensees, and the public, to ensure diverse perspectives help inform agency initiatives, rulemaking, and continuous improvement efforts.
- Continue participating in statewide learning opportunities and collaborating with the Governor's Office, DAS, OCC, and partner agencies to remain informed of emerging best practices related to affirmative action, accessibility, equal employment opportunity, and organizational excellence.
- Provide employees and Board members with regular updates regarding statewide initiatives, policy changes, professional development opportunities, and agency progress in implementing the Affirmative Action Plan.
- Integrate affirmative action, accessibility, and DEIB principles into the Board's strategic planning process and performance management framework to ensure these commitments remain embedded in the agency's long-term goals, decision-making, and organizational culture.
- Establish performance measures and periodically evaluate progress toward affirmative action goals to support accountability, transparency, and continuous organizational improvement.

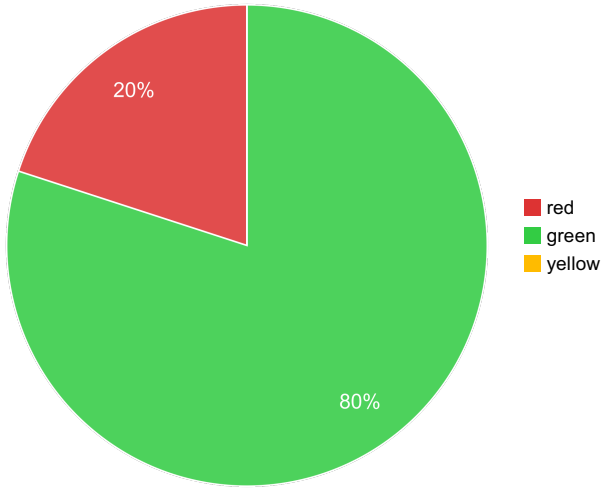
Board of Dentistry

Annual Performance Progress Report

Reporting Year 2026

Published: 7/29/2026 9:32:00 PM

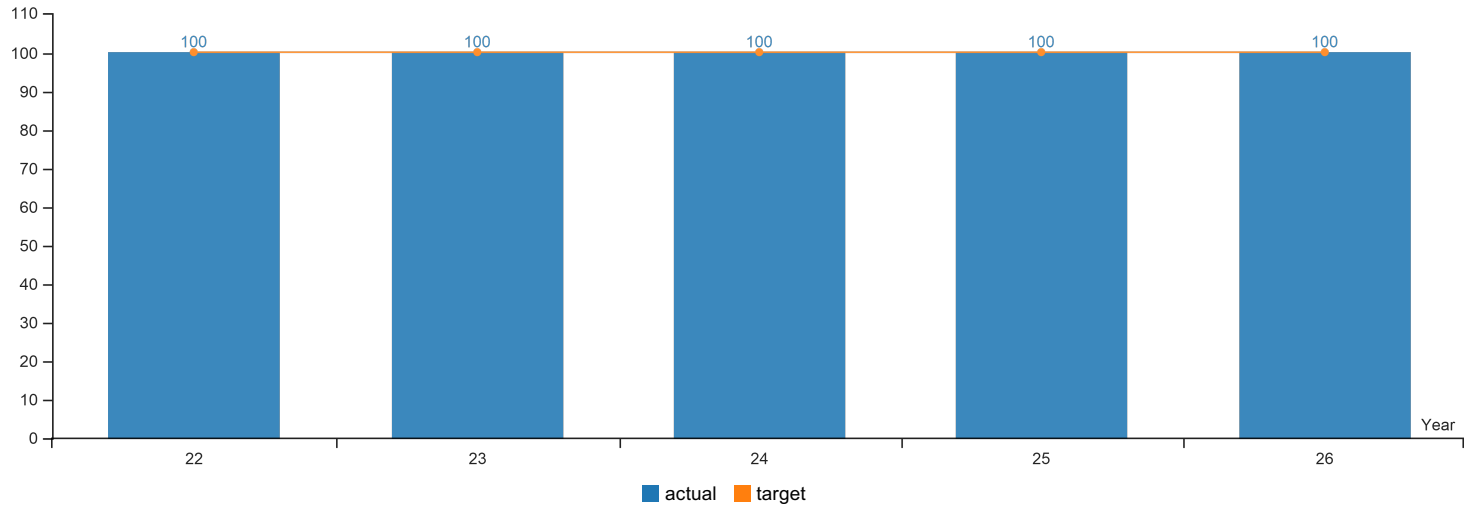
KPM #	Approved Key Performance Measures (KPMs)
1	Continuing Education Compliance - Percent of Licensees in compliance with continuing education requirements.
2	Time to Investigate Complaints - Average months from receipt of new complaints to completed investigation.
3	Days to Complete License Paperwork - Average number of working days from receipt of completed paperwork to issuance of license.
4	Customer Satisfaction with Agency Services - Percent of customers rating their satisfaction with the agency's customer service as "good" or "excellent": overall, timeliness, accuracy, helpfulness, expertise, availability of information.
5	Board Best Practices - Percent of total best practices met by the Board.



Performance Summary	Green	Yellow	Red
	= Target to -5%	= Target -5% to -15%	= Target > -15%
Summary Stats:	80%	0%	20%

KPM #1	Continuing Education Compliance - Percent of Licensees in compliance with continuing education requirements.
	Data Collection Period: Jul 01 - Jun 30

** Upward Trend = positive result*



Report Year	2022	2023	2024	2025	2026
Percent of Licensees in Compliance with Continuing Education Requirements					
Actual	100%	100%	100%	100%	100%
Target	100%	100%	100%	100%	100%

How Are We Doing

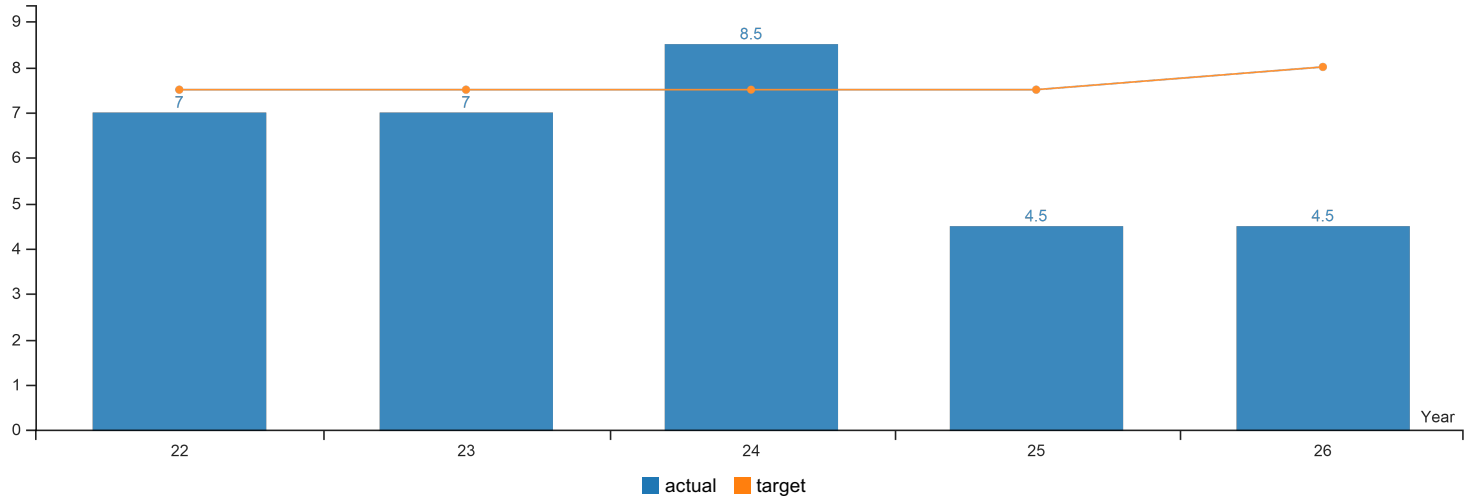
In FY 2026, the Board achieved this goal by ensuring licensees completed and complied with continuing education (CE) requirements. The Board believes that maintaining current knowledge of clinical practice, regulatory changes, and emerging issues is essential to protecting the public. Licensees are required to complete continuing education during each two-year licensure period. Compliance is monitored through license renewal attestations, reviewed during investigations when applicable, and verified through random audits each renewal cycle. Board staff follow up as needed to ensure all licensees satisfy the required continuing education standards.

Factors Affecting Results

Board staff work closely with licensees to communicate and clarify the requirements necessary to comply with Board statutes and administrative rules.

KPM #2	Time to Investigate Complaints - Average months from receipt of new complaints to completed investigation.
	Data Collection Period: Jul 01 - Jun 30

** Upward Trend = negative result*



Report Year	2022	2023	2024	2025	2026
Average time to Investigate Complaints					
Actual	7	7	8.50	4.50	4.50
Target	7.50	7.50	7.50	7.50	8

How Are We Doing

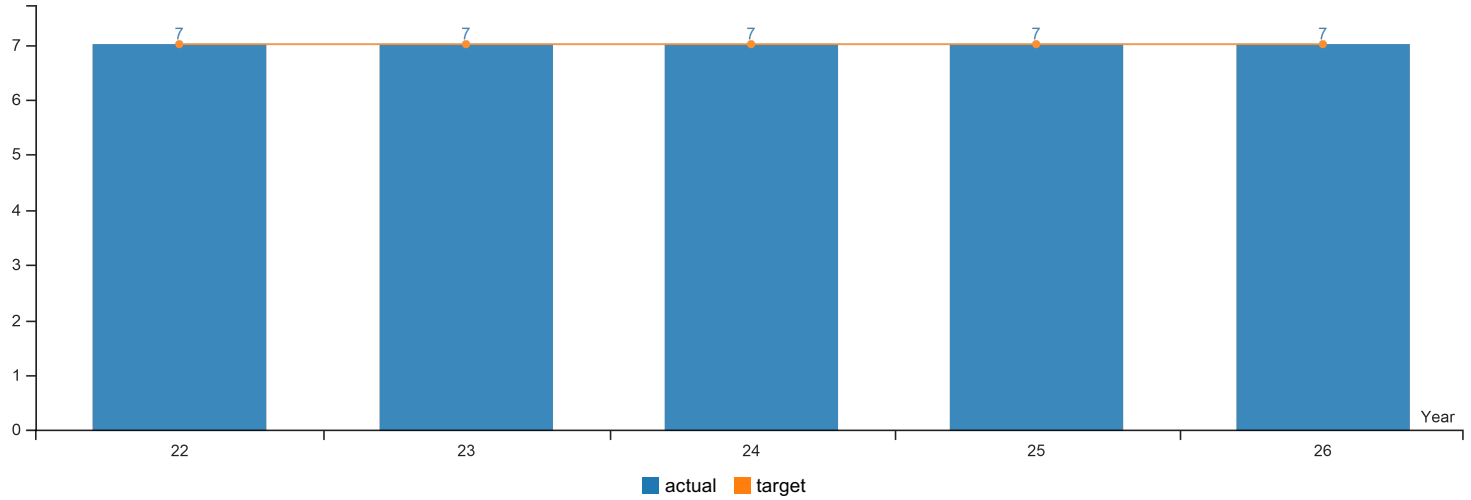
In FY 2026, Board investigators continued to process and close cases efficiently while maintaining the quality and thoroughness of investigations. Regularly scheduled Board meetings proceeded as planned despite ongoing operational challenges. Investigation timelines may vary based on factors such as case complexity, the number of treatment providers involved, the timeliness of responses, and the cooperation of all parties throughout the investigative process.

Factors Affecting Results

The total number of investigations opened in FY 2026 was 209 compared to 213 in FY 2025. The number of cases closed in FY 2026 was 215 compared to 225 in FY 2025. All new complaints are addressed and investigated in a timely manner.

KPM #3	Days to Complete License Paperwork - Average number of working days from receipt of completed paperwork to issuance of license.
	Data Collection Period: Jul 01 - Jun 30

** Upward Trend = positive result*



Report Year	2022	2023	2024	2025	2026
Average Number of Working Days to Issue license after Paperwork is Completed.					
Actual	7	7	7	7	7
Target	7	7	7	7	7

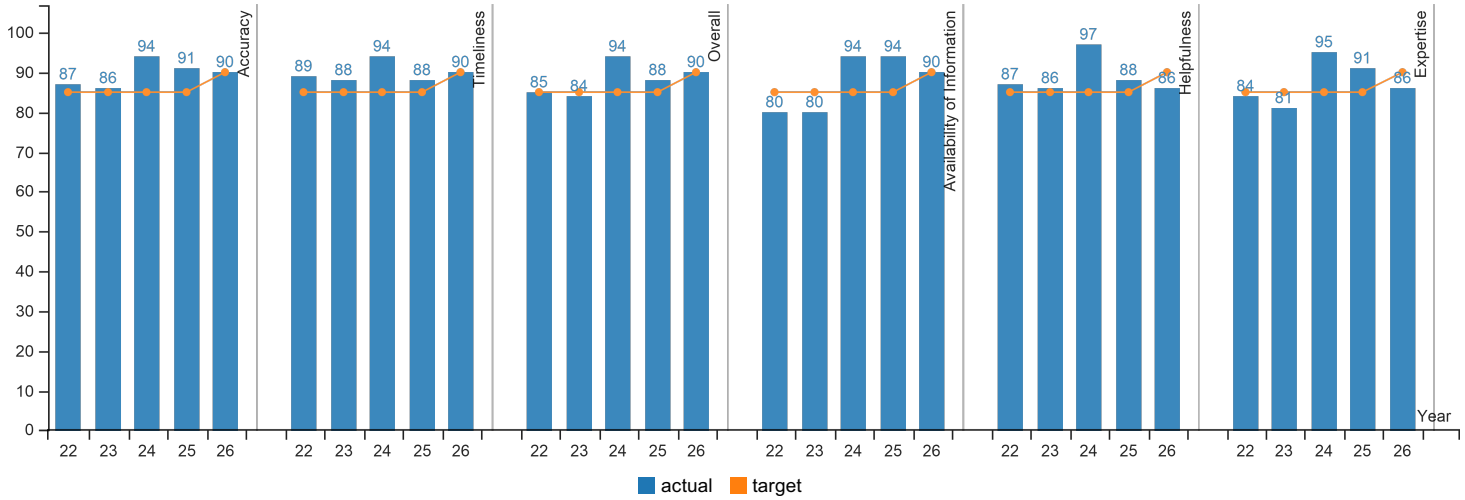
How Are We Doing

In FY 2026, the Board successfully achieved this goal. Although processing times were occasionally affected by external agencies, educational institutions, licensing boards in other states, and other third parties, Board staff processed and issued licenses with minimal delay once all required documentation was received through the online licensing portal.

Factors Affecting Results

The OBD is committed to processing license applications and renewals accurately, efficiently, and in a timely manner to ensure qualified applicants are licensed without unnecessary delay.

KPM #4	Customer Satisfaction with Agency Services - Percent of customers rating their satisfaction with the agency's customer service as "good" or "excellent": overall, timeliness, accuracy, helpfulness, expertise, availability of information.
	Data Collection Period: Jul 01 - Jun 30



Report Year	2022	2023	2024	2025	2026
Accuracy					
Actual	87%	86%	94%	91%	90%
Target	85%	85%	85%	85%	90%
Timeliness					
Actual	89%	88%	94%	88%	90%
Target	85%	85%	85%	85%	90%
Overall					
Actual	85%	84%	94%	88%	90%
Target	85%	85%	85%	85%	90%
Availability of Information					
Actual	80%	80%	94%	94%	90%
Target	85%	85%	85%	85%	90%
Helpfulness					
Actual	87%	86%	97%	88%	86%
Target	85%	85%	85%	85%	90%
Expertise					
Actual	84%	81%	95%	91%	86%
Target	85%	85%	85%	85%	90%

How Are We Doing

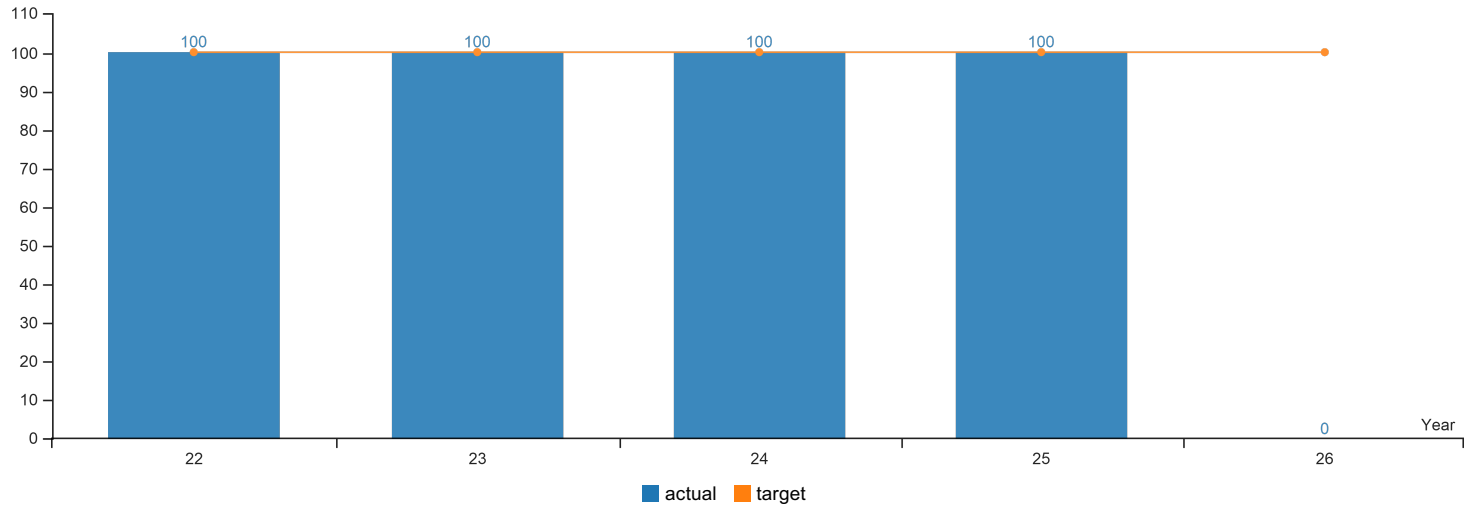
In FY 2026, the Board successfully achieved this goal. In accordance with the Oregon Legislature's directive, the Board conducted its annual Customer Service Survey to assess stakeholder satisfaction with the Board's services and its fulfillment of statutory responsibilities. Overall, the survey results were positive, demonstrating the Board's continued commitment to providing accurate, timely, and professional service.

Factors Affecting Results

Participation in the Customer Service Survey is voluntary, and the Board will continue to promote the survey and encourage stakeholder feedback. In addition to survey responses, the Board regularly receives direct feedback from licensees, applicants, and the public. This input provides valuable insight into how the Board's actions and services affect stakeholders and helps identify opportunities for continuous improvement.

KPM #5	Board Best Practices - Percent of total best practices met by the Board.
	Data Collection Period: Jul 01 - Jun 30

** Upward Trend = positive result*



Report Year	2022	2023	2024	2025	2026
Compliance with Best Practices Performance Measurement					
Actual	100%	100%	100%	100%	0%
Target	100%	100%	100%	100%	100%

How Are We Doing

The Board annually reviews the 15 performance metrics outlined in the Board Best Practices framework during its August Board meeting. As part of its commitment to effective governance and accountability, the Board also conducts an annual performance evaluation of the Executive Director. The Executive Director has received an annual performance review each year since 2015. Through its ongoing review of the Best Practices Performance Measures for Governing Boards and Commissions, the Board continues to assess its effectiveness and identify opportunities to strengthen governance and organizational performance.

Factors Affecting Results

The Board Members are engaged and dedicated to their responsibilities, duties and obligations serving Oregon in their capacity. The Board will review the Board Best Practices' Assessment document at its August 21, 2026, Board Meeting.

NEWSLETTERS & ARTICLES OF INTEREST

4 ways dentists can make dental assistants feel valued

May 13, 2026

Behind every smooth procedure, calm patient, and efficient day at the practice, there's a dental assistant making it all happen. So why do many feel undervalued? Despite touching every area of the office, dental assistants often feel they are overlooked, underappreciated, and not fairly compensated for their work.

"I hope doctors and managers really realize what a dental assistant does on a daily basis," says Denys, a dental assistant in Washington. "They are the glue to the office and take on a lot that sometimes isn't recognized and appreciated! There's more to a dental assistant than many think. It's hard work that only the greatest can do!"

By taking intentional actions to recognize their impact, such as offering fair pay and encouraging career growth, dentists can ensure dental assistants feel respected and valued as essential members of the team. We talked to dental assistants from around the country about ways dentists can provide support for dental assistants.

A simple thank-you

Dental assistants contribute a lot to dental practices, and their position should never be taken for granted. They guide the patient experience, lead infection control processes, assist chairside, and much more. While it may seem like a small gesture, giving verbal recognition shows appreciation and boosts morale. Especially on busy days, dentists should take the time to thank their dental assistants for all they do to keep the schedule and procedures running smoothly. This recognition can help dental assistants feel valued, increase job satisfaction, and improve patient care.

Jeanne says, “Knowing I have a supervisor who recognizes our importance, how much we do behind the scenes, and is constantly letting us know how appreciative they are of our services helps me feel valued at work.”

Invest in career development

From updated infection control protocols to new industry standards, there is always new information to learn. By investing in career development opportunities, such as certifications or continuing education(opens in a new window), dentists show they are confident in their dental assistants’ careers and want them to grow within the profession.

“A well-trained dental assistant is a credit to the practice!” says Jenifer. “There are numerous duties a Certified Dental Assistant can do that take the pressure off the doctor, allowing the office to run more efficiently and helping other staff members keep the practice clean and stocked between patients.”

Dental practices can benefit from dental assistants earning certifications, as shown in DANB’s Dental Assistants Salary and Satisfaction Survey. The data shows that Certified Dental Assistants (CDAs) are less likely to change jobs and more likely to be leaders or trainers in the office. Investing in certification can demonstrate to dental assistants that their career growth is valued, helping practices improve staff retention and maintain a more stable, experienced workforce.

Offer competitive pay

Earning a fair wage is important to all dental assistants, and salary is the top factor that impacts their job satisfaction. Dentists should offer pay that reflects a dental assistant’s experience and credentials to demonstrate that their contributions are valued within the practice. Competitive compensation sends a strong message of appreciation and acknowledges the work dental assistants do every day. Additionally, recognizing their value through fair pay helps build employer loyalty and increases job satisfaction. DANB’s Financial Impact of Dental Assistants on the Dental Practice(opens in a new window) report explains how higher pay can increase dental assistant retention — resulting in increased productivity and higher revenues for practices.

Nicole shares, “Dental assistants deserve recognition, fair pay, and genuine respect — not as ‘support staff,’ but as critical professionals whose skill, dedication, and heart make quality dental care possible.”

Dentists can use DANB’s Salary and Satisfaction Survey or look at what other offices in the area are paying to gauge a fair wage based on factors such as location, experience, and credentials.

Honor breaks and time off

Dentists can support dental assistants by ensuring they have opportunities to recharge during the day, such as encouraging short breaks. Dentists can also promote a healthy work-life balance by providing staff with reasonable paid time off. If a practice is experiencing staffing shortages and dental assistants are taking on more responsibilities, there should be an open dialogue between dental assistants and office leaders to strategize the best approach to scheduling and workload distribution.

Welcome feedback

When dentists listen to feedback, dental assistants feel heard and more established in a professional space. Having an open line of communication between dentists and dental assistants creates a welcoming environment where staff members feel comfortable raising concerns, areas of improvement, and thoughts regarding patient care.

“Clear communication and being included in conversations about patient care matter a lot,” says Courtney. “When my input is asked for or trusted — whether it’s anticipating a procedure, suggesting a workflow improvement, or advocating for a patient — it reinforces that my role is seen as essential, not replaceable.”

This mutual respect encourages collaboration, strengthens trust within the team, and can lead to better clinical outcomes. Over time, consistent communication builds confidence and reinforces a culture where every team member’s perspective is valued.

The State of the U.S. Dental Economy

1st Quarter 2026 Update
Plus: A Closer Look into Staffing Challenges

HPI Health Policy Institute
ADA American Dental Association®

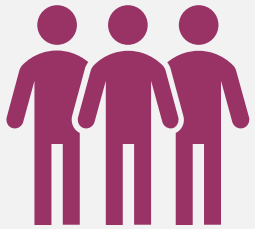
Q1 2026 State of the U.S. Dental Economy Report

This quarterly overview of the state of the U.S. dental economy from the ADA Health Policy Institute draws insights from proprietary data collected from a robust sample of dental practices in the U.S. and the latest economic data related to dentistry from various government sources. The report includes four sections:

- **Dentists' Economic Confidence:** Key indicators of the general sentiment in dental practices
- **Consumer Dental Spending:** Statistics on dental spending by households
- **Dental Practice Economics:** Trends in provider reimbursement rates, prices for dental equipment and supplies, dentist busyness, and future investment decisions
- **Dental Jobs Market:** The state of the job market in dental offices, including employment trends, staffing and recruitment issues

Plus: A Closer Look into Staffing Challenges

This quarter's report also includes valuable insights from dentists on the adequacy of their dental practice staff.



Staff Adequacy

Dentists' perceived adequacy of dental hygienists, dental assistants, and administrative staff in their practice.

Employee Benefits

Dentists' offerings of employee benefits such as health insurance and paid time off and how this varies by staffing adequacy.

Dentists' Economic Confidence

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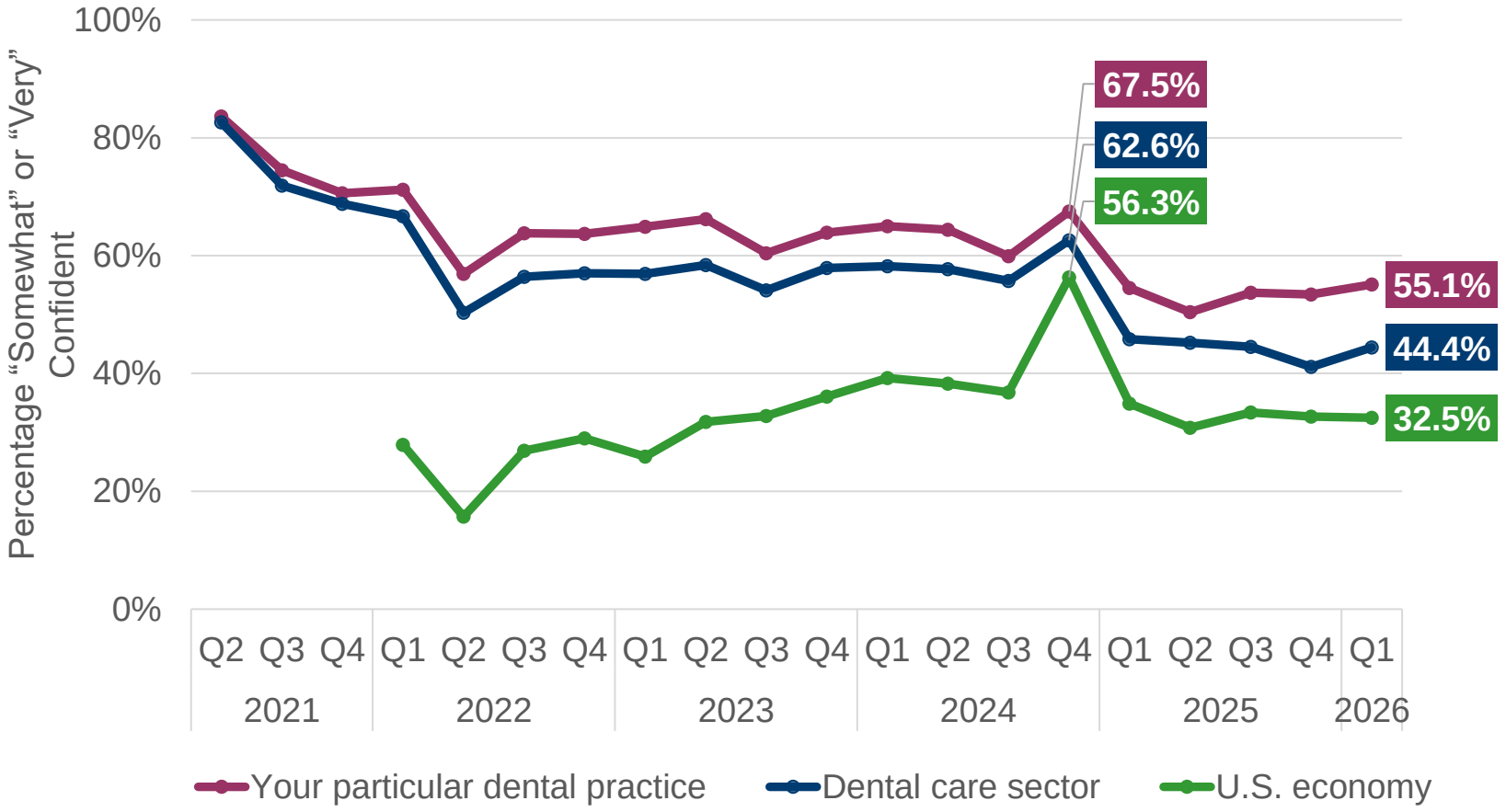
Dentists' Economic Confidence Steady



In Q1 2026, dentists' confidence **in their own practice** and the **dental sector** is up slightly compared to Q4 2025. Confidence in the **overall U.S. economy**, meanwhile, remains virtually unchanged.

Dentists' economic confidence has been stable since early 2025 after dropping from a surge in late 2024. The stability can be seen for all three sectors.

Source: ADA Health Policy Institute

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Why Dentists Feel **Confident** about the **Dental Sector**

More dentists are confident than are skeptical in the dental care sector. These are the top reasons for this rating among dentists who are confident about the U.S. economy in Q1 2026.

44.4%
Share of Dentists Confident about the Dental Care Sector in Q1 2026

TOP FIVE REASONS FOR CONFIDENCE

1. Dentistry is always needed (33.3%)
2. Strong demand, practice busyness (31.6%)
3. Economic resilience of dental sector (11.0%)
4. Positive economic outlook in general (7.4%)
5. Patient demand exceeds supply of dentists in the area (7.1%)

Source: ADA Health Policy Institute

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Why Dentists Feel **Confident** about the **Dental Sector**

WHAT DENTISTS ARE SAYING…

"There is always a need for dental care as long as people have teeth."

"In my area, it seems like there are more patients and less dentists."

"People need dentistry done – even if they aren't doing elective cases, there will always be a need."

""Even when the economy is bad… people still need care."

"In my 20 years in practice… generally always stayed stable."

"We have been very busy."

Source: ADA Health Policy Institute

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Why Dentists Feel **Skeptical** about the **Dental Sector**

More dentists are confident than are skeptical in the dental care sector. These are the top reasons for this rating among dentists who are skeptical about the U.S. economy in Q1 2026.

29.1%
Share of Dentists Skeptical about the Dental Care Sector in Q1 2026

TOP FIVE REASONS FOR SKEPTICISM

1. Low reimbursement, insurance pressures (36.3%)
2. Rising practice costs, inflation (30.5%)
3. U.S. economic downturn (21.5%)
4. Staffing shortages (11.7%)
5. Uncertainty due to current administration or war (11.2%)

Source: ADA Health Policy Institute

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Why Dentists Feel **Skeptical** about the **Dental Sector**

WHAT DENTISTS ARE SAYING…

"Supplies and dental materials are either unavailable or much more expensive. The tariffs are killing our practice…"

"The economy is changing. The Iranian War has affected prices that were already affected by tariffs."

"Managed care/dental insurance reimbursement rates are downright abysmal."

"When general economy suffers, generally, so does dentistry. People tend to consider dentistry elective despite our best efforts."

"Patients will NOT pay for teeth if they can't buy gas and groceries."

"I already see the production falling. Patients with uncertainty hesitate to treat even routine procedures."

Source: ADA Health Policy Institute

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Consumer Dental Spending

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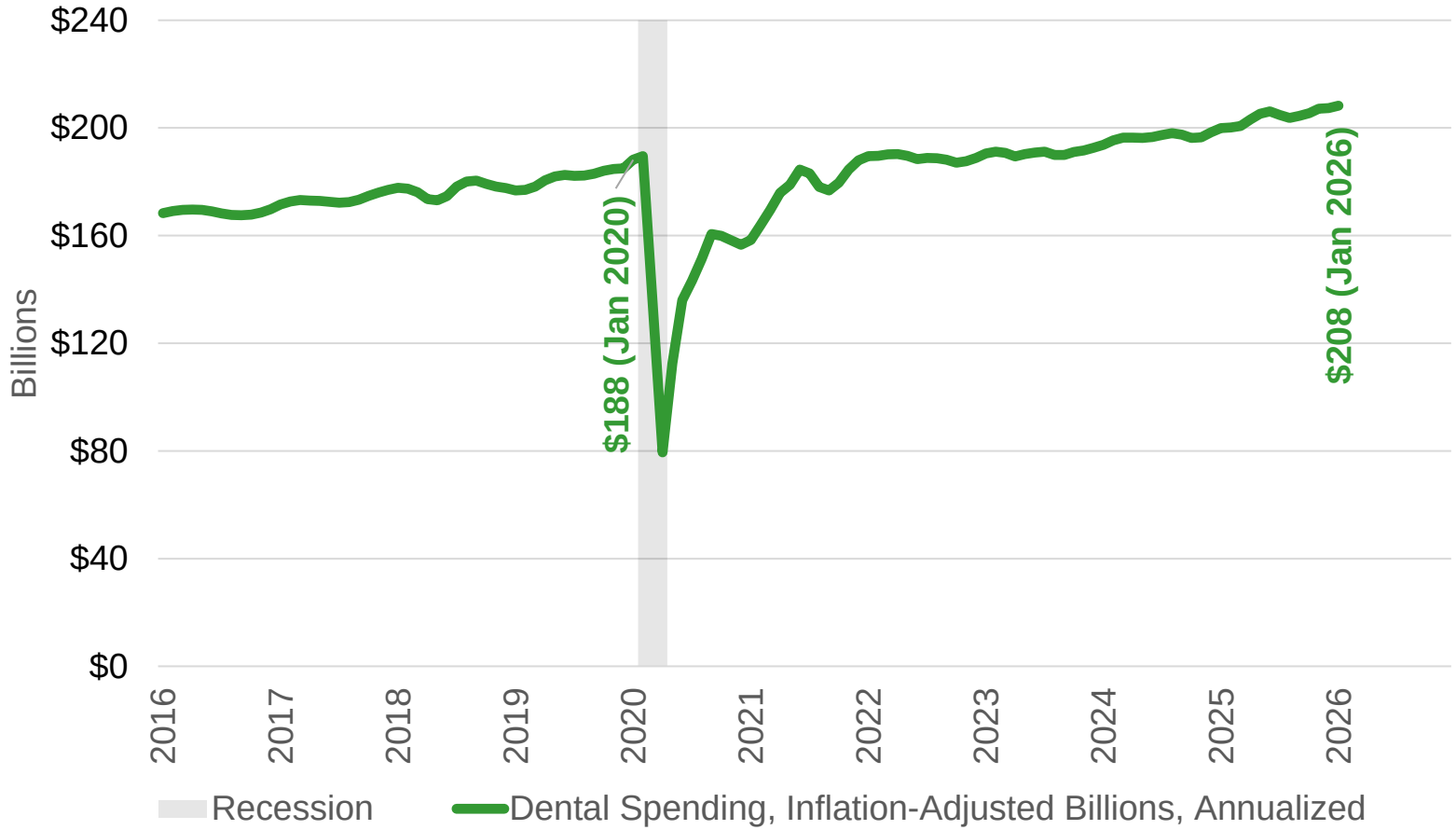
Consumer Dental Spending Rising Gradually

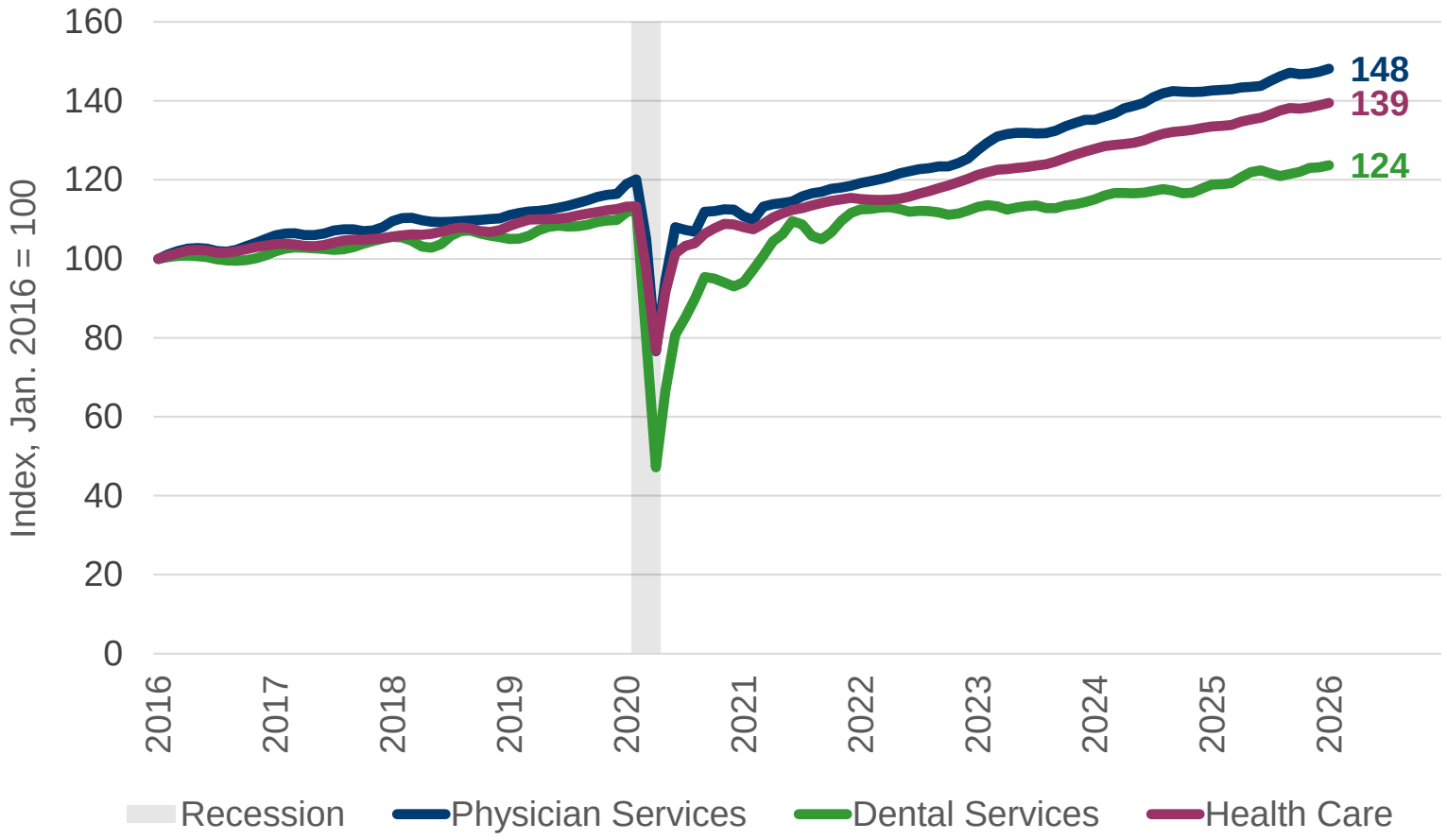


In January 2026, consumer dental spending was **up**:

- 0.4% from month prior
- 0.4% year-to-date
- 4% from 12 months prior
- 11% from pre-pandemic

Source: Bureau of Economic Analysis. Note: Adjusted for inflation, 2026 dollars.

Dental Spending Lags Health Care Spending



Consumer dental spending continues to lag health care spending overall.

Over 10 years, consumer spending on:

- **physician services** is up by 48%
- **health care** is up by 39%
- **dental services** is up by 24%

Source: Bureau of Economic Analysis. Note: Adjusted for inflation. Growth measured in January 2026 relative to January 2016.

Dental Practice Economics

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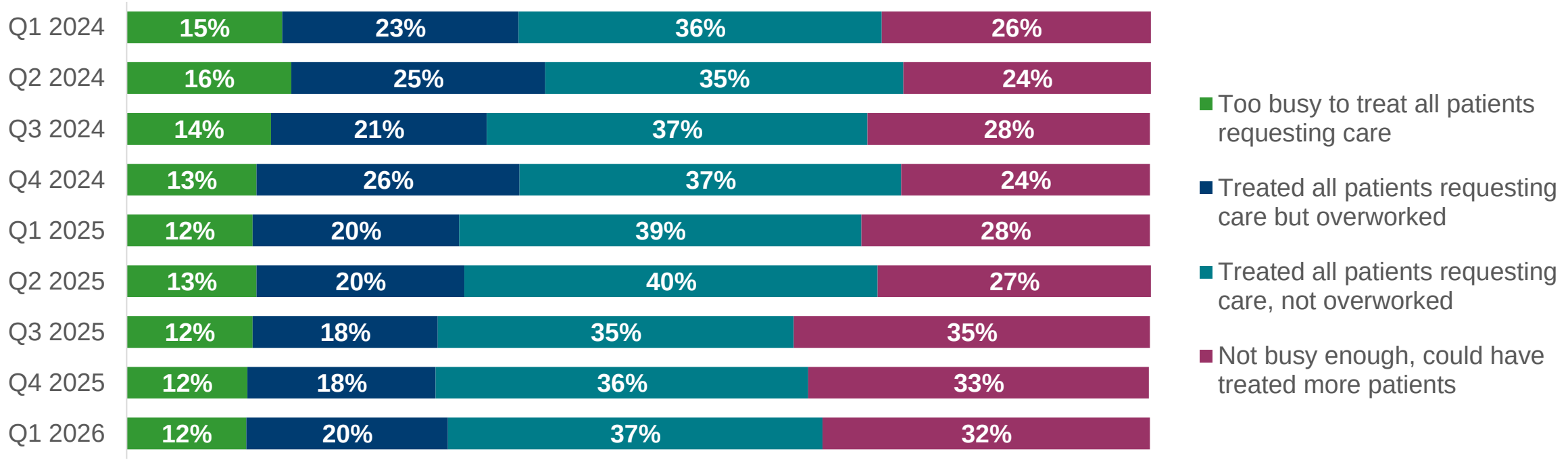
One-Third of Dentists Not Busy Enough



As of Q1 2026, one-third of dentists report they are **not busy enough**. Since early 2024, the overall share of dentists not busy enough has gone up while the shares who are **too busy** and **overworked** have gone down.

Source: ADA Health Policy Institute

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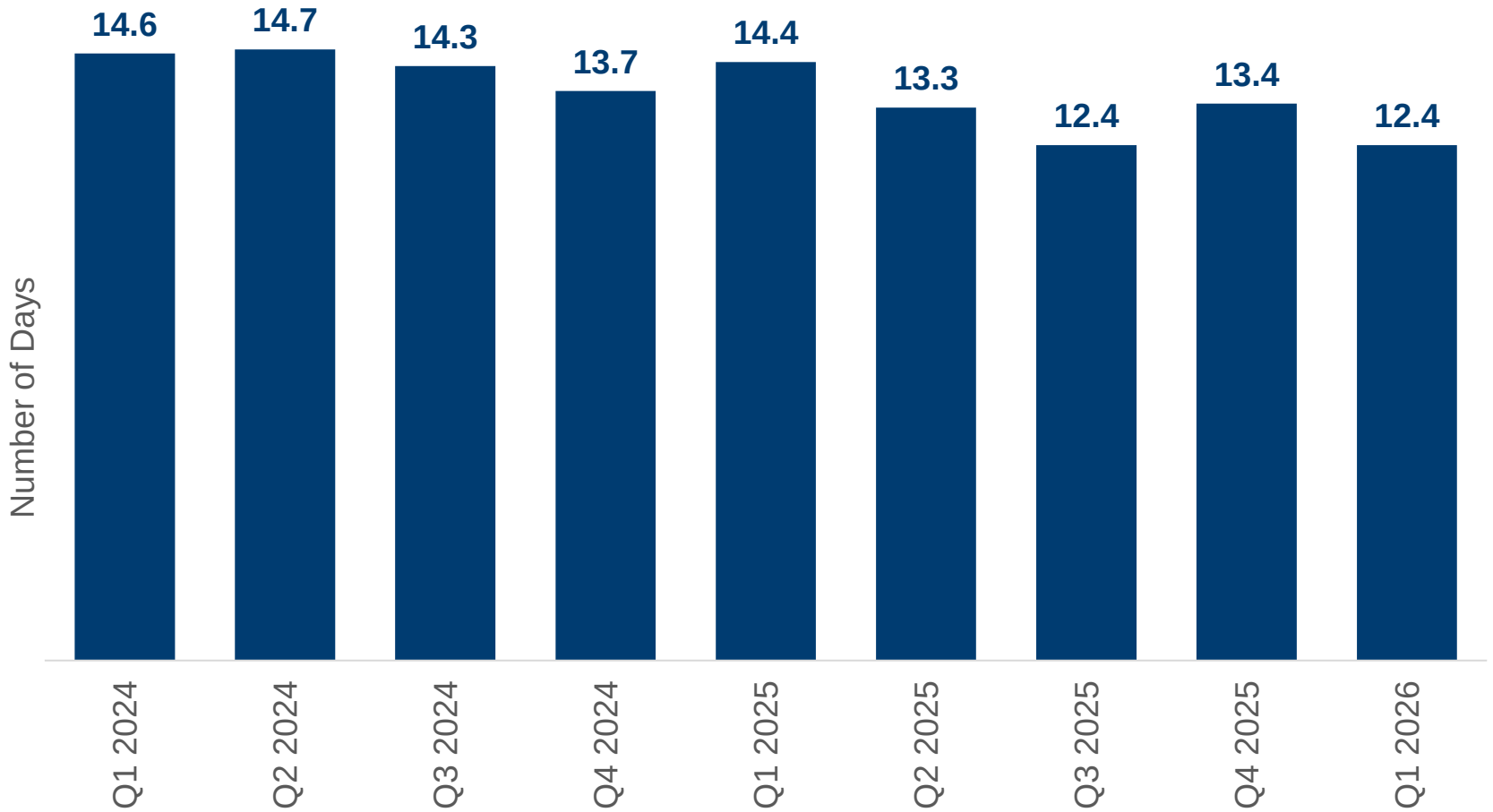
Appointment Wait Times Down



Wait times in Q1 2026 have slightly declined compared to last quarter to an average of 12.4 days.

Appointment wait times for new patients have gone down by approximately two days since Q1 2024.

Source: ADA Health Policy Institute

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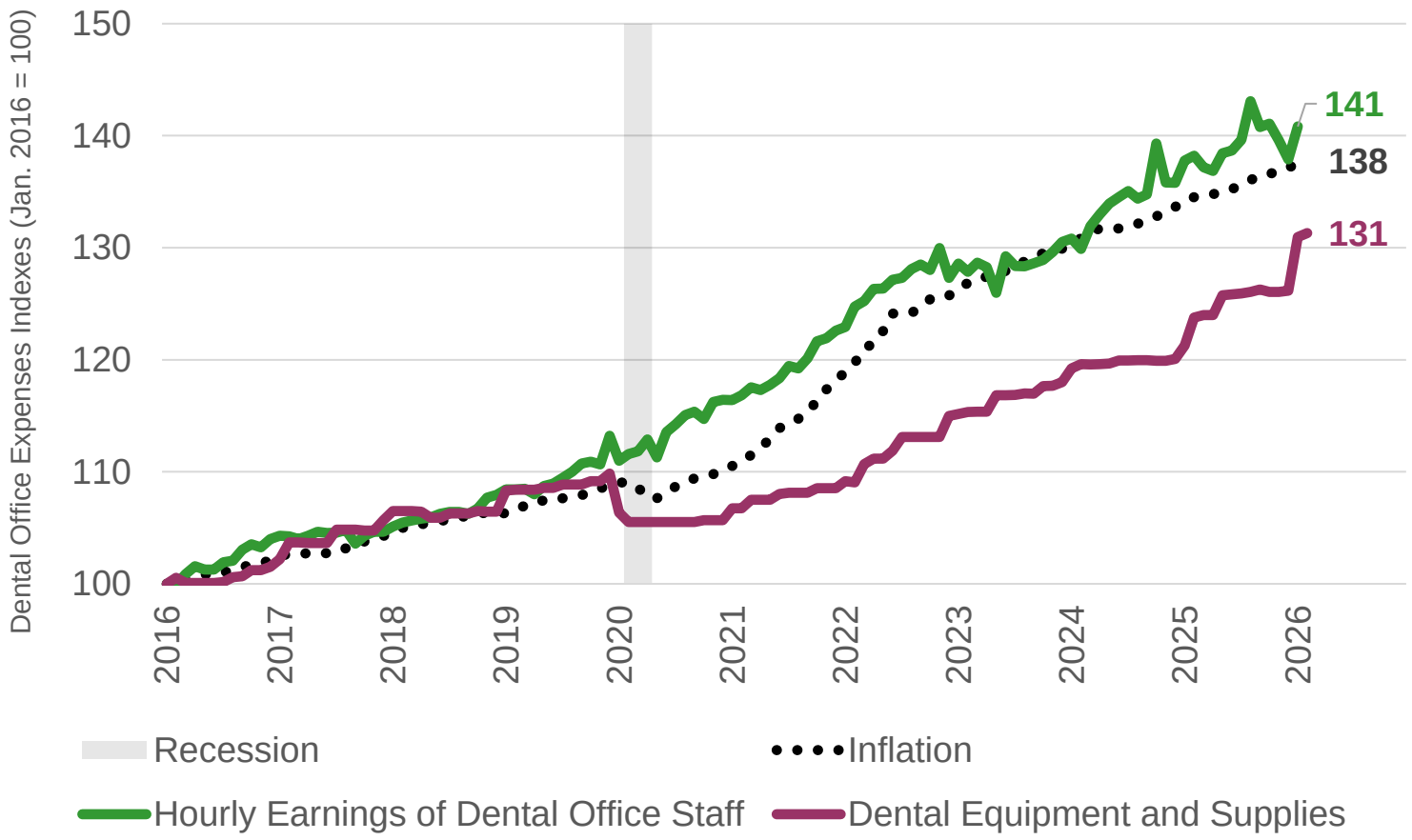
Prices for Dental Practice Expense Items Rising



For the 12 months ending with February 2026, prices for dental equipment and supplies increased by 6%. Hourly earnings of dental office staff increased by 2%.

During the same period, overall inflation was 2%.

Source: U.S. Bureau of Labor Statistics

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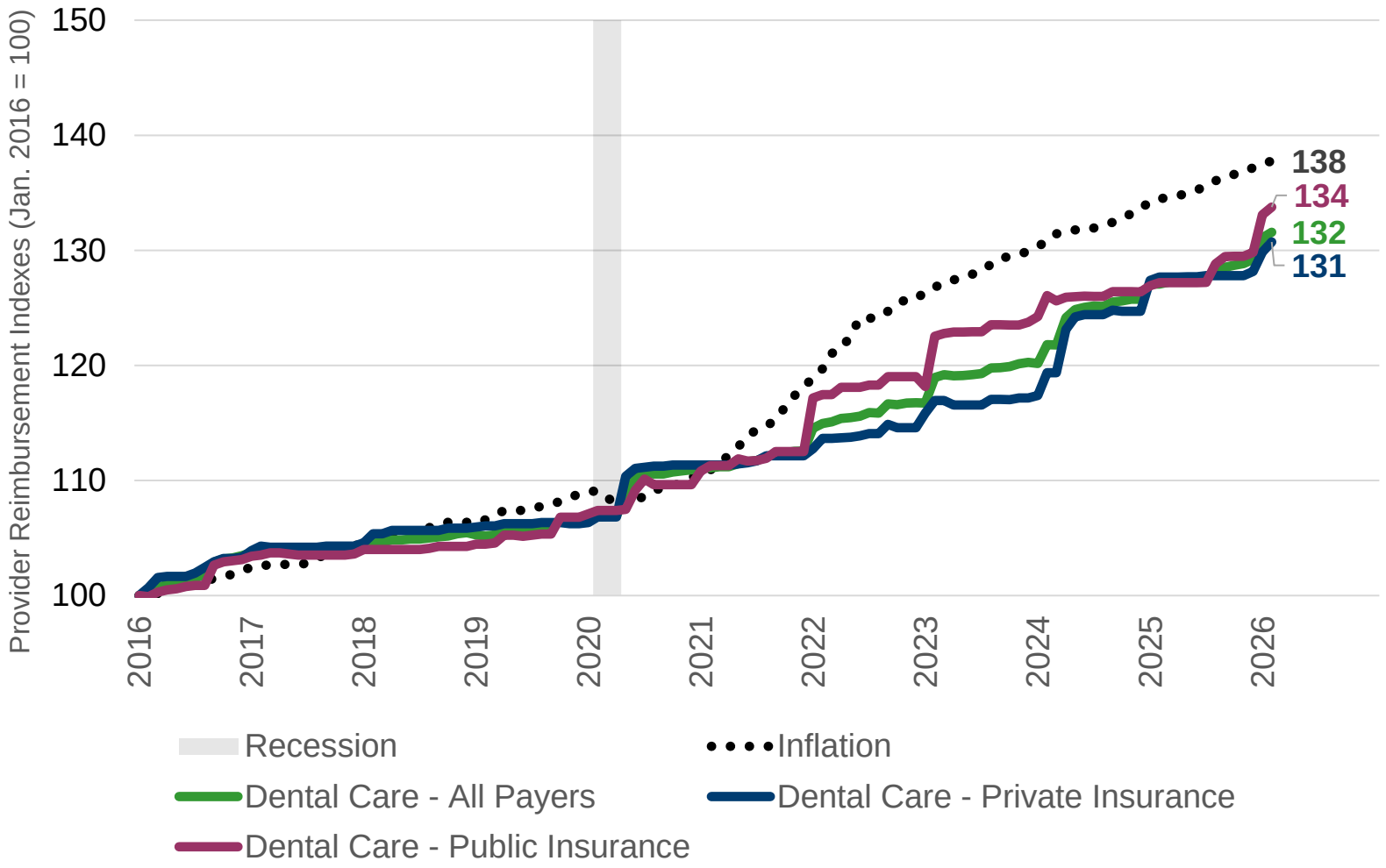
Reimbursement Rates Not Keeping Up with Inflation

In February 2026, provider reimbursement rates in the dental sector increased slightly. However, longer term, they are not keeping pace with overall inflation and certainly not with practice expenses. These trends are putting a significant “fiscal squeeze” on dental practices.



Source: U.S. Bureau of Labor Statistics

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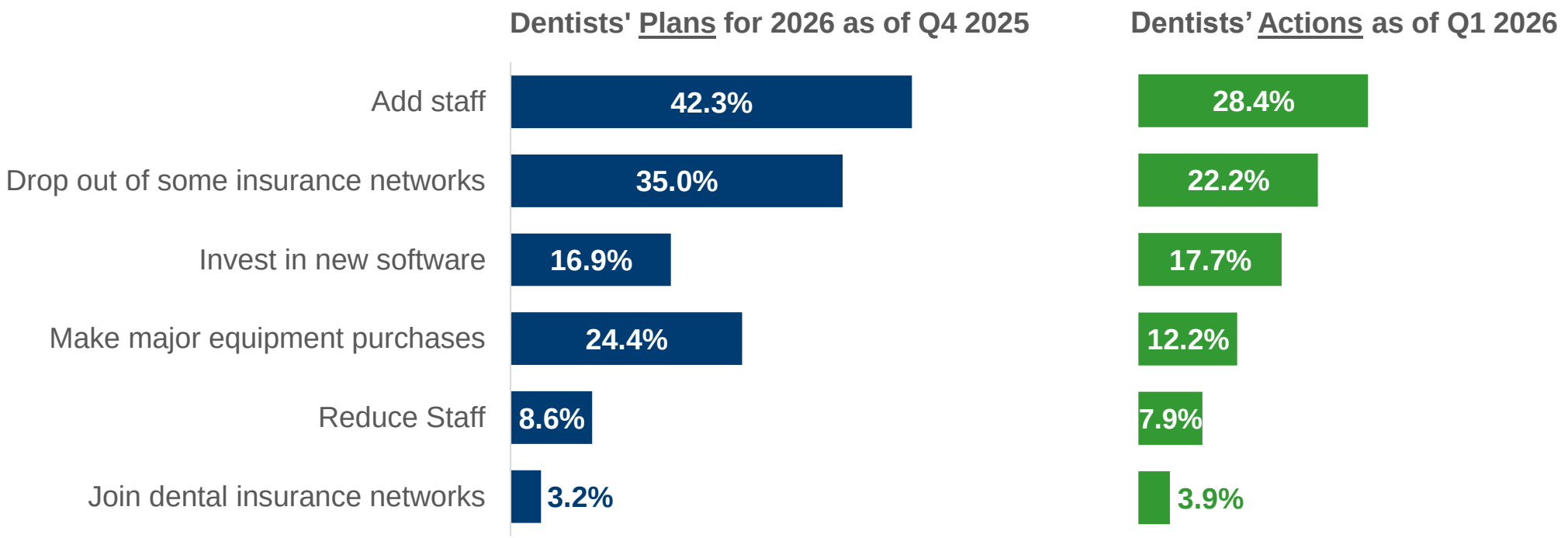
Dentists' Intentions vs. Actions in 2026



In Q4 2025, dentists were asked about **their plans for 2026**. We asked them in Q1 2026 whether they **had taken action** on any of these plans. In Q1 2026, dentists are moving towards their plans for the year and have already surpassed their intentions for new software investments.

Source: ADA Health Policy Institute

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Dental Jobs Market

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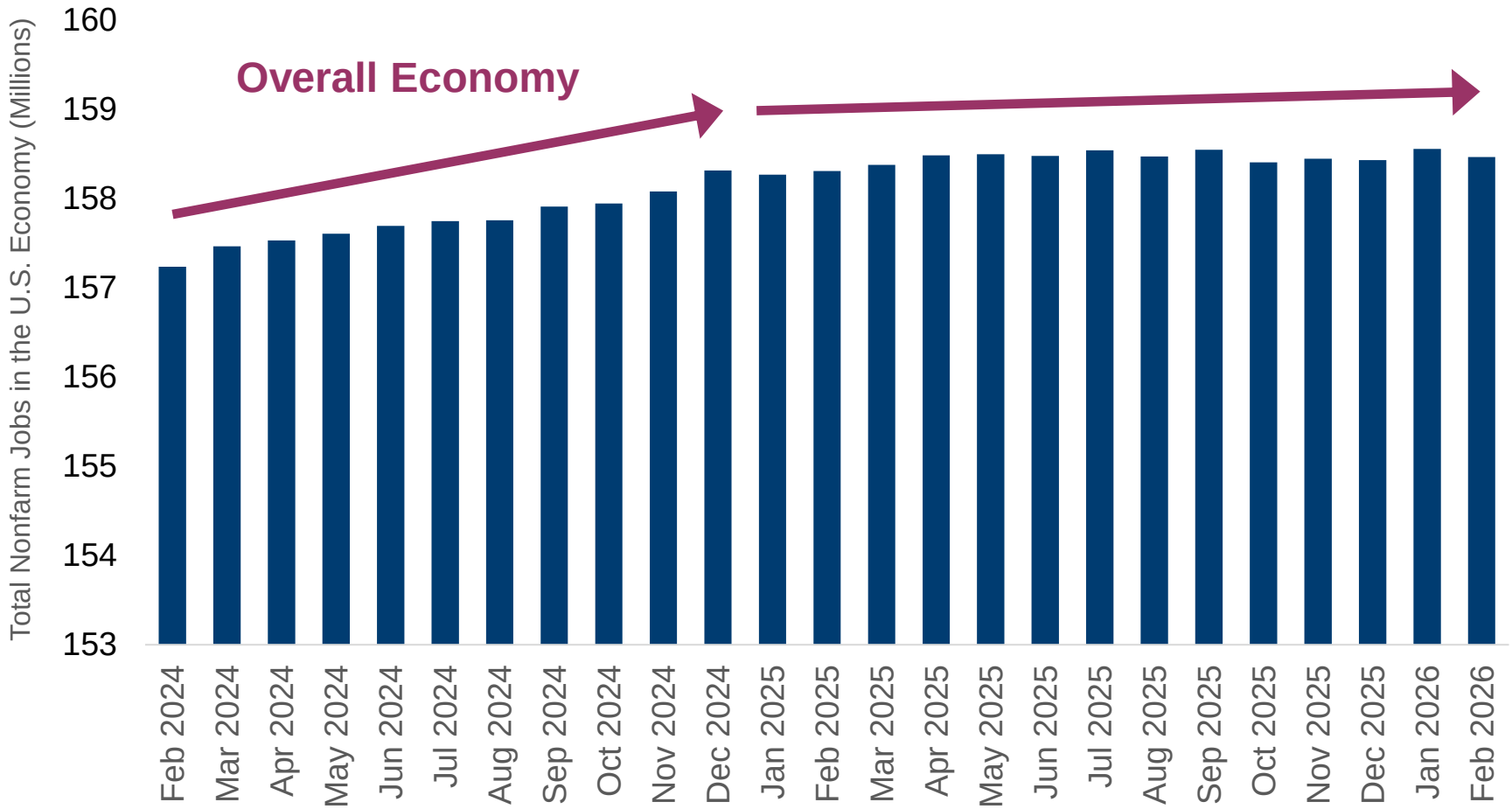
U.S. Economy Adding Jobs at Slower Pace



Job growth slowed in the U.S. economy after December 2024; 92,000 jobs were lost in February 2026.

Source: U.S. Bureau of Labor Statistics

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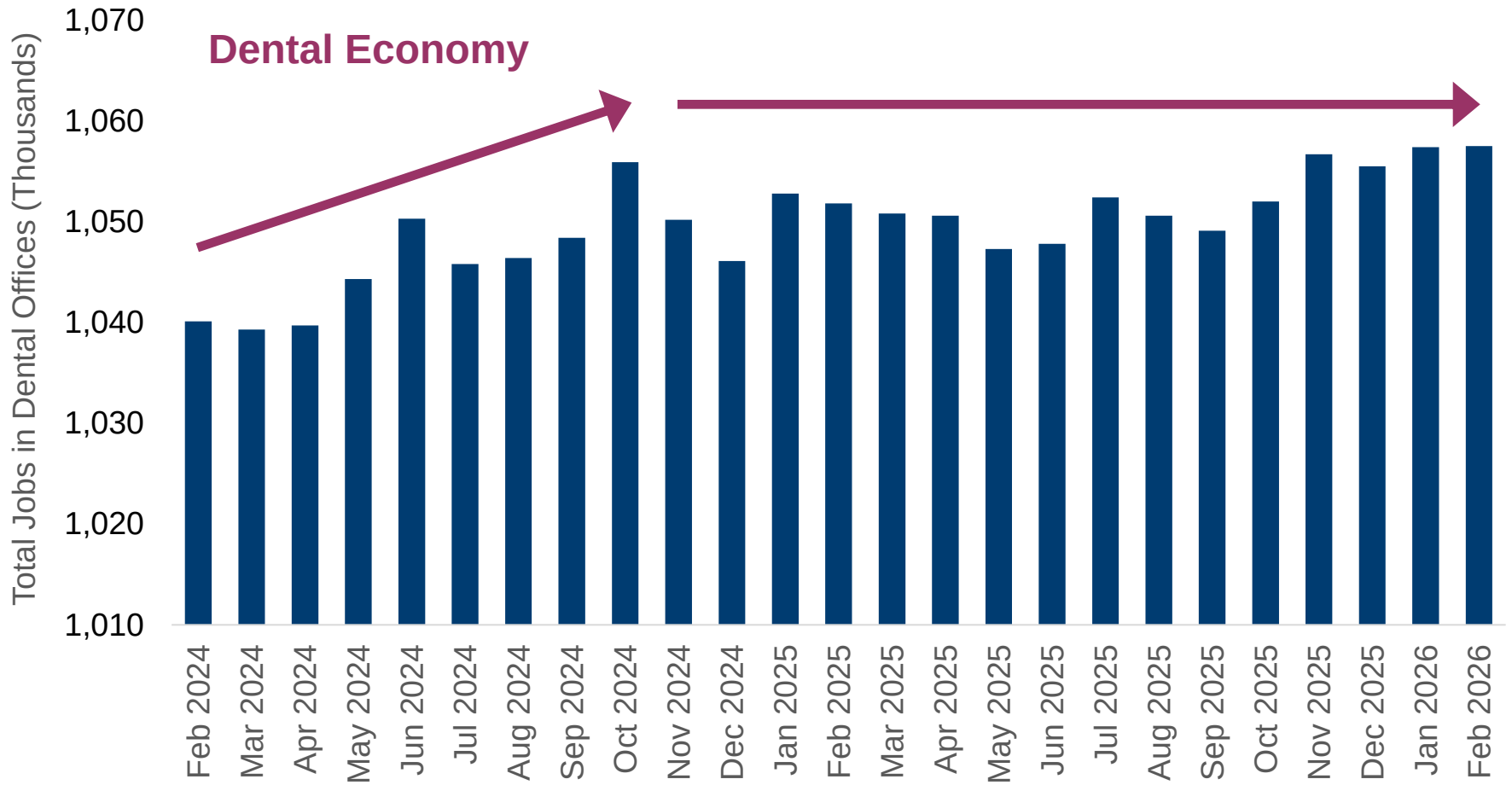
Dental Sector Employment Flat



In February 2026, the total number of jobs in dental offices was:

- Up less than 0.1% from month prior
- Up 0.5% over 12 months

Source: U.S. Bureau of Labor Statistics

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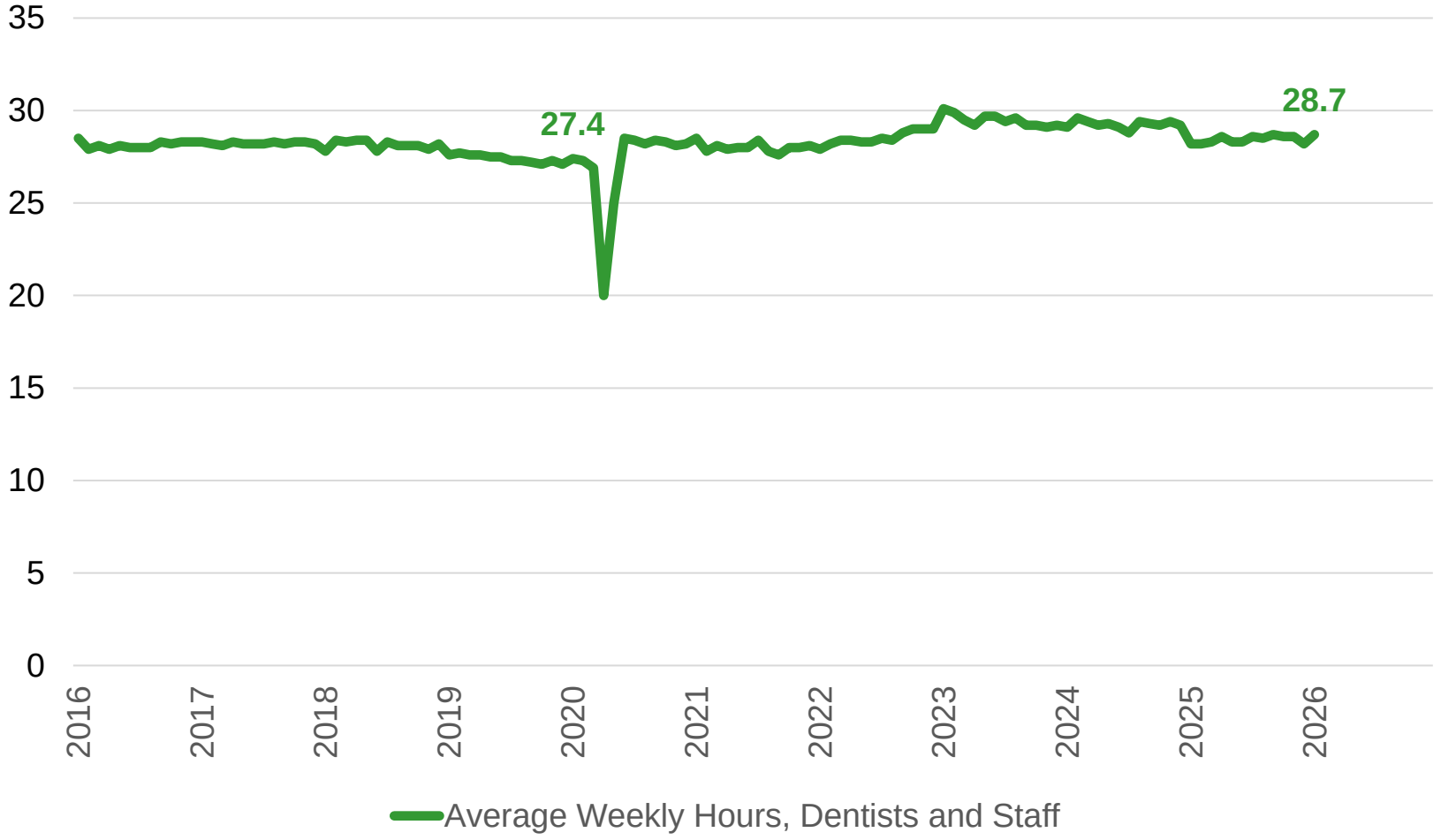
More Hours Worked in Dental Sector



There is a slight upward trend from a year ago in hours worked. Specifically, in January 2026, average hours worked per week among dentists and their staff were:

- Up 0.5 hour from one month prior
- Up 0.5 hour in 2026
- Up 0.5 hour from 12 months prior

Source: U.S. Bureau of Labor Statistics

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A Closer Look Into Staffing Challenges

HPI® Health Policy Institute

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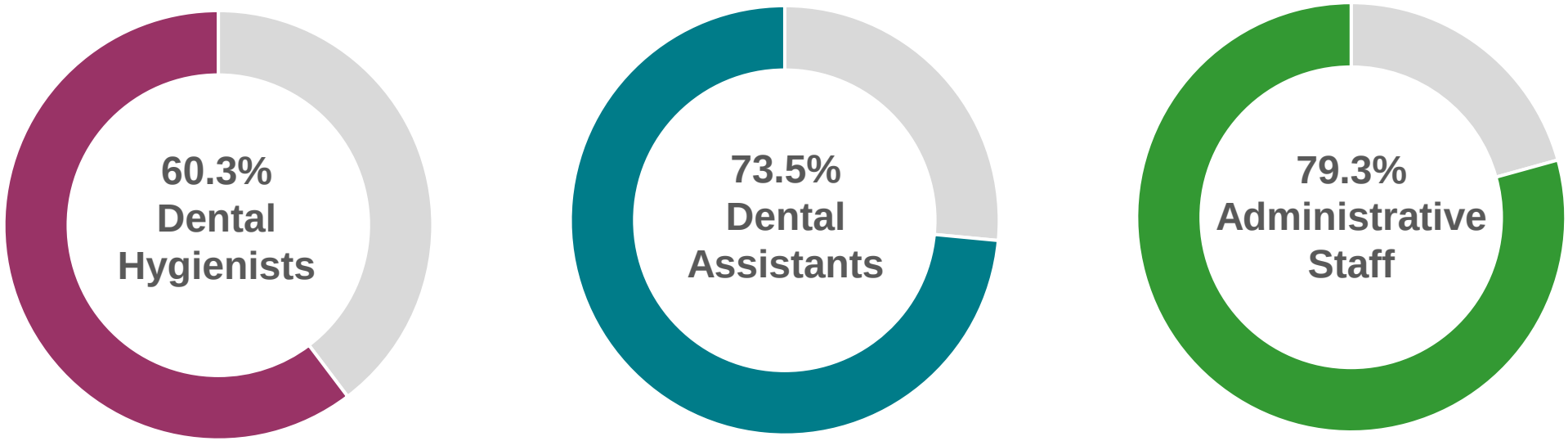
Around 3 out of 5 Dentists Have Enough Hygienists

Does your practice currently have an adequate number of non-dentist staff in each of the following categories? (Percentage saying "Yes.")



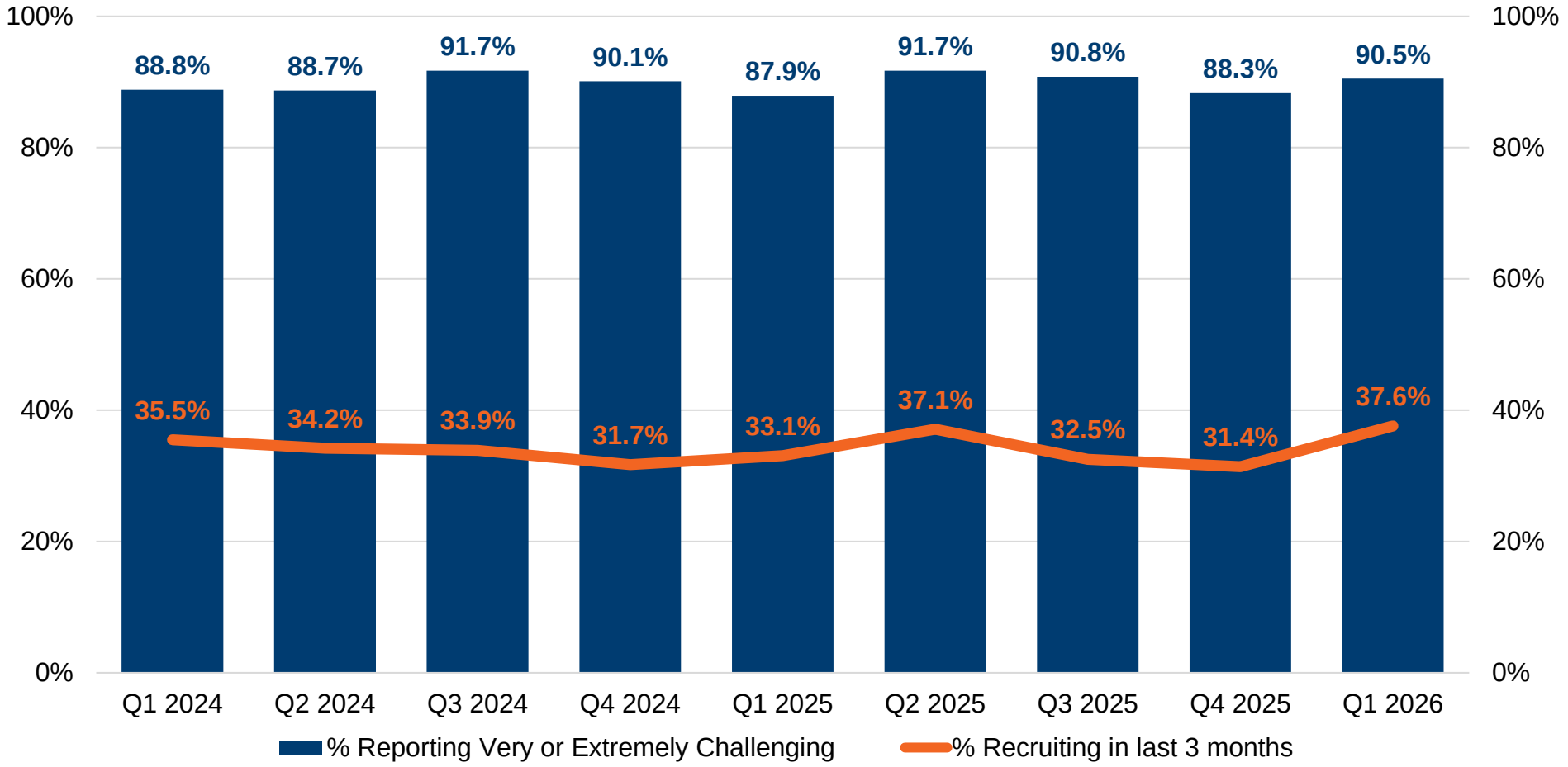
Dentists are more likely to report not having enough dental hygienists compared to other staff positions, though a lack of adequacy is reported by at least 1 in 4 dentists for each of these positions.

Source: ADA Health Policy Institute

HPI Health Policy Institute

ADA American Dental Association®

Dental Hygienists the Hardest to Recruit



Nearly 2 in 5 dentists were recruiting dental hygienists in the last three months. Among these dentists, the vast majority report recruiting hygienists is "very" or "extremely challenging.“ This trend has been consistent over the last two years.

Source: ADA Health Policy Institute

HPI Health Policy Institute

ADA American Dental Association®

Challenges in Recruiting Dental Hygienists

In Q1 2026, 37.6% of dentists reported having recruited a dental hygienist in the past three months. Among those dentists, over 90% said recruiting was either "very" or "extremely challenging."

What specifically has been challenging about recruiting dental hygienists?

TOP FIVE REASONS

1. Not enough applicants, hygienist shortage (66.5%)
2. Demand for high wages, benefits (36.8%)
3. Applicants do not want to work advertised hours (7.9%)
4. Applicants not qualified or of poor quality (5.9%)
5. Mismatch between wages vs. insurance reimbursement (5.9%)

Source: ADA Health Policy Institute

HPI Health Policy Institute

ADA American Dental Association®

Challenges in Recruiting Dental Hygienists

WHAT DENTISTS ARE SAYING…

"Very few unemployed dental hygienists in this area. No new graduates."

"Not a single application in 9 months."

"3 months of sponsored advertising… and one tattoo artist applied."

"The hygienists that temp have no interest in working full time."

"There are none, and all my colleagues also have ads out for hygienists."

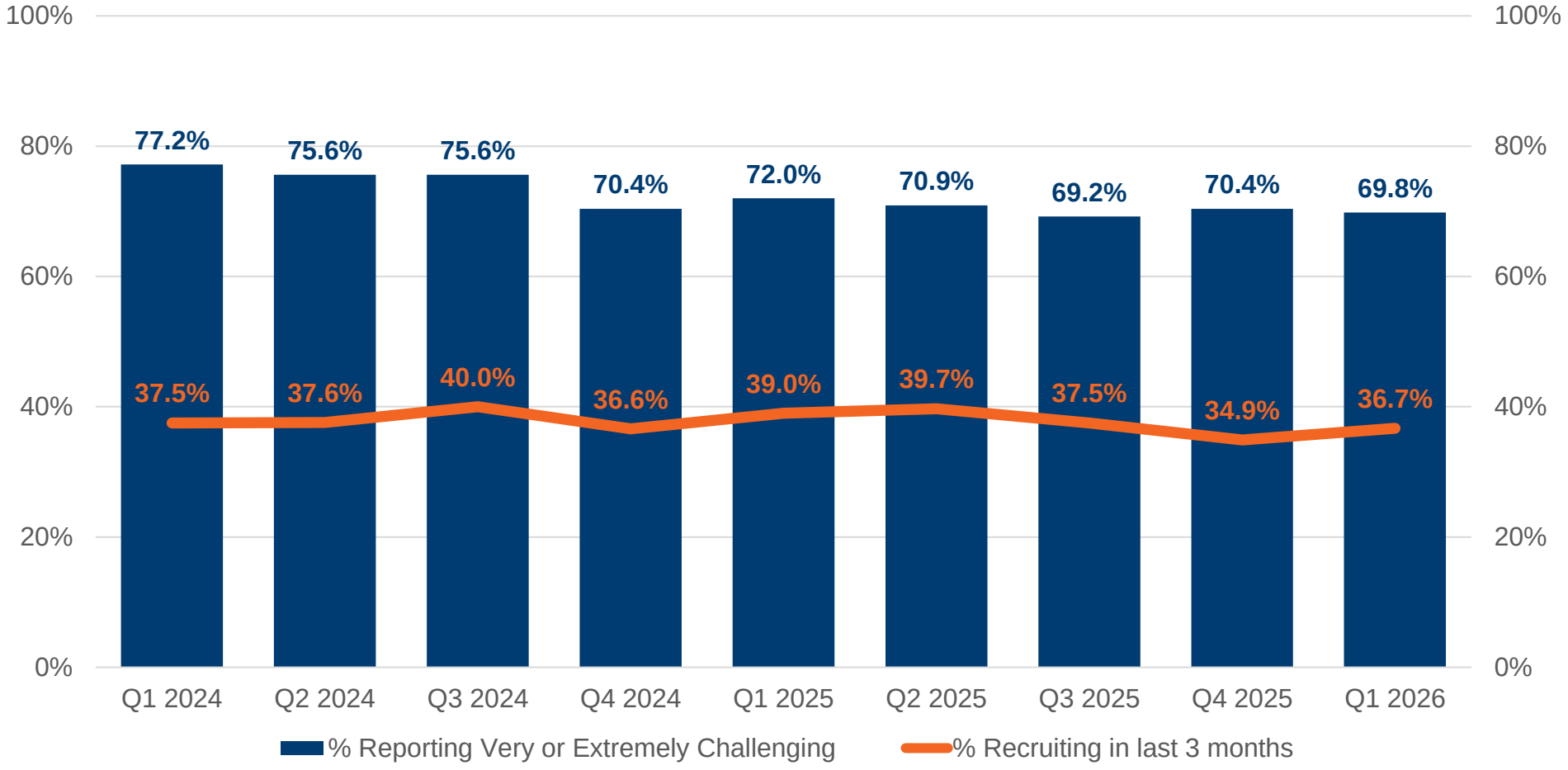
"There are not enough and the wages they are asking for are over reimbursement rates."

Source: ADA Health Policy Institute

HPI Health Policy Institute

ADA American Dental Association®

Dental Assistants Slightly Less Difficult to Recruit



Over the last two years, a slightly higher share of dentists have reported trying to recruit dental assistants compared to hygienists.

However, dentists' perceived difficulty of recruiting assistants is lower than for hygienists and is becoming lower over time.

Source: ADA Health Policy Institute

HPI Health Policy Institute

ADA American Dental Association®

Challenges in Recruiting Dental Assistants

In Q1 2026, 36.7% of dentists reported having recruited a dental assistant in the past three months. Among those dentists, about 70% said recruiting was either "very" or "extremely challenging."

What specifically has been challenging about recruiting dental assistants?

TOP FIVE REASONS

1. Not enough applicants, assistant shortage (57.5%)
2. Applicants not qualified or of poor quality (40.9%)
3. Demand for high wages and benefits (17.1%)
4. Applicants do not show up to interviews (5.0%)
5. Location of practice makes recruitment challenging (2.8%)

Source: ADA Health Policy Institute

Challenges in Recruiting Dental Assistants

WHAT DENTISTS ARE SAYING…

"Although there are now responses for these positions, the asking salaries for the position are now far too expensive for practices engaged in treating patients in government programs and/or PPOs. Those payers have not increased reimbursement in over 20 years but these asking salaries have now almost tripled."

"Heavy recruiting, and I cannot compete against the DSO EFDA… because of all the benefits they pay them."

"We now have to use a recruiter and pay 17% of first year's wage. This drives up everyone's cost. They are just stealing assistants from other practices."

"Nobody with experience applies. The candidate pool is large but VERY shallow."

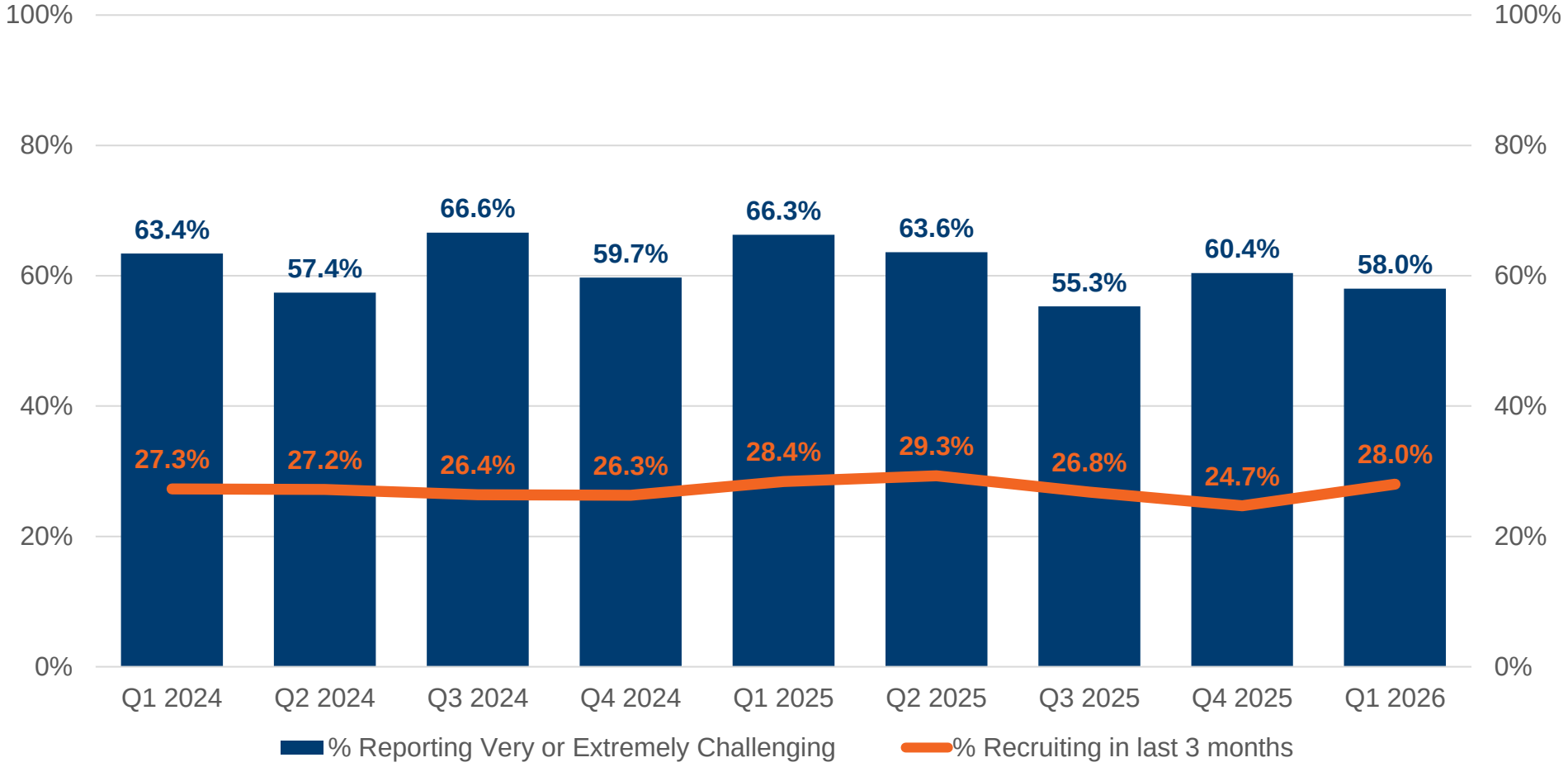
"Often applicants apply and don't respond to phone calls or don't keep scheduled phone calls or interviews."

Source: ADA Health Policy Institute

HPI Health Policy Institute

ADA American Dental Association®

Demand for Admin Staff Lower, Still Difficult to Recruit



Compared to dental hygienists and dental assistants, demand for administrative staff is lower, as is the perceived difficulty in recruiting them. Still, more than half of dentists who have tried agree that recruiting administrative staff is “very” or “extremely challenging.”

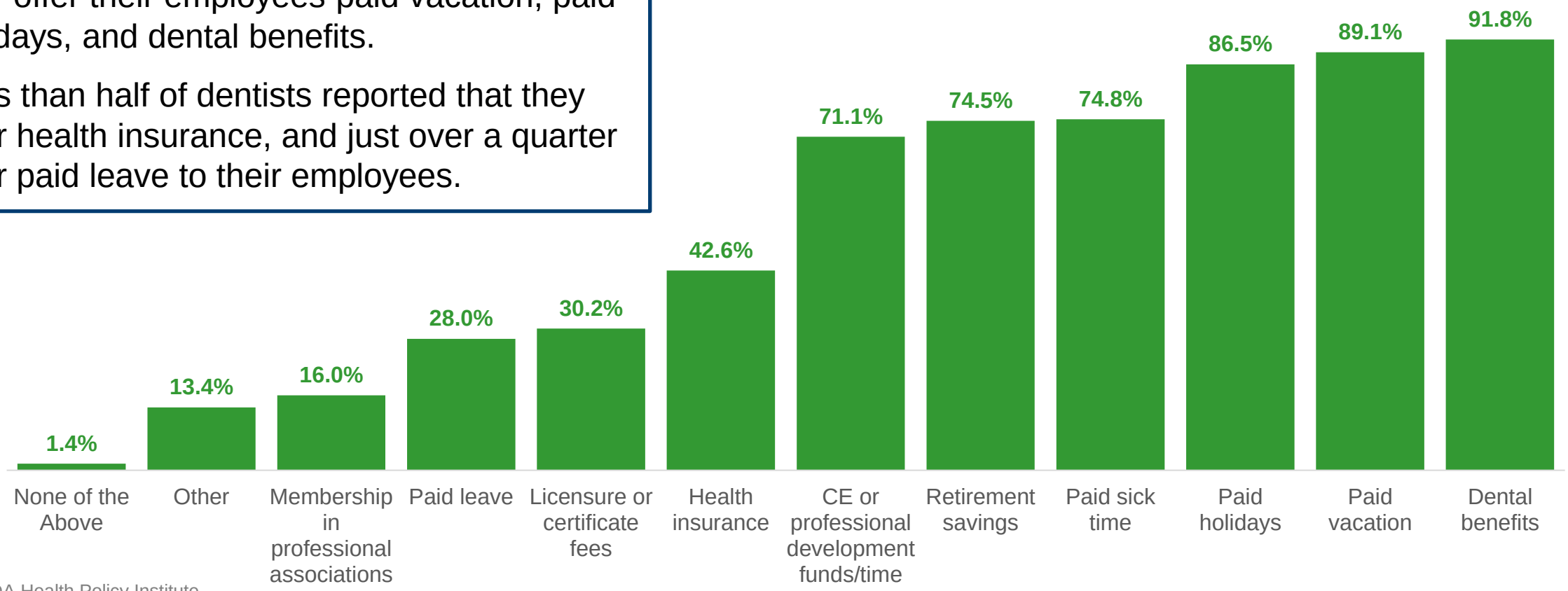
Source: ADA Health Policy Institute

HPI Health Policy Institute
ADA American Dental Association®

Dental, Vacation and Holidays: Most Offered Benefits

At least eight out of ten dentists reported that they offer their employees paid vacation, paid holidays, and dental benefits.

Less than half of dentists reported that they offer health insurance, and just over a quarter offer paid leave to their employees.



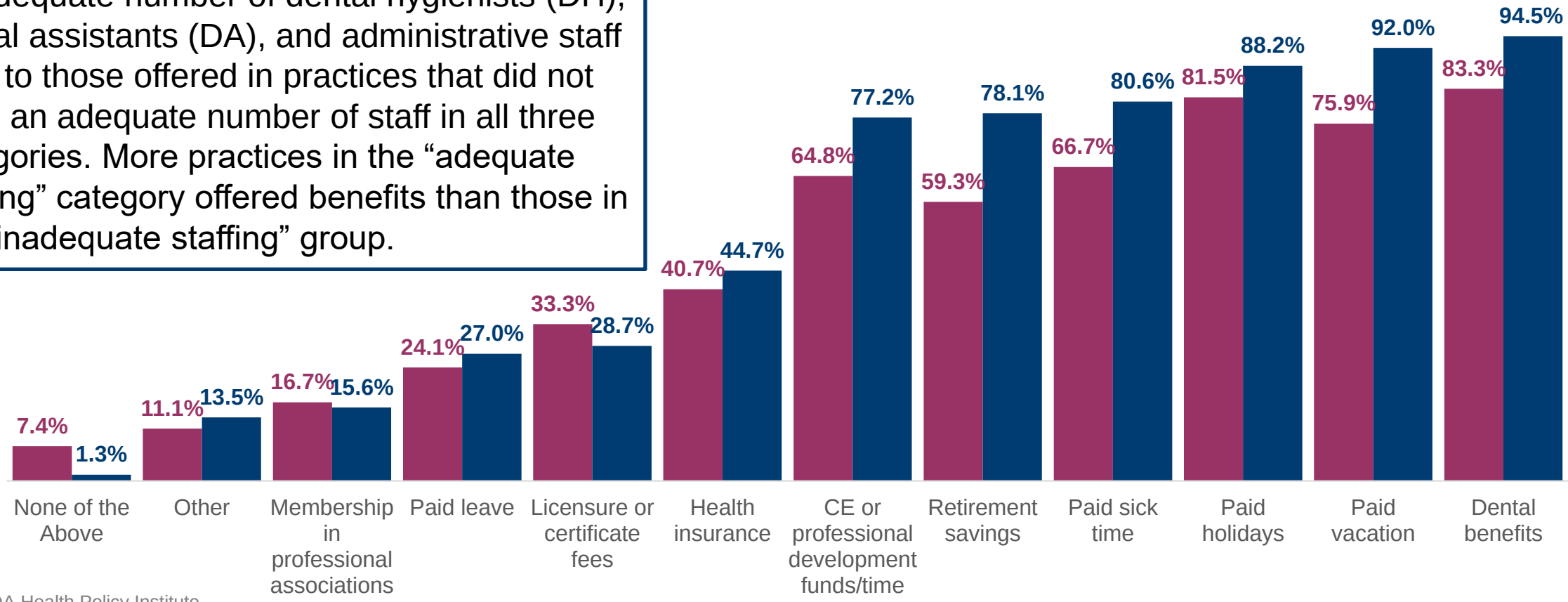
Source: ADA Health Policy Institute

HPI Health Policy Institute

ADA American Dental Association®

Benefits Offered vs. Adequacy of Number of Staff

We compared benefits offered in practices with an adequate number of dental hygienists (DH), dental assistants (DA), and administrative staff (AS) to those offered in practices that did not have an adequate number of staff in all three categories. More practices in the “adequate staffing” category offered benefits than those in the “inadequate staffing” group.



Source: ADA Health Policy Institute

HPI Health Policy Institute

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Key Takeaways for Q1 2026

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Key Takeaways

Dentists' economic confidence is holding steady. In Q1 2026, dentists' confidence in their own practice and the dental sector is up ever so slightly compared to Q4 2025. But looking at the past year, it is flat. Reasons dentists felt confident about the dental sector included a stable demand for dentistry, practice busyness, and the overall economic resilience of the dental sector. For dentists that were skeptical about the dental sector, the most common reasons were insurance pressures such as low reimbursement rates, inflation and rising practice costs, and the overall U.S. economic downturn.

Consumer dental spending is growing modestly while dentist busyness is stable. Consumer spending on dental care is up 4% over the last 12 months (and 24% over 10 years) but is still behind health spending. The modest growth in dental spending is easily absorbed within dental practices. In Q1 2026, around one-third of dentists reported that they are not busy enough, up from one-quarter of dentists in Q1 2024. Appointment wait times for new patients have gone down by approximately two days since Q1 2024.

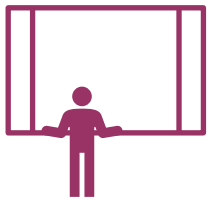
Key Takeaways

Prices for dental equipment and supplies are rising while reimbursement rates are not. After adjusting for inflation, prices for common practice expenses are rising much faster than reimbursement rates. The “fiscal squeeze” on dental practices continues.

Total employment in the dental sector is flat. The number of jobs in the dental sector has grown less than 1% over the last twelve months.

Recruitment challenges persist: 2 out of 5 dentists report they do not have enough dental hygienists compared to one-quarter not having enough dental assistants and one-fifth not having enough administrative staff. At least four out of five dentists who have recruited hygienists consistently report that it is “very” or “extremely challenging” to do so, citing issues such as limited pool of applicants or unqualified applicants, high demand for wages and benefits, and applicants preferring temporary employment.

Big Picture



The data from Q1 2026 show a continuation of several trends seen throughout 2025: stable economic confidence among dentists, decreasing shares of dentists feeling overworked, modest growth in dental spending, and a continued "fiscal squeeze" stemming from equipment and supply prices, as well as wages, rising faster than reimbursement rates.

Our deep dive into staffing issues reveals continued recruitment challenges. One-third of dentists consistently say they are trying to recruit dental hygienists and of that one-third, filling vacant positions is very challenging. Ultimately, some dentists struggle to find any applicants at all while others cannot find qualified applicants willing to work the advertised hours and for the advertised wages and benefits. The ongoing “fiscal squeeze” is likely contributing challenges offering competitive salaries and benefits for qualified applicants. In fact, the latest data show average hourly wages for dental office staff in the U.S. are unchanged over the past 12 months, once inflation is accounted for. Recruitment challenges, thus, are likely to persist.

Thank you!

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marko-vujicic

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Data Sources and Methods

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Data Sources and Methods

Dentists' Economic Confidence

- **Slides 5 to 9**

  Source: ADA Health Policy Institute, Economic Outlook and Emerging Issues in Dentistry Poll, Q1 2026. Unpublished data. Based on 796 responses.

  Notes for Slide 5: Data represent the combined share of dentists responding, "somewhat confident" or "very confident" to "Looking ahead the next 6 months, how confident are you in the economic conditions in… (1) your particular dental practice, (2) the dental care sector, and (3) the U.S. economy."

  Notes for Slide 6 and 8: Data represent a summary of open-ended responses to question, "Please briefly describe the reasons for your skepticism/confidence in the dental care sector."

  Notes for Slide 7 and 9: Data represent a summary of open-ended responses to question, "Please briefly describe the reasons for your skepticism/confidence in the dental care sector in general," as well as select verbatim quotes provided by respondents to illustrate the top reasons.

Data Sources and Methods

Consumer Dental Spending

- **Slide 11**

  Sources: U.S. Bureau of Economic Analysis, Table 2.4.6U, Real Personal Consumption Expenditures, Dental Services, Chained Dollars [Billions of chained (2017) dollars]. Table 2.4.5U, Personal Consumption Expenditures, Dental Services [Billions of current dollars]. Months are seasonally adjusted at annual rates. Available at https://www.bea.gov/data/consumer-spending/main, accessed Mar. 13, 2026.

  Federal Reserve Bank of St. Louis, NBER based Recession Indicators for the United States from the Peak through the Trough [USRECM], retrieved from FRED, Federal Reserve Bank of St. Louis. Available at https://fred.stlouisfed.org/series/USRECM, accessed Mar. 13, 2026.

  Notes: The Bureau of Economic Analysis (BEA) releases monthly estimates of consumer spending for dental services. Each month's spending amount is annualized, i.e., presented as the amount of spending that would occur in a year, based on that month's rate of spending. This graph represents inflation-adjusted spending in terms of 2026 dollars.

Data Sources and Methods

Consumer Dental Spending

- **Slide 12**

  Sources: U.S. Bureau of Economic Analysis, Table 2.4.6U, Real Personal Consumption Expenditures, Health Care, Physician Services, Dental Services, Chained Dollars [Billions of chained (2017) dollars]. Table 2.4.5U, Personal Consumption Expenditures, Health Care, Physician Services, Dental Services [Billions of current dollars]. Months are seasonally adjusted at annual rates. Available at https://www.bea.gov/data/consumer-spending/main, accessed Mar. 13, 2026.

  U.S. Bureau of Economic Analysis, Population [POPTHM], retrieved from FRED, Federal Reserve Bank of St. Louis. Available at https://fred.stlouisfed.org/series/POPTHM, accessed Mar. 13, 2026.

  Federal Reserve Bank of St. Louis, NBER based Recession Indicators for the United States from the Peak through the Trough [USRECM], retrieved from FRED, Federal Reserve Bank of St. Louis. Available at https://fred.stlouisfed.org/series/USRECM, accessed Mar. 13, 2026.

  Notes: These indexes measure the change over time in spending relative to January 2016. An index value of 101 would indicate spending 1% higher than the spending level in January 2016.

Data Sources and Methods

Dental Practice Economics

- **Slides 14-15**

  Source: ADA Health Policy Institute, Economic Outlook and Emerging Issues in Dentistry Poll, Q1 2026. Unpublished data. Based on 796 responses.

  Notes for Slide 14: Data represent a summary of answers to question, “Which of the following best describe your general busyness level over the last 3 months?”

  Notes for Slide 15: Data represent a summary of answers from owner dentists to the question, “[If accepting new patients] Currently, how many business days does the average new patient have to wait for an initial appointment (excluding emergencies)?" Respondents of this question had previously answered "Yes" to the question, "Is your practice currently accepting new patients?“

Data Sources and Methods

Dental Practice Economics

- **Slide 16**

Sources: U.S. Bureau of Labor Statistics, Current Employment Statistics, Average hourly earnings of production and nonsupervisory employees, offices of dentists, seasonally adjusted. Available at https://www.bls.gov/ces/data/. Accessed Mar. 18, 2026; U.S. Bureau of Labor Statistics, Producer Price Index by Commodity: Miscellaneous Products: Professional Dental Equipment and Supplies (WPU156501071), not seasonally adjusted. Available at https://www.bls.gov/ppi/databases/. Accessed Mar. 18, 2026; U.S. Bureau of Labor Statistics (BLS), Consumer Price Index (CPI-U), All Items, seasonally adjusted. Available at https://www.bls.gov/cpi/data.htm. Accessed Mar. 18, 2026.; Federal Reserve Bank of St. Louis, NBER based Recession Indicators for the United States from the Peak through the Trough [USRECM], retrieved from FRED, Federal Reserve Bank of St. Louis. Available at https://fred.stlouisfed.org/series/USRECM, accessed Mar. 18, 2026.

Notes: “Hourly Earnings of Dental Office Staff” is the label for the index of average hourly earnings of production and nonsupervisory employees in offices of dentists. Average earnings are a measure of gross payrolls divided by total hours worked. The index for Dental Equipment and Supplies reflects the change in prices received by domestic producers of those products.

Data Sources and Methods

Dental Practice Economics

- **Slide 17**

Sources: U.S. Bureau of Labor Statistics (BLS), Producer Price Index by Commodity, PPI Commodity data for Health care services-Dental care, seasonally adjusted. Available at https://www.bls.gov/ppi/databases/. Accessed Mar. 18, 2026.

U.S. Bureau of Labor Statistics (BLS), Consumer Price Index (CPI-U), All Items, seasonally adjusted. Available at https://www.bls.gov/cpi/data.htm. Accessed Mar. 18, 2026.

Federal Reserve Bank of St. Louis, NBER based Recession Indicators for the United States from the Peak through the Trough [USRECM], retrieved from FRED, Federal Reserve Bank of St. Louis. Available at https://fred.stlouisfed.org/series/USRECM, accessed Mar. 18, 2026.

Notes: These indexes measure the average change over time in prices received by domestic health care providers. Prices collected for the Producer Price Index reflect the total amounts received by providers for rendering services to patients. The index for Dental Care measures change in the reimbursement amount dentists receive per visit for a representative snapshot of dental service delivery. Includes payments from patients, private insurance, Medicaid, Medicare, and other payers.

Data Sources and Methods

Dental Practice Economics

- **Slide 18**

  Source: ADA Health Policy Institute, Economic Outlook and Emerging Issues in Dentistry Poll, Q4 2025 and Q1 2026. Unpublished data. Based on 796 responses.

  Notes: Data for the graph Dentists' Plans for 2026 as of Q4 2025 represent owner dentist responses to the question, "Looking ahead to 2026, how likely are you to do each of the following for your practice?" Data for the graph Dentists' Actions so far in 2026 as of Q1 2026 represent owner dentist responses to the question, "Since the beginning of 2026, have you done any of the following in your practice?" Responses include dentists who selected “very likely” or “somewhat likely.”

Data Sources and Methods

Dental Jobs Market

- **Slide 20**

  Source: U.S. Bureau of Labor Statistics (BLS), Current Employment Statistics. All employees, millions, total nonfarm, seasonally adjusted. Available at https://www.bls.gov/ces/data/. Accessed March 6, 2026.

- **Slide 21**

  Source: U.S. Bureau of Labor Statistics (BLS), Current Employment Statistics. All employees, thousands, offices of dentists, seasonally adjusted. Available at https://www.bls.gov/ces/data/. Accessed March 6, 2026.

- **Slide 22**

  Source: U.S. Bureau of Labor Statistics (BLS), Current Employment Statistics. Average weekly hours of all employees, offices of dentists, seasonally adjusted. Available at https://www.bls.gov/ces/data/. Accessed March 6, 2026.

Data Sources and Methods

Staffing Shortages

- **Slides 24-33**

  Source: ADA Health Policy Institute, Economic Outlook and Emerging Issues in Dentistry Poll, Q1 2026. Unpublished data. Based on 796 responses.

  Notes for Slide 24: Data represent those responding to the question, “Does your practice currently have an adequate number of non-dentist staff in each of the following categories: (1) dental hygienists (2) dental assistants (3) administrative staff?“ Data represent dentists who answered “yes.”

  Notes for Slide 25: Data represent those choosing the "very challenging" and "extremely challenging" responses to the question, "How challenging has it been to recruit the position(s) below?" Respondents of this question had previously answered "Yes" to the question, "Currently, or at any time during the last 3 months, have you recruited any of the following positions?”

  Notes for Slide 26: Data represent a summary of open-ended responses to question, “What specifically has been challenging about recruiting dental hygienists?”

Data Sources and Methods

Staffing Shortages

- **Slides 24-33 (continued)**

  Notes for Slide 27: Data represent a summary of open-ended responses to question, “What specifically has been challenging about recruiting dental hygienists?” as well as select verbatim quotes provided by respondents to illustrate the top reasons.

  Notes for Slide 28: Data represent those choosing the "very challenging" and "extremely challenging" responses to the question, "How challenging has it been to recruit the position(s) below?" Respondents of this question had previously answered "Yes" to the question, "Currently, or at any time during the last 3 months, have you recruited any of the following positions?“

  Notes for Slide 29: Data represent a summary of open-ended responses to question, “What specifically has been challenging about recruiting dental assistants?”

  Notes for Slide 30: Data represent a summary of open-ended responses to question, “What specifically has been challenging about recruiting dental assistants?” as well as select verbatim quotes provided by respondents to illustrate the top reasons.

Data Sources and Methods

Staffing Shortages

- **Slide 24-33 (continued)**

  Notes for Slide 31: Data represent those choosing the "very challenging" and "extremely challenging" responses to the question, "How challenging has it been to recruit the position(s) below?" Respondents of this question had previously answered "Yes" to the question, "Currently, or at any time during the last 3 months, have you recruited any of the following positions?"

  Notes for Slide 32-33: Data represent responses to the question, “Which of the following benefits do you offer to your employees?”

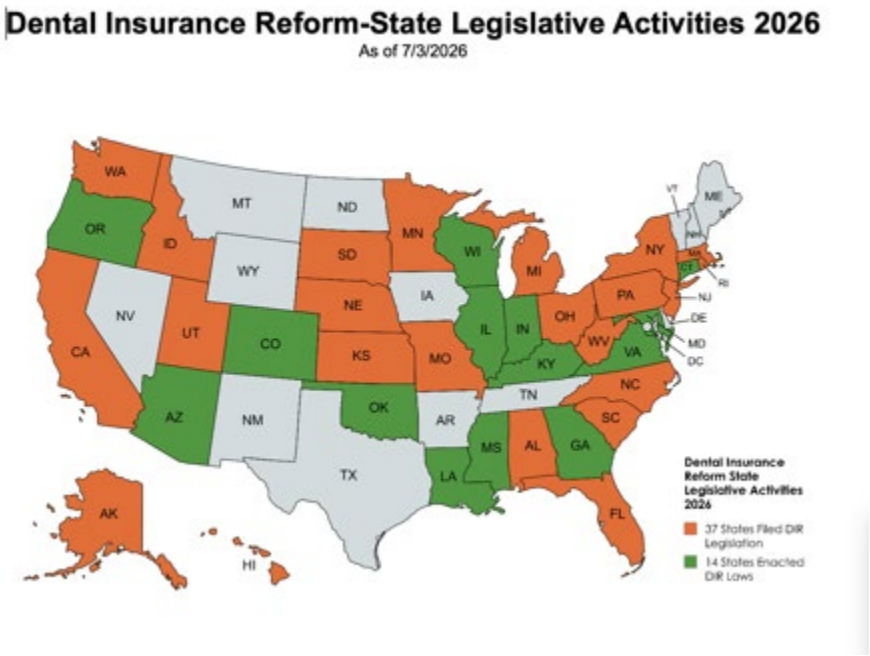
State dental insurance reforms continue momentum in 2026 legislative sessions

As most state legislatures conclude their 2026 sessions, lawmakers across the country have continued advancing dental insurance reforms aimed at improving transparency, strengthening patient protections and reducing administrative burdens on dentists.

More than 100 dental insurance reform bills were introduced in 37 states during the 2026 legislative season. So far, 16 states have enacted 30 new laws, with additional measures still awaiting governors' signatures.

The legislative successes build on years of advocacy by state dental associations working alongside the ADA to address longstanding concerns involving dental benefit plans. This year's activity focused on issues including dental loss ratios, virtual credit card payments, network leasing, assignment of benefits, retroactive claim denials and downcoding.

According to the ADA, this steady trend of enacting new dental insurance reform laws is rooted in effective advocacy strategies from membership funneled through their state constituent societies along with support from the Association.



Note from the ADA: Advocacy professionals are adept at timing dental insurance reform campaigns to maximize opportunity for success; careful consideration goes into planning issues and timing of campaigns.

Dental loss ratio

Ten states considered dental loss ratio legislation during the 2026 session.

Mississippi enacted a new law requiring dental insurers to report the percentage of premium dollars spent on patient care, creating greater transparency for employers, consumers and policymakers evaluating dental plans.

According to the ADA, the Mississippi Dental Association worked closely with legislators to address technical questions regarding dental loss ratio calculations after insurers raised concerns about how spending should be measured. Following a review of existing state laws, supporters demonstrated that the bill's methodology aligned with approaches already adopted elsewhere, helping advance the legislation.

Virtual credit cards

States also continued efforts to address insurer payment practices.

Wisconsin enacted legislation limiting insurers' exclusive use of virtual credit cards, ensuring dentists have a choice in how they receive claim payments. The new law enacted in Michigan was one of only a few bills to be approved in the 2026 session. Even with legislative impasse being the prevailing environment, it was the continued promotion of the virtual credit card law's value that helped get the law passed as one of only 65 enacted out of the 3300 bills filed this year.

Georgia and Louisiana strengthened existing virtual credit card laws by replacing an opt-out system with an opt-in requirement. Under the new approach, insurers must obtain a dentist's express permission before issuing payment through a virtual credit card or another payment method that carries transaction fees.

Georgia Dental Association Senior Health Policy Manager Jon Hoin said House Bill 1374 was modeled after updates to the National Council of Insurance Legislators', or NCOIL, Transparency in Dental Benefits Contracting Model Act adopted with support from the ADA.

"Georgia's recent [House Bill] 1374 was modeled after a recent update to the Transparency in Dental Benefits Contracting Model Act supported by ADA at NCOIL last fall. The bill updates existing language to require 'express consent' (or an opt-in) to virtual credit card and any form of payment that would incur additional fees to the dentist. Previously, Georgia law required companies to allow the dentist to opt-out. The law also requires that the dentist's payment method decision to remain in place until a future contract is executed," Mr. Hoin said.

Mr. Hoin credited Rep. Lee Hawkins, D.M.D., the bill's sponsor, and Sen. Ben Watson, M.D., for helping guide the legislation through the General Assembly.

"The bill enhances existing regulation of the use of virtual credit cards to maximize dentists' — and in Georgia all healthcare providers — choice of payment method from insurance companies," he said. "Virtual credit cards, and other payment methods that require a fee, can be quite expensive for practices cutting into the bottom line and reducing funds available for staffing, investment in quality improvement, and other things that directly benefit dentists and their patients."

Network leasing

Seven states introduced legislation addressing network leasing this year, with Colorado and Wisconsin both enacting new protections.

Colorado became the second state to require insurers to obtain a dentist's permission before including that dentist in a leased network. The law also prohibits insurers from

penalizing dentists who decline to participate and increases transparency by requiring payment explanations to identify the source of any network discounts.

Colorado Dental Association President Jeff Lodl, D.D.S., said the legislation gives dentists greater control over their contractual relationships while improving transparency for patients.

“The CDA is proud to have passed a network leasing bill that puts dentists in control of their contracts with insurance carriers and gives them the power to decide whether or not they will be part of a leased network,” he said. “Colorado’s House Bill 1070 adds much needed clarity and transparency to insurance contracting for dental services."

He said House Bill 1070 ensures there is an opt-in process that carriers must follow for network leasing, rather than making dentists scramble after they’ve already been added to a leased network without their express consent.

“This is important for dentists to have a say in what dental benefit plans they will be part of, and really important for patients to know that they’re getting accurate and reliable cost estimates for dental services, based on their dental benefit plans,” Dr. Lodl said.

He also said the bill requires communication from carriers to dentists about leased networks to ensure dental offices have the information they need about insurance plans that they are part of.

“Uncertainty and financial strain can be avoided by simply ensuring dentists are agreeing to be part of dental benefit networks, and ensuring they are informed about the terms and conditions of those benefit networks, which is what House Bill 1070 achieves,” Dr. Lodl said.

Wisconsin also enacted legislation allowing dentists to terminate participation in a leased network without terminating their original provider contract while preserving existing transparency requirements governing leased networks.

Assignment of benefits

Oregon and Maryland enacted assignment of benefits legislation this year, bringing the total number of states with assignment of benefits laws to 30.

The new laws require insurers to pay dentists directly when patients request assignment of benefits regardless of whether the dentist participates in the insurer's network. Maryland's law also establishes patient notification requirements regarding payments made directly to patients when assignment of benefits is not selected.

Retroactive denials

Several states also narrowed insurers' ability to seek repayment of previously paid claims.

Connecticut reduced the period during which insurers may seek recovery of overpayments from 18 months to 12 months.

Indiana shortens its recoupment period from two years to 180 days under their new law, while Oregon establishes an 18-month limit on repayment requests and also requires dental insurers to pay or deny clean claims within 45 days.

Downcoding

Indiana enacted legislation establishing new standards governing insurer downcoding practices.

The law prohibits insurers from relying solely on automated systems when reducing reimbursement based on medical necessity, instead requiring review by an individual. It also requires insurers to provide written explanations supporting downcoding decisions, establishes an appeals process and allows providers to submit batch appeals involving substantially similar claims.

Shane Springer, director of government affairs for the Indiana Dental Association, said the legislation provides long-sought transparency for dentists.

“What this bill does is really establish guardrails around downcoding. It ensures that, if something is downcoded, it’s clinically justified, transparent, and cannot be done through an automated process. It has to have a human review of the dental records,” he said.

Mr. Springer said the legislation came together unexpectedly after association leaders noticed the bill initially applied only to medical providers.

“It really wasn’t on our radar this session if I’m going to be honest. We were actually looking at going after this downcoding language in 2027 but we noticed when the bill was filed back in January, it applied only to medicine. That’s when I reached out to the bill author and the bill sponsor and said, ‘Hey guys look this is a huge problem in dentistry as well. Can we please be included on this bill?’,” Mr. Springer said. “So it was kind of the cherry on top to a turbulent, short session. It was something where we saw an opportunity and we took it.”

He added that the law addresses a longstanding concern among dentists.

“At the end of the day, we just really want to ensure dentists can focus on patient care, while reducing the burden and the financial uncertainty that they’re experiencing with this recoupment and downcoding. So it’s a pretty good win for dentistry,” he said.

Comprehensive reforms-provider protections

Utah enacted a robust dental insurance reform law encapsulating several measures ensuring dentists retain more control over practice management decisions. For example, dental insurers are prohibited from charging a fee for paper checks. Explanation of benefits reforms include a prohibition on insurers suggesting that non-coverage results in a write-off for dentists and a requirement that explanation of benefits include reasons for any downcoding or bundling.

Another new provision prohibits insurers from forcing dentists to submit their regular fees on claims which helps prevent insurers from showing the patient the "discount." Insurers cannot penalize dentists based on whether they file their own fee or the insurers' contracted fee when filing claims.

Prior to this law, insurers could apply out-of-state payment laws under certain circumstances. Now regardless of the location of the insurer's principle place of business, location where the dental plan was written, issued, or delivered, or a contractual choice-of-law provision, insurers must comply with all Utah payment laws for services provided so long as at least 10% of enrollees are Utahans. Dentists are protected from undisclosed policy changes and shifting administrative requirements under the handbook provisions in the law.

Terms 'professionally accepted treatment' and 'unbundling' now are defined in statute to ensure when used as part of a claim adjudication, they are accurate and align with ethical patient care while protecting dentists from insurers' retaliation.

Federal focus

Although states continue to enact dental insurance reforms, according to the ADA many of those protections do not apply to patients covered by self-funded employer plans because of how certain insurers interpret the Employee Retirement Income Security Act, or ERISA.

According to the ADA, insurers administering many large self-funded employer plans have asserted that ERISA preempts numerous state insurance laws, limiting the reach of state dental insurance reforms for many covered patients.

To address that issue, the Association is advocating for the Improving Dental Administration, or IDA, Act, federal legislation that the ADA says would clarify that state dental insurance laws apply more broadly and prevent insurers from avoiding those requirements through ERISA preemption.

"We need to fix this ERISA loophole that keeps state regulators from enforcing pro-consumer insurance laws enacted in their states," said Richard Rosato, D.M.D., president

of the American Dental Association. “Patients and providers should not be left unprotected based simply on how their dental benefits are purchased.”

The ADA said it encourages dentists to engage with members of Congress in support of the legislation, highlighting that federal action is needed to ensure patients enrolled in self-funded dental benefit plans receive the same protections available under many state laws.

Dentists wanting to learn more about ERISA and dental insurance reform can visit www.ada.org/ERISA, and those wanting to take contact their member of Congress about support for IDA can do so here: https://www.ada.org/advocacy/grassroots-action-center/ida-alert

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

H9239	Blanchard, Lyndsey Renee	2026-06-01
H9240	Hayes, Natali Renae	2026-06-01
H9241	Dixon, Leah Taylor	2026-06-02
H9242	Luc, Hang Khanh	2026-06-04
H9243	West, Danica Marie	2026-06-04
H9244	Miller, Emma Nicole	2026-06-08
H9245	Taggart, Emma Rose	2026-06-08
H9246	Morgan, Kenadi Faye	2026-06-08
H9247	Nishimura, Gail Schmidt	2026-06-08
H9248	Carter, Heather Cathryn	2026-06-10
H9249	Jackson, Brittnei N	2026-06-10
H9250	Tupper, Rianne Ashley	2026-06-10
H9251	Cuti, Cora Simone	2026-06-15
H9252	Palacios, Veronica Alicia	2026-06-15
H9253	Maina, Elizabeth Wanjiku	2026-06-15
H9254	Zabolotska, Alina	2026-06-15
H9255	Brokaw, Rachel	2026-06-16
H9256	Torres Lopez, Jessica	2026-06-16
H9257	Morales, Jose Ricardo	2026-06-17
H9258	Watson, Ashleigh Ann	2026-06-17
H9259	King, Kayla Jo	2026-06-17
H9260	Titus, Clara Susan	2026-06-17
H9261	Glaeser, Hadley Faith	2026-06-18
H9262	Ford, Lissette	2026-06-18
H9263	Heverly, Gabrielle Jule	2026-06-18
H9264	Bryan, Madelyn	2026-06-18
H9265	McKown, Morgan Marie	2026-06-18
H9266	Stewart, Meghan Ashley	2026-06-18
H9267	Hodge, Abigail D	2026-06-18
H9268	Cumiford, Alexis Shirrie	2026-06-18
H9269	Kitzmiller, Rainee C	2026-06-18
H9270	Hanson, Lauren Paige	2026-06-18
H9271	Cao, Khanh	2026-06-18
H9272	Shults, Savannah	2026-06-18

H9273	Cole, Holly Angela	2026-06-18
H9274	Hernandez Rangel, Yasmin Guadalupe	2026-06-18
H9275	LE, NGUYEN Hoang	2026-06-22
H9276	Davis, Lauren	2026-06-22
H9277	Fields, Hunter Jordan	2026-06-22
H9278	Gonzalez Galindo, Rafael	2026-06-22
H9279	Rivera, Margaret Rose	2026-06-23
H9280	Ramirez, Carolina	2026-06-23
H9281	Offill-Sherman, Haley	2026-06-23
H9282	Golliher, Emily Elizabeth	2026-06-23
H9283	Smith, Michelle	2026-06-23
H9284	Balusa, Bethany Kay	2026-06-23
H9285	Berry, Amber Moneque	2026-06-23
H9286	Yang, Isabelle Ai Lien	2026-06-23
H9287	Tidwell-Cripe, Savanah Marie	2026-06-23
H9288	Arellano, Luis Angel	2026-06-23
H9289	Simonsen, Emily Elizabeth	2026-06-23
H9290	Brown, Annabell Marie	2026-06-24
H9291	Williams, Cinthia	2026-06-24
H9292	DeChenne, Tiffany DeAnn	2026-06-25
H9293	Schultz, Lindsey	2026-06-25
H9294	Ferris, Jamie Lynn	2026-06-25
H9295	Fernstrom, Kylie Renea	2026-06-26
H9296	Doan, Khang Quoc	2026-06-29
H9297	Adamson, Alicia Nicole	2026-06-29
H9298	Upshaw, Dakota Reeves	2026-06-30
H9299	Jackson, McKenzie	2026-06-30
H9300	Franchi-Deedon, Sara Rossella	2026-06-30
H9301	Denn, Sierra	2026-06-30
H9302	Phillips, Victoria Anne	2026-07-01
H9303	Biederman, Emma Isabella	2026-07-01
H9304	Reaboi, Adriana	2026-07-01
H9305	Rojas, Guadalupe	2026-07-01
H9306	Nguyen, Amy Truc	2026-07-01
H9307	Nduta, Majax Mareza	2026-07-01
H9308	Struzan, Taylor	2026-07-01
H9309	Page, Julianna Lisette	2026-07-01
H9310	Nasholm, Sarah Marie	2026-07-01
H9311	Osborne, Madison Noel	2026-07-02
H9312	Horton, Jeremiah Lamar	2026-07-02
H9313	Morrow, Madison Louise	2026-07-02
H9314	Shan, Rachel Mulan	2026-07-02
H9315	Patel, Dhvani	2026-07-02
H9316	Reynolds, Abigail Joleen	2026-07-08
H9317	Vue, Jasmine	2026-07-08

H9318	Bancroft, Hope K	2026-07-08
H9319	Harrison, Ruby Rae	2026-07-08
H9320	Rubalcava, Araceli	2026-07-08
H9321	Brown, Nina	2026-07-10
H9322	Moore, Britney Alysa	2026-07-10
H9323	Ortega-Garcia, Jennifer Kristen	2026-07-10
H9324	Piluyeva, Regina	2026-07-13
H9325	Hernandez Contreras, Lizbeth	2026-07-13
H9326	Lewis, Madison Jayne	2026-07-14
H9327	Hoorain, Amna	2026-07-16
H9328	Reyes Perez, Roselia Mirella	2026-07-16
H9329	Zago-Berg, Amanda Virginia	2026-07-21
H9330	Patino Contreras, Samantha	2026-07-21
H9331	Fiorito, Sara Elizabeth	2026-07-21
H9332	Ferrito, Madelyn Whitney	2026-07-29
H9333	Juarez-Rodriguez, Sarai	2026-07-29
H9334	Figueroa Ramirez, Daniela	2026-07-29
H9335	Santiago, Sophia Amaris	2026-08-05
H9336	Moes, Deana Marie	2026-08-05
H9337	Jordan, Ruba Jay	2026-08-05
H9338	Leppanen, Jessica	2026-08-07

DENTISTS

D12341	Baxter, Shane	2026-06-01
D12342	Sunar, Maya	2026-06-02
D12343	Furrer, Summer Vandala	2026-06-02
D12344	Aparicio, Gino	2026-06-04
D12345	Trapnell, Gregory	2026-06-08
D12346	Hori, Tyler	2026-06-08
D12347	Elhussiny, Sherif Naeil	2026-06-08
D12348	Chuang, Kelly	2026-06-10
D12349	Brimhall, Andrew Vincent	2026-06-15
D12350	Ollerton, Justin	2026-06-15
D12351	Holland, Haley Anne	2026-06-15
D12352	Herring, Andrew Jun Ye	2026-06-15
D12353	Hareb, Caleb	2026-06-15
D12354	Salar, Emmanuel	2026-06-16
D12355	Garcia, Regina Marie Javier	2026-06-16
D12356	Luna, Refugio	2026-06-16
D12357	Koh, Joon	2026-06-17

D12358	Braginton, Aaron	2026-06-18
D12359	Bell Cares, Aaron Joseph	2026-06-22
D12360	Damodaran, Meera Janani	2026-06-22
D12361	Cherry, Owen Ernest	2026-06-22
D12362	Purohit, Rishi	2026-06-22
D12363	Kuramkote, Jyotsna	2026-06-22
D12364	Maldonado, Oscar	2026-06-23
D12365	Fogel, Sandra	2026-06-24
D12366	Montague, Dane	2026-06-25
D12367	Truong, Valerie	2026-06-29
D12368	Sanon, Serena	2026-06-29
D12369	Brown, David Miles	2026-06-29
D12370	Esau, Avery Jayne	2026-06-29
D12371	Schaefer, William Donald	2026-06-29
D12372	Wright, Lewis Randall	2026-06-29
D12373	Warth, Whitney Hope	2026-06-29
D12374	Mitchell, Jackson	2026-06-29
D12375	Ouda, Katherine Samir	2026-06-30
D12376	Sigurdson, Joy Anna	2026-06-30
D12377	Hartley, Mark Steele	2026-06-30
D12378	Walle, Lyndan Nam	2026-06-30
D12379	Murray, Kevin Patrick	2026-06-30
D12380	Viramontes, Jaime	2026-06-30
D12381	Park, Sehoon	2026-06-30
D12382	Chopra, Jordan Kumar	2026-06-30
D12383	Hakoum, Joelle	2026-06-30
D12384	Brediger, Sydney Irene	2026-07-01
D12385	Jones, Sydney	2026-07-02
D12386	Bumrung, Suchunya	2026-07-02
D12387	Pugh, Amy	2026-07-08
D12388	Ha, Kaylan Nguyen	2026-07-08
D12389	Patel, Twisha Mit	2026-07-08
D12390	Banh, Danika	2026-07-08
D12391	Klar, Jack	2026-07-08
D12392	Yoon, Christopher Heeso	2026-07-08
D12393	Nguyen, Jonathan Vinhthuy	2026-07-08
D12394	Hortaleza, Dominic Pham-Vu	2026-07-08
D12395	Ha, Dalena Mai Huong Thi	2026-07-08
D12396	Mansour, Sydney Anne	2026-07-10
D12397	Lee, Kelsey Ann	2026-07-13
D12398	Rapson, Katheryn	2026-07-21
D12399	Chou, Catherine Kai-Lin	2026-07-22
D12400	George, Luke Lacuna	2026-07-22
D12401	Le, Dao T.	2026-07-23
D12402	Kingery, Nathan	2026-07-23

D12403	De Villa, Patricia Kristine	2026-07-29
D12404	Hsieh, Alex	2026-07-29
D12405	Li, Jessica A	2026-07-29
D12406	Little, Sean Roldan	2026-07-29
D12407	Shaban, Oveyseh	2026-07-29
D12408	Osmond, Steven Wayne	2026-07-31
D12409	Dietz, Nicholas	2026-07-31
D12410	Flores, Franklin Gustavo	2026-07-31
D12411	Park, Connor Nicholas	2026-08-05
D12412	Lee, Yujin	2026-08-05
D12413	Khan, Zeba Meher	2026-08-07
D12414	Lee, Hans J	2026-08-07

LICENSE, PERMIT & CERTIFICATION

Request for reinstatement of an expired license – Jasmine Hodgert, R.D.H.

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 several 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."

Jasmine Hodgert (H8190) held a license to practice dental hygiene in Oregon that expired on September 30, 2023. Since Ms. Hodgert's dental hygiene license expired, she has held an active license in Florida, which was issued in 2020. Ms. Hodgert would now like to reinstate her Oregon dental hygiene license so she can resume practicing in Oregon. Ms. Hodgert has submitted a License and Permit Reinstatement Application, fees, proof of continuing education for the renewal cycle(s) during which her license was expired, passed the Board's Jurisprudence Examination, and has submitted a background check. No other licensing agencies report any adverse action taken against Ms. Hodgert. Board staff submitted an inquiry to the National Practitioners Data Bank and the Healthcare Integrity Data Bank and no negative information regarding Ms. Hodgert 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 Ms. Hodgert to take any further examination and whether to reinstate Ms. Hodgert's dental hygiene 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

JUN 1 8 2026

Oregon Board of Dentistry

OREGON BOARD OF DENTISTRY
LICENSE AND PERMIT REINSTATEMENT APPLICATION

Return to: Oregon Board of Dentistry
Unit 23
PO Box 4395
Portland, OR 97208-4395

2105 $527.00
1290 $750.00
1707 $50.00
1707 $8.00

Name JASMINE HODGERT
License # H8190

Licensure Fees:	$527.00
Penalty Fee:	$250.00
Reinstatement:	$500.00
OWHI Survey Fee:	$8.00
Total:	$1285.00

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

Request for reinstatement of an expired license – Julie C. McClaire, R.D.H.

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."

Julie C. McClaire (H3033) held a license to practice dental hygiene in Oregon that expired on September 30, 2024. Since Ms. McClaire's dental hygiene license expired, she has not held any other licenses. Ms. Penselin would now like to reinstate her Oregon dental hygiene license so she can resume practicing in Oregon. Ms. McClaire has submitted a License and Permit Reinstatement Application, fees, proof of continuing education for the renewal cycle(s) during which her license was expired, passed the Board's Jurisprudence Examination, and has submitted a background check. No other licensing agencies report any adverse action taken against Ms. McClaire. Board staff submitted an inquiry to the National Practitioners Data Bank and the Healthcare Integrity Data Bank and no negative information regarding Ms. McClaire 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 Ms. McClaire to take any further examination and whether to reinstate Ms. McClaire's dental hygiene 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

2105 $251.00
1290 $750.00
1707 $4.00

Name JULIE C MCCLAIRE R.D.H.
License # H3033

Licensure Fees:	$251.00
Penalty Fee:	$250.00
Reinstatement:	$500.00
OWHI Survey Fee:	$4.00
Total:	$1,005.00

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

Request for reinstatement of a retired license – Holly K. Beck, R.D.H.

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."

Holly K. Beck (H6065) held a license to practice dental hygiene in Oregon that was retired on September 30, 2023. Since Ms. Beck 's dental hygiene license was retired, she has not held any other licenses. Ms. Beck would now like to reinstate her Oregon dental hygiene license so she can resume practicing in Oregon. Ms. Beck has submitted a License and Permit Reinstatement Application, fees, proof of continuing education for the renewal cycle(s) during which her license was expired, passed the Board's Jurisprudence Examination, and has submitted a background check. No other licensing agencies report any adverse action taken against Ms. Beck. Board staff submitted an inquiry to the National Practitioners Data Bank and the Healthcare Integrity Data Bank and no negative information regarding Ms. Beck 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 Ms. Beck to take any further examination and whether to reinstate Ms. Beck dental hygiene 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

2105 $526.00
1290 $500.00
1707 $8.00

Name HOLLY K BECK R.D.H.
License # H6065

Licensure Fees:	$526.00
Reinstatement:	$500.00
OWHI Survey Fees:	$8.00
Total:	$1,034.00

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

Request for Approval of Soft Reline Course – Andrew Martinez EFDA

The Board has received a request for approval of a Soft Reline Course. This course would be provided so the EFDA Dental Assistants could qualify to apply soft relines in accordance with OAR 818-042-0090 – Additional Functions of EFDAs.

Relevant Rules:

OAR 818-042-0090 – Additional Functions of EFDAs

Upon successful 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 certified Expanded Function Dental Assistant may perform the following functions under the indirect supervision of a licensee providing that the procedure is checked by the licensee prior to the patient being dismissed:

(1) Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a licensee.

(2) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.

(3) Place retraction material subgingivally.

To Whom It May Concern:

I am writing to respectfully request approval of my course on soft relines for Expanded Function Dental Assistants. This course is intended to provide participants with the didactic instruction, hands-on training, and competency assessment required to perform soft reline procedures in accordance with Oregon state requirements.

As a dental assistant with more than 11 years of experience at Willamette Dental, I am committed to supporting the continued education and professional development of our employees. In my role as Clinical Support Specialist, I help lead education and development initiatives across the organization.

I have included the course materials and supporting documentation for the Board's review. I would appreciate the opportunity to have this course considered for approval and would be pleased to provide any additional information as needed.

Thank you for your time and consideration. Please let me know if there are any additional forms, supporting materials, or steps required to complete the approval process.

Sincerely,

A.J. Martinez *(he/him/his)*
Clinical Support Specialist
amartinez@willamettedental.com | 855.433.6825
Administrative Office, 6950 NE Campus Way, Hillsboro, OR 97124
willamettedental.com

TEMPORARY SOFT RELINES FOR FULL DENTURES

Syllabus

Instructor: A.J. Martinez, EFDA

Course Description

This class will provide Expanded Functions Dental Assistants (EFDA) with the education and certificate required to apply soft relines for patients with full dentures.

Purpose

As approved by the Oregon Board of Dentistry and upon passing this course, the Expanded Functions Dental Assistant will be able to apply temporary soft reline material to a full denture under the indirect supervision of a dentist or dental hygienist, providing that the denture is checked by the dentist or dental hygienist prior to patient dismissal.

Delivery Method

Lecture, student workbook, instructor demonstration, group discussion, and laboratory practice.

Evaluation

Class grade and certification will be determined by an exam and laboratory performance evaluations. A score of 80% or higher must be achieved for successful completion.

Requirements

Students must be currently certified as Expanded Function Dental Assistants (EFDA) in the State of Oregon and must be in good standing. Students are required to submit proof of certification to the instructor at the time of class registration. Students will not be allowed to participate in class without the proper documentation of certification.

Learning Objectives

Upon successful completion of this course, the student should be able to:

- Explain the legal requirements to place soft relines.
- Distinguish between the different types of relines.
- Explain the difference between relining and tissue conditioning.
- Understand the purpose of soft relines.
- Evaluate the patient's medical and dental history.
- Understand the physiological aspects of dentures.
- Understand the use of the powder and liquid.
- Understand the polymerization process in the reline material.
- Understand the health hazard and first aid of the reline material.
- List and describe purpose of armamentarium.
- Describe the steps for applying a soft reline.
- Provide proper home care instructions for denture(s).
- Make accurate and appropriate chart entry in patient's chart.
- Demonstrate in lab setting the ability to properly mix, apply, and trim material.

Materials

The following materials are presumed to be present in our instructional location:

- Basic setup (mirror, explorer, and forceps)
- Denture brush/toothbrush
- Soft Reline Material (Coe-Soft)
- Suction tips
- Slow speed handpiece and lab bur
- Patient bib and bib clip
- Cotton supplies (cotton rolls, 2x2s)
- Air/water syringe tips
- Vaseline
- Patient safety glasses

PPE

Students must wear scrubs to the clinical and laboratory portion of the course and bring their own protective eyewear. Gloves, masks, and over-gowns will be provided.

Laboratory Practice

Successful completion of the laboratory portion of this training includes:

- Provide pre-op and post-op instructions/address questions to lab partner.
- Utilize knowledge learned in lecture portion to apply soft relines to practice dentures.
- Must pass with 100% proficiency

Course Content

- Review Dental Practice Act Divisions 35 and 42
- Introduction
- Differences in Relines
- Ingredients
- Hazards and First Aid
- PPE
- Medical and Dental History
- Indications
- Contraindications
- Procedure
- Patient Instructions
- OTC reline material
- Proper chart documentation

References

1. Bird, D. L., & Robinson, D. S. (2021). Modern dental assisting (13th ed.). Elsevier
2. Phinney and Halstead, Dental Assisting: A Comprehensive Approach, 3rd Edition, 2008.Product manufacturer information.
3. Product Material Safety Data Sheets.
4. Dental Practice Act 2011 Division 35 and Division 42.
5. Evidence-based guidelines for the care and maintenance of complete dentures: A publication of the American College of Prosthodontists David Felton, Lyndon Cooper, Ibrahim Duqum, Glenn Minsley, Albert Guckes, Steven Haug, Patricia Meredith, Caryn Solie, David Avery, and Nancy Deal

Chandler. JADA February 2011 142(suppl 1): 1S-20S; doi:10.14219/jada.archive.2011.0067

6. Treatment of the edentulous mandible GORDON J. CHRISTENSEN JADA February 2001 132(2): 231-233; doi:10.14219/jada.archive.2001.0160

Willamette Dental

Temporary Soft Relines

Presented by: A.J. Martinez, EFDA

Course Objective

Upon successful completion of this course, you will be able to apply temporary soft relines to complete dentures for the purpose of tissue conditioning under indirect supervision of a dentist or dental hygienist.

Prerequisites

- Must hold an Oregon Expanded Function Dental Assistant (EFDA) certification

Format

Classroom

To be completed during your initial in-person training

- Lecture
- Assessment **must score 80% to pass*
- Lab

Visit Sealant, Soft Reline, Cord Packing Connect page for additional information.

Definitions

Board of Dentistry Administrative Rule 818-042-0090 allows Expanded Functions Dental Assistants (EFDAs) to apply temporary soft relines to complete dentures for the purpose of tissue conditioning under the following circumstances:

"Upon successful 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 certified Expanded Function Dental Assistant may apply temporary soft relines to complete dentures for the purpose of tissue conditioning under the indirect supervision of a dentist of dental hygienist ***providing the procedure is checked by the dentist or dental hygienist prior to the patient being dismissed."***

Indirect Supervision: *A dentist must authorize the procedure and be on the premises while the procedures are being performed.*

Direct Supervision: *A dentist must diagnose the condition to be treated, authorize the procedure to be performed, and remain in the dental treatment room while the procedures are performed.*

Lesson 1: *Types of Relines*

Rebase

- Entire denture base is replaced
- Original denture acts as an impression tray
- Denture is processed with existing teeth
- Patients are without denture during this process

When would a rebase be recommended?

When the acrylic base is old, cracked, broken or weakened but the teeth are still in good condition. Can address poor fitting dentures. To transition from an immediate denture to a more permanent one with the same teeth once healing has occurred. If teeth are misaligned.

Hard Reline

- Existing denture is used as impression tray
- New resin is applied to existing resin, then cured
- Resurfaces the denture, filling in the gaps between tissue and denture base
- Patients are without denture during this process

When would a hard reline be recommended?

Loose fitting dentures, sore spots, difficulty chewing or food being trapped under the denture. Reduce need for denture adhesive. Longer term solution compared to soft reline.

Chairside Soft Reline

- Chemically activated, self-curing
- Quick, temporary solution
- Creates a pliable, cushioned layer inside the denture
- Completed chairside, patient is not without denture

When would a soft reline be recommended?

Sore spots, difficulty chewing, loose denture. Shorter term solution compared to hard reline. Longer lasting than tissue conditioner 6-18mos.

Tissue Conditioner

- Used when tissues are inflamed or irritated
    - Could be from an ill-fitting denture or recent procedure
- Soft tissue must be healed (no open wounds) prior to application
- Allows further healing and cushioning by adapting to shape of underlying tissues as they recover to a healthy state
- Completed chairside, patient is not without denture

When would a tissue conditioner be recommended?

Recent extractions, new denture wearer, poor fit causing pain or instability, inflamed tissue or rapid tissue change. Expected to last weeks to months. This is the type of reline this course will focus on.

Lesson 2: *Reline Materials*

Material Properties

There are several brands/products available for temporary soft reline and tissue conditioners.

Most products consist of a powder (polymer) and liquid (monomer)

Soft reline material is self-curing

A chemical reaction occurs when you mix the polymer and monomer

The material will harden on its own over the course of a few minutes

True or False:

A curing light is necessary for the soft reline material to set and be ready for patient use?

False

Material Hazards and Accident Prevention

Always review the manufacturer's instructions prior to use.

Who in your office should you tell immediately if there is a splash or spill, that can help you seek the proper treatment?

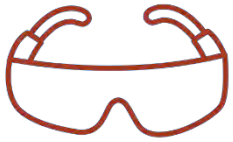
Practice manager, managing dentist, lead, SICC

MSDS

You can access the material safety data sheets online

Polymer Hazards

- Inhalation
- Eyes
- Skin
- Ingestion
- Spill



Monomer Hazards

- Inhalation
- Eyes
- Skin
- Ingestion
- Spill

PPE Required

List the PPE needed to perform a soft reline:

Gloves, mask, protective eyewear, overgown.

Lesson 3: *Patient Considerations*

Medical History

Take into consideration the patients:

- Overall health
- Medications
- Existing conditions
    - Malnutrition
    - Stroke
    - Cancer

Dental History

- Soft tissue exam
- Age of present denture
- Progression of bone loss
- Occlusion/bite relationship
- Comfort/fit of current denture

Indications for Soft Reline

- Loss of suction
- Uncomfortable, ill-fitting
- Loss of chewing capability
- Angular cheilitis
- Oral habits – grinding, clenching, mouth breathing
- Anatomic features – palatal tori
- Patients age and overall health

Contraindications for Soft Reline

- Allergies to reline material
- Temporary measure
- Material can discolor over time
- Softness is short-live
- Could support growth of candida
- Material could become detached from denture base
- Patient not interested in soft reline

Lesson 4: *Procedure*

Armamentarium

- Basic setup
- Slow-speed handpiece with acrylic bur
- Reline material
- Lubricant
- Paper cup or mixing cup provided with product
- Tongue depressor or spatula for mixing
- Metal spatula or scissors for trimming

What factors would you consider in choosing a tool for trimming the excess reline material?

Safety (high risk of accidents with blades), cost, single-use vs sterilizable, blades are sharper/faster, scissors tend to create a softer edge that is more acceptable to patients. Metal spatula is easy, creates a soft edge and carries no risk of pokes to clinician.

Procedure

- Review product instructions prior to seating patient
- Update patients' medical history
- *Dentist must complete an exam and prescribe a soft reline*
    - Provider should assess the following:
        - Condition of soft tissue
        - Fit and condition of current denture
        - Oral cancer screening
        - Assess progression of bone loss
        - Assess occlusion/bite relationship
- Plan the procedure in the patient's EHR and inform patient of any associated fees

How would you code a soft reline?

Consider clinical indication, partial vs complete, max vs mand, and tissue conditioner vs chairside reline

- Have the patient remove their denture and rinse with an antimicrobial mouthrinse to reduce bacterial load. Ask them to apply chapstick or petroleum jelly to their lips to avoid cracking or adhesion of material to soft tissue
- Examine the patient's mouth for any anatomical features that may make this process difficult or uncomfortable for the patient

List some examples below:

Cracking at the corners of the mouth, Tori, limited opening

- Examine the denture

What are you looking for?

Cracks, calculus, overall condition, plaque, food debris

- Clean the denture using a denture brush and cool water
- Dentist may remove any existing reline material and/or roughen the intaglio surface of the denture
    - In Oregon, a dental assistant may remove existing reline material, roughen the denture surface using a slow speed handpiece, or adjust the denture outside of the patient's mouth if directed to do so by the dentist
- Lubricate the labial and buccal surfaces of the denture, avoiding within 3mm of the peripheral border. If the denture has plastic teeth, coat the teeth as well
- Measure liquid and powder and mix for approx. 30 seconds

Why should you avoid overmixing or whipping the material?

To prevent air bubbles from developing in the material which will impact outcome

---

- Load material into the denture and spread on the surfaces to be relined
- Insert denture into the patient's mouth and instruct the patient to close in centric occlusion
- Have the patient remain closed for approximately 3 minutes
- After approximately 3 minutes, instruct the patient to remain closed but ask them to move their lips and cheeks to mimic chewing to obtain muscle periphery
- Remove the denture and rinse under cold water
- Trim away any excess material
- Re-insert the denture and instruct the patient to hold firmly in centric occlusion for another 5 minutes
- Remove denture again and rinse with cold water
- Have the dentist evaluate the denture before the patient is dismissed
- Denture is now ready for use

Homecare Instructions for Patient

- Dentures should remain moist
- Never rinse with hot water
- No abrasives or brushes as these can quickly wear away the reline
- Cleaning is best achieved by gently holding the denture under cold running water and wiping lightly with wet cotton
- Commercial cleaners (such as Efferdent) should not impact the reline material

OTC Materials

Patients may see over the counter reline materials available at their local pharmacy; however, these are generally discouraged due to:

- Accidental misuse
- Incorrect fit
- Burning of soft tissue
- Improper mix leading to improper setting of material

It is best to visit a dental professional

Documentation

Once treatment is completed be sure to complete the appropriate CDT code and document the following in the patient's chart:

- Who performed the reline
- What material was used
- Homecare instructions provided
- Any future treatment needs

Resources

Bird, D. L., & Robinson, D. S. (2021). Modern dental assisting (13th ed.). Elsevier

Evidence-based guidelines for the care and maintenance of complete dentures: A publication of the American College of Prosthodontists David Felton, Lyndon Cooper, Ibrahim Duqum, Glenn Minsley, Albert Guckes, Steven Haug, Patricia Meredith, Caryn Solie, David Avery, and Nancy Deal Chandler. JADA February 2011 142(suppl 1): 1S-20S; doi:10.14219/jada.archive.2011.0067

Phinney and Halstead, Dental Assisting: A Comprehensive Approach, 3rd Edition, 2008.

Treatment of the edentulous mandible GORDON J. CHRISTENSEN
JADA February 2001 132(2): 231-233; doi:10.14219/jada.archive.2001.0160

Soft Reline Clinic Check-Off Sheet

Student Name _____

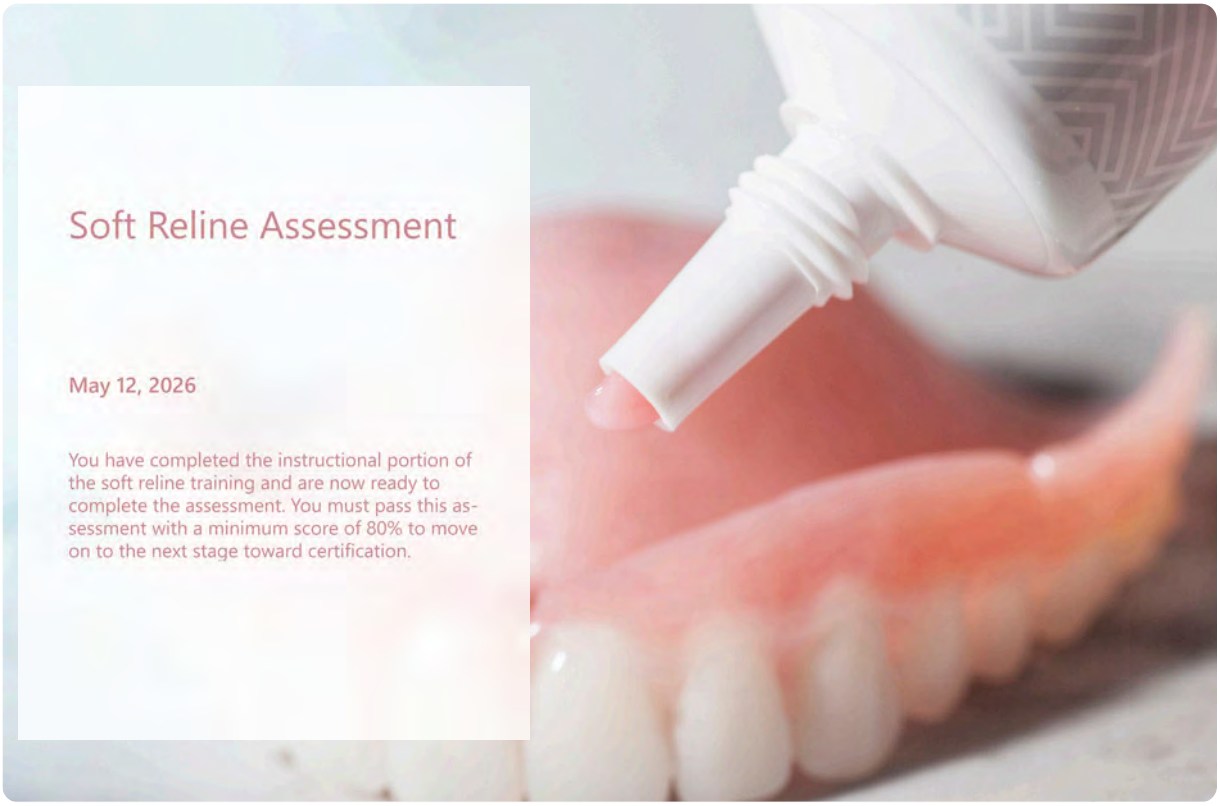
Date _____

Before participating in the clinical aspect of this course, the following are required:

- Student has passed the written examination with 85% or better.
- Student has obtained 100% proficiency in laboratory session.

Task: Soft Reline for Full Denture Max Mand Both	Satisfactory Yes or No
1. Student has set up all necessary armamentarium	Yes No
2. Student demonstrates appropriate use of PPE.	Yes No
3. Properly cleans the denture utilizing denture brush.	Yes No
4. Removes any existing reline material using slow speed handpiece and lab bur.	Yes No
5. Roughens tissue surface for better adhesion.	Yes No
6. Applies Vaseline or lubricant provided with material to labial and buccal surfaces, avoiding 3 mm from peripheral border.	Yes No
7. Measures, mixes, and spatulates material for approximately 30 seconds, and load into denture, being careful not to over-fill. (This could cause patient to gag.)	Yes No
8. Inserts denture into patient's mouth and has them close in Centric (Normal) occlusion.	Yes No
9. After approximately 3 minutes, with the patient remaining closed, has the patient start to move their lips and cheeks to obtain good muscle periphery. Mimic chewing.	Yes No
10. Student removes denture and rinses it under cold water.	Yes No
11. Excess material is trimmed away.	Yes No
12. Student re-inserts denture and has the patient close in Centric (Normal) Occlusion. Has patient remain	Yes No

closed for 5 minutes.	
13. Student removes denture one last time and rinses it thoroughly with cold water.	Yes No
14. Student makes any final adjustments.	Yes No
15. Demonstrates ability to deliver homecare instructions.	Yes No
Instructor feedback: Student correctly applied soft reline material: PASS Student did not correctly apply soft reline material: FAIL	Assistant must pass this check off with 100% proficiency.



Total: 41 Points

* Required

* This form will record your name, please fill your name.

Personal Information

1. Full Legal Name *

2. Home Office: *

3. Training Date: *

Assessment

4. Anyone can prescribe a soft reline. * (1 Point)

- ◯ True
- ◯ False

5. Assistants can apply soft relines under what level of supervision? * (1 Point)

- ◯ Direct supervision
- ◯ Indirect supervision
- ◯ General supervision
- ◯ No supervision as long as the doctor has prescribed it, you may apply the material

6. A denture rebase _____. * (1 Point)

- ◯ Replaces the existing denture base
- ◯ Can be done chairside
- ◯ Is a temporary fix
- ◯ Patient will not be without denture

7. A hard reline _____. * (1 Point)

- ◯ Requires the manufacture of a brand new denture
- ◯ Resurfaces the denture, filling in the gaps between denture base and tissue
- ◯ Is a temporary fix
- ◯ Patient will not be without denture

8. A soft reline _____. Select all that apply. * (4 Points)

- [ ] Is sometimes referred to as a "chairside reline"
- [ ] Is quick and simple to apply
- [ ] Is a temporary solution
- [ ] Patient is never without their denture

9. What are characteristics of tissue conditioners? Select all that apply. * (2 Points)

- [ ] Used when tissues are healthy
- [ ] Applied chairside
- [ ] Can be applied after the soft reline
- [ ] Allow for healing after irritation or inflammation

10. How are soft reline materials packaged? Select all that apply. * (2 Points)

- [ ] As a powder and liquid
- [ ] As a 2-paste system
- [ ] Includes lubricants and measuring materials
- [ ] As a 2-tube cartridge used with an automix extruder

11. Soft reline material requires the use of a curing light. * (1 Point)

- ◯ True
- ◯ False

12. It is not necessary to review product instructions and MSDS sheets prior to use. * (1 Point)

- ◯ True
- ◯ False

13. What should you do if you get powder in your eye? * (1 Point)

- ◯ Rinse your eye under the eye wash for 30 minutes
- ◯ Ask for help, and quickly review the MSDS
- ◯ Do nothing since it's only powder
- ◯ Rinse your eye with milk

14. What PPE is needed when applying soft relines? * (1 Point)

- ◯ Chairback covers, light covers, and air/water tips
- ◯ Gloves only
- ◯ Gloves, glasses, mask, and gown
- ◯ No PPE is required

15. Why should medical history be reviewed prior to a soft reline? Select all that apply. * (2 Points)

- ☐ To assess current medications
- ☐ To assess patient's overall health
- ☐ To invade patient's privacy
- ☐ To build rapport with patients

16. What should be done during the dental exam before a soft reline? * (2 Points)

- ☐ Cancer screening
- ☐ Assess progression of bone loss
- ☐ There is no reason to do an exam since patient has a denture
- ☐ Assess occlusion/bite relationship

17. What are indications for applying a soft reline? Select all that apply. * (4 Points)

- [ ] Ill-fitting denture
- [ ] Loss of chewing capability
- [ ] Loss of suction
- [ ] Angular Cheilitis

18. What are contradictions for applying a soft reline? Select all that apply. * (2 Points)

- [ ] Material stays the same color over time
- [ ] It's only a temporary solution
- [ ] Softness is short lived
- [ ] Material could become detached from denture base

19. What armamentariums can be included for soft relines? Select all that apply. * (4 Points)

- [ ] Reline material
- [ ] Scissors or #15 blade
- [ ] Lubricant
- [ ] Paper cup

20. It is only necessary to clean the denture when there is visible food debris. * (1 Point)

- ◯ True
- ◯ False

21. A dental assistant can apply a soft reline whenever he/she feels it's appropriate. It is not necessary to have a doctor prescribe a soft reline. * (1 Point)

- ◯ Both statements are false
- ◯ Both statements are true
- ◯ The 1st statement is true, the 2nd statement is false
- ◯ The 2nd statement is true, the 1st statement is false

22. It is not necessary to measure the powder and liquid. The higher the viscosity, the better. * (1 Point)

- ◯ True
- ◯ False

23. After you load the denture with reline material and insert the denture in the patient's mouth, you should have them close in _____ occlusion. * (1 Point)

- ◯ Lateral
- ◯ Posterior
- ◯ Centric
- ◯ Protrusive

24. What should be done when applying lubricant to the denture? * (1 Point)

- ◯ Coat the entire denture
- ◯ Coat the posterior teeth only
- ◯ Coat the labial and buccal surfaces, avoiding within 3mm of the peripheral border
- ◯ Coat only canine to canine

25. After approximately 3 minutes, you should remove the denture and give it back to the patient. The procedure is complete. * (1 Point)

- ◯ True
- ◯ False

26. What must be included when documenting the soft reline? Select all that apply. * (3 Points)

- ☐ Name of soft reline material
- ☐ Name of dental office
- ☐ Name of person who performed the reline
- ☐ Home care instructions were provided

27. Which of the following can be included in the home care instructions for patients? * (1 Point)

- ◯ Use only hot water to clean the denture
- ◯ Use a hard toothbrush to brush the denture
- ◯ It's ok the leave them out overnight without soaking them in water
- ◯ None of these are appropriate

28. After the reline is set and the patient is ready to leave, it is necessary to have _____ evaluate the denture before the patient is dismissed. * (1 Point)

- ◯ Dentist or Hygienist
- ◯ Office Manager
- ◯ Lead Assistant
- ◯ Lab

Andrew Martinez

6950 NE Campus Way, Hillsboro, OR 97124 | (503) 949-3870 | amartinez@willamettedental.com

PROFILE

As a Clinical Support Specialist, I support the onboarding and development of new dental assistants and I see teaching soft reline techniques as a meaningful extension of that work.

EXPERIENCE

CLINICAL SUPPORT SPECIALIST

WILLAMETTE DENTAL - ADMINISTRATIVE HEADQUARTERS | APRIL 2026 – PRESENT

- Provide virtual and onsite training and mentorship to Willamette Dental clinics across OR, WA, and ID
- Develop content for dental clinicians to learn new processes, equipment and technology as needed

LEAD DENTAL ASSISTANT

WILLAMETTE DENTAL – LANCASTER PRACTICE | JULY 2022 – APRIL 2026

- Lead training of new dental assistants, and continued skill development of existing dental assistants
- Drive professional growth and development of dental assistants through coaching, feedback, and mentorship
- Identify, create, and implement process improvements to enhance workflow and patient care
- Collaborate with the leadership team to ensure the highest standard of care is delivered
- Lead weekly huddles with back-office staff to align goals and priorities
- Act as an extension of the management team, supporting leadership initiatives and objectives
- All aspects of chairside dental assisting for various general providers and specialists

DENTAL ASSISTANT

WILLAMETTE DENTAL – LANCASTER PRACTICE | DECEMBER 2014 – PRESENT

- Prepared for and assisted with dental procedures.
- Prepared, sterilized, and maintained instruments, dental equipment, and treatment rooms.
- Captured radiographs.
- Reviewed and input patient medical history, medications, and vitals.
- Provided patient education and post-operative instructions.
- Followed all infection control policies.

EDUCATION

BACHELOR OF SCIENCE IN SCIENCE

PORTLAND STATE UNIVERSITY, PORTLAND, OR | DECEMBER 2022

CERTIFICATIONS

- Oregon Expanded Functions Dental Assistant

OREGON BOARD OF DENTISTRY
Dental Assistant

A31067
CERTIFICATE NUMBER

Andrew J Martinez

Expanded Functions (General)
Radiologic Proficiency

Issued: 01/20/2015

THIS CERTIFICATE MUST BE POSTED IN A CONSPICUOUS PLACE IN PLAIN SIGHT OF PATIENTS

Request for Approval of Soft Reline Course – Alyssa Kobylinsky, EFDA

The Board has received a request for approval of a Soft Reline Course. This course would be provided so the EFDA Dental Assistants could qualify to apply soft relines in accordance with OAR 818-042-0090 – Additional Functions of EFDAs.

Relevant Rules:

OAR 818-042-0090 – Additional Functions of EFDAs

"Upon successful 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 certified Expanded Function Dental Assistant may perform the following functions under the indirect supervision of a dentist or dental hygienist providing that the procedure is checked by the dentist or dental hygienist prior to the patient being dismissed:

(1) Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a dentist or dental hygienist.
(2) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.
(3) Place cord subgingivally.

DENTURE SOFT RELINE

Course for Oregon Expanded Functions Dental Assistants

Course submission for Oregon Board of Dentistry Approval

Alyssa Kobylinsky
Alyssa.kobylinsky@clackamas.edu

August 5, 2026

Oregon Board of Dentistry
1500 SW 1st Ave, Ste. 770
Portland, OR 97201

Dear Oregon Board of Dentistry,

Please consider this request for approval of attached Denture Soft Reline course for Expanded Functions Dental Assistants in Oregon.

Attached you will find the following:

- Instructor Curriculum Vitae
- Copies of related certifications
- Course Syllabus/Outline
- Lecture PowerPoint
- Course exam with answer key
- Clinical check-off/ competency
- Course evaluation

Please let me know if you have any questions.

Thank you for your consideration,

Alyssa Kobylinsky, CDA, EFDA_RF

Associate Faculty

Address: 7738 SE Harmony Road, Milwaukie, OR 97222
Direct Line: 503.594.0693 • E-Mail: Alyssa.kobylinsky@clackamas.edu

Clackamas Community College HEALTH SCIENCES | Dental Assistant Program

CURRICULUM VITAE

Alyssa Kobylinsky, CDA, EFDA_RF
Associate Faculty

Professional Summary

Experienced Dental Assistant and educator with over 16 years of clinical expertise and a dedicated focus on dental education and curriculum development. Currently serving as the Dental Assisting Lab instructor at Clackamas Community College, with previous experience in designing and delivering hands-on clinical training and didactic programs for Expanded Functions Dental Assistants (EFDA).

Professional Experience

Dental Assistant Lab Instructor | Clackamas Community College (September 2025 - Present)
Clinical Lab Instructor for the Clackamas Community College Dental Assisting Program, providing hands-on clinical instruction in dental assisting procedures and teaching courses in Clinical Procedures, Dental Materials, and Dental Radiology.

Dental Assistant Program Specialist | Willamette Dental (October 2020 - September 2025)
Served as the subject matter expert for Dental Assistant training and development, designing and delivering continuing education and clinical training, including certification courses in Pit and Fissure Sealants, Temporary Soft Relines, and Subgingival Cord Packing. Developed instructional materials and evaluation tools, managed training projects, facilitated virtual and hands-on learning, and mentored Lead Dental Assistants to support workforce development and clinical excellence.

Clinical Experience

- Over 16 years of chairside dental experience in offices of various sizes and with various providers - Dentists, Dental Therapists, and Dental Hygienists.
- Certified in placement of soft reline since 2015, placed temporary soft relines on a regular basis in patient care as a full-time EFDA until 2020.
- Actively engaged chairside as on-call assistant to ensure clinical skills remain current and directly applicable to training.

Credentials

- Certified Dental Assistant (CDA)
- Expanded Functions Dental Assistant (EFDA)
- EFDA with Restorative Functions Certificate (EFDA_RF)
- Placement of Pit and Fissure Sealant, Soft Reline, Subgingival Retraction Cord Certificates
- Instructor Permits: Soft Reline, Pit and Fissure Sealant, and Subgingival Retraction Cord Placement

Additional Courses Taken

- Project Management Certification Course
- Teaching Online-An Introduction to Online Delivery
- Micro-Learning Course – Gathering and Using Student Feedback
- Bloodborne Pathogens
- Infection Control
- Best Practices in Dental Charting
- Cultural Sensitivity
- Building Cultures of Trust
- A-dec Technical Service Training Certificate

Professional Involvement

- Board Member and Marketing chair, Oregon Dental Assistant Association.
- Committee Member, Dental Assistant Workforce Shortage Advisory Committee – Oregon Board of Dentistry.
- Program Advisory Committee Member for Clackamas Community College, Portland Community College, and Concorde Career College

OREGON BOARD OF DENTISTRY

Dental Assistant

Expanded Functions Dental Assistant
Issued: December 23, 2014
Restorative Functions Add-On
Issued: June 17, 2024

119532
CERTIFICATE NUMBER

Alyssa V Kobylinsky

Radiological Proficiency
Issued: April 22, 2010

Certificate Print Date: June 27, 2024

Dental Assisting National Board

This confirms that

Alyssa V Kobylinsky

has fulfilled the certification requirements approved by the Board of Directors of the Dental Assisting National Board and is authorized to use the certification mark

Certified Dental Assistant

CDA

The mark conferred above is a certification mark of DANB.

DANB

Certification Number: 286709
Expiration Date: 02/11/2027

Barbara L. Mousel

Barbara Mousel, D.D.S., CDA, RDH
DANB Board Chair

Kerri Friel

Kerri Friel, CDA, COA, RDH, M.A.
DANB Board Secretary

Course Attendance Verification

Willamette Dental

6950 NE Campus Way
Hillsboro, Oregon 97124
Provider ID# 302477

Attendance for this course is confirmed for

Alyssa Kobylinsky

Soft Reline

2.00 CDE Hours

Dr. Mimi Whittemore
CCOO

Completed on
06.15.2015

AGD #	State and Dental License #	AGD Subject Codes	Educational Method
		149	In-Person

Verification Code	Instructor Contact	Location
SoftReline	Helen Massar, RDH	Willamette Dental Group

PACE ACADEMY OF GENERAL DENTISTRY PROGRAM APPROVAL FOR CONTINUING EDUCATION

Willamette Dental Group, P.C.
Nationally Approved PACE Program Provider for FAGD/MAGD credit.
Approval does not imply acceptance by any regulatory authority or AGD endorsement.
12/1/2023 to 11/30/2027
Provider ID# 302477

Keep this form for your records.

AGD Members: Willamette Dental Group will submit attendance verification to the AGD on your behalf. Please allow at least 30 days for documentation of participation to be added to your transcript.

CERTIFICATE OF INSTRUCTOR APPROVAL

The OREGON BOARD OF DENTISTRY certifies that:

I3033
LICENSE NUMBER

Alyssa V Kobylinsky

has met the requirements to teach courses in Soft Relines.

Issued: 02/21/2024
Expires: 02/21/2028

COURSE SYLLABUS

Course Description

This course provides Expanded Functions Dental Assistants (EFDA) with the required didactic and clinical education to apply temporary denture soft reline material to removable dentures.

Requirements

- Prerequisite: Participants must be a certified Expanded Function Dental Assistant (EFDA) in Oregon
- Proof of Certification: A copy of the EFDA certification must be submitted at registration.

Format

To receive a certificate for soft reline at CCC, the following requirements need to be met:

- Lecture/Didactic: Completion of the didactic portion
- Examination: Class participants must take a 25-question exam with a minimum passing score of 80% prior to starting the lab portion of the course.
- Hands-on Lab Session: Students must demonstrate 100% proficiency during the lab competency check-off to pass.
- Course Evaluation: Students have the option to complete a Training Feedback Form or course evaluation to assess the effectiveness of the instructor and the clinical applicability of the course.

Objective

Upon successful completion, students will be able to apply temporary soft reline material to a denture under the indirect supervision of a dentist or dental hygienist, ensuring the procedure is checked before the patient is dismissed.

Learning Outcomes

- Explain the legal requirements and OSHA standards related to procedure
- Assess patient factors related to reline procedures, including medical/dental histories
- Explain indications/ contraindications and purpose of denture soft reline
- Identify and properly use PPE and armamentarium for soft reline placement
- Demonstrate knowledge and skills to place denture soft reline, including mixing, application, trimming and finishing techniques.
- Provide appropriate patient education and home care instructions
- Accurately document treatment procedures in the patient record.

Course Outline

I. Legal Framework

- Review of OAR 818-042-0090: Additional Functions of EFDAs.
- Defining Indirect Supervision and the requirement for final checks.

II. Patient Assessment

- Medical/Dental History review
- Anatomical review
- Potential health impacts of ill-fitting dentures

III. Types of Relines

- Rebase
- Hard Reline
- Soft Reline (including indications and contraindications)
- Tissue Conditioners

IV. Materials and Safety

- Common soft reline brands
- Chemistry
- Standard precautions and OSHA standards
- Armamentarium: Reline material, slow-speed handpiece, acrylic burs, spatulas, lubricants, cup for mixing, and trimming tools.

V. Clinical Procedure Step-by-Step

1. Medical/ Dental history is reviewed
2. Dentist prescribes the reline and may roughen the surface.
3. Discuss procedure with the patient and answer any questions.
4. Examine the patient's mouth and try the denture in to see patient's occlusion
5. Prepare the denture
6. Coat labial/buccal surfaces and denture teeth with lubricant
7. Mix and apply reline material according to manufacturer instructions and spread in the denture evenly to prevent gaps or bubbles.
8. Seat the denture and have the patient close in centric occlusion for 3 minutes (or as recommended by manufacturer's instructions).
9. Have the patient move lips/cheeks to obtain muscle periphery.
10. Remove, evaluate reline coverage, rinse in cold water, trim excess, and re-insert for a final 5-minute set. Ask the patient to check or comfort and complete finishing touches as needed.
11. Dentist or Hygienist must check the fit before dismissal.

VI. Post-Operative & Administrative

- Patient Instructions
- Documentation

TEMPORARY SOFT RELINE

Course for Oregon Expanded Functions Dental Assistants

Clackamas Community College

LEARNING OUTCOMES

- Explain the legal requirements and OSHA standards related to procedure
- Assess patient factors related to reline procedures, including medical/dental histories
- Explain indications/ contraindications and purpose of denture soft reline
- Identify and properly use PPE and armamentarium for soft reline placement
- Demonstrate knowledge and skills to place denture soft reline, including mixing, application, trimming and finishing techniques.
- Provide appropriate patient education and home care instructions
- Accurately document treatment procedures in the patient record

RULE: OAR 818-042-0090

Upon successful 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 certified Expanded Function Dental Assistant may perform the following functions under the **indirect supervision** of a dentist or dental hygienist providing that the **procedure is checked by the dentist or dental hygienist prior to the patient being dismissed:**

(1) Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a dentist or dental hygienist.

(2) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.

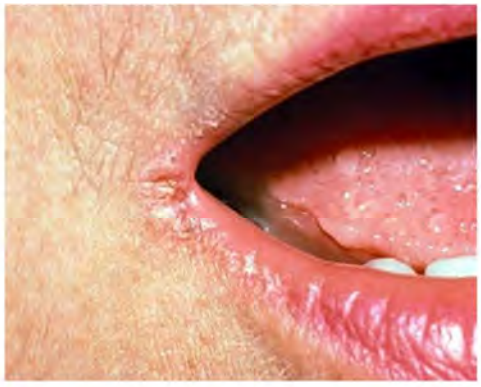
(3) Place retraction material subgingivally.

INDIRECT SUPERVISION

Requires that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.

MEDICAL HISTORY REVIEW

Review the patient's medical and dental history for any factors that may affect temporary soft reline treatment.



Consider the following factors:

- Allergies
- Medications
- Cancer or stroke
- Date of last cancer screening
- Active oral infection
- Angular cheilitis or Dry/chapped lips
- Healing of recent oral surgery

POTENTIAL HEALTH IMPACTS OF POORLY FITTING DENTURE/S

- **Tissue Damage and Infections:** Chronic rubbing causes sore spots, ulcers, and inflammation, which increase the risk of denture stomatitis and fungal infections like oral candidiasis.

- **Jawbone and Facial Changes:** Uneven pressure accelerates bone resorption (shrinkage), leading to facial sagging and a prematurely aged appearance, or angular cheilitis.

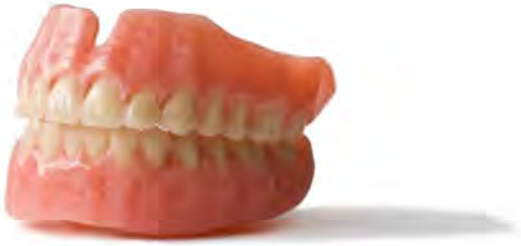
- **Nutritional Deficiencies:** Chewing difficulties often force patients into a limited diet, which can lead to inadequate intake of essential minerals and proteins.

POTENTIAL HEALTH IMPACTS OF POORLY FITTING DENTURE/S CONT.

- **Speech and Swallowing Issues:** Slipping dentures can cause slurred speech, clicking sounds, or difficulty pronouncing certain words.
- **Oral Cancer Risk:** Long-term chronic irritation and persistent inflammation from a poorly fitting prosthesis may contribute to abnormal cell growth.
- **Psychological and Quality-of-Life Impact:** Constant discomfort and embarrassment from slippage or speech issues can reduce self-confidence and lead to social withdrawal

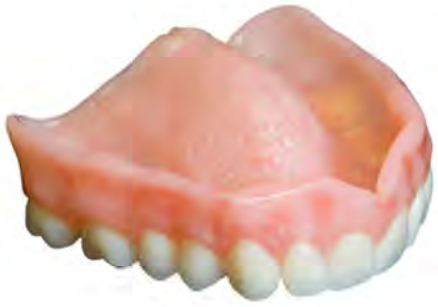
TYPES OF RELINES
DENTURE REBASE

- Entire denture base is replaced while keeping existing teeth
- Used when denture base is worn or damaged but denture teeth are in good condition with acceptable occlusion
- Often completed in the lab with processing time
- Long term solution



TYPES OF RELINES
HARD RELINE

- Reline with hard acrylic resin, similar to denture base (typically completed in a lab)
- Feels firm, rigid, and durable
- Long term solution
- Restores denture fit after the tissue changes
- Best for healthy stable tissues with ridge resorption
- Easier to clean and less likely to harbor bacteria than soft reline
- Less follow up than soft reline



TYPES OF RELINES
TEMPORARY SOFT RELINE

- Soft, resilient liner material
- Quick application can be completed in the office (often called chairside reline), providing same-day relief
- Feels soft and cushioning
- Temporary or short term solution (weeks to months)
- Cushions sensitive tissues to improve comfort and stability
- Best for tender tissues, prominent ridges, tori, or healing tissues
- More difficult to clean and maintain and susceptable to fungi/bacteria

TYPES OF RELINES
TISSUE CONDITIONERS

- Conditioning and healing to the tissues
- Lasts days - weeks
- Indicated for denture stomatitis or following extractions
- Transitional treatment
- Promotes healing of irritated tissues
- Provides immediate comfort
- Difficult to clean

TEMPORARY SOFT RELINE
INDICATIONS

- Loss of retention or stability
- Decreased comfort during denture wear
- Reduced function affecting chewing or speaking
- Recent oral surgery requiring protection of healing tissues
- Residual ridge resorption resulting in an ill-fitting denture
- Prominent bony undercuts or tori that create pressure areas and discomfort with hard acrylic
- Thin, sensitive, or easily traumatized oral mucosa requiring additional cushioning

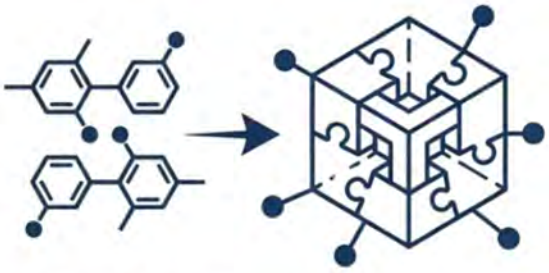
TEMPORARY SOFT RELINE
CONTRAINDICATIONS

- Known allergy or sensitivity to soft reline materials
- Active oral infection or untreated oral pathology
- Poor oral hygiene that may contribute to material deterioration or microbial growth
- Severely ill-fitting, damaged, or unstable dentures that require replacement or rebase
- Need for long-term or definitive treatment solution
- Inability or unwillingness to comply with home care and follow-up instructions/ appointments
- Excessive occlusal discrepancies that should be corrected before relining

TEMPORARY SOFT RELINE
COMMON BRANDS

TEMPORARY SOFT RELINE
THE CHEMISTRY

- Soft relines can be silicone based or consists a powder (polymer) and a liquid (monomer)
- Undergo a self-curing (chemically activated) reaction when mixed



- Liquid monomers are often highly flammable and may contain methacrylate or salicylates
- Once set, the material is porous, which allows it to provide comfort but also means it can harbor microorganisms like bacteria or fungi if not maintained

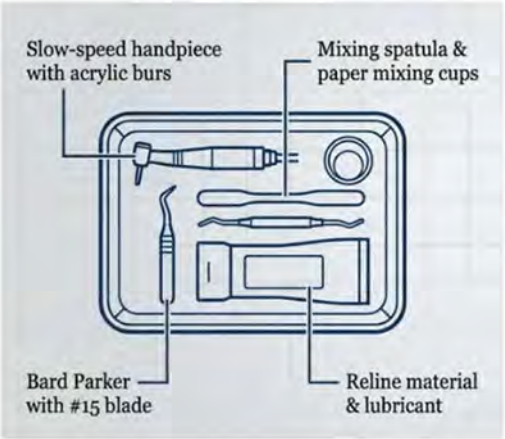
TEMPORARY SOFT RELINE
SAFETY

- Follow Standard Precautions with every patient
- Wear appropriate PPE (gown, mask, protective eyewear or shield, gloves)
- Properly disinfect dentures prior to handling to prevent cross contamination

TEMPORARY SOFT RELINE
SAFETY

- Follow OSHA standards
- Review the manufacturer's Safety Data Sheet (SDS) before use
- Understand:
  - Flammability hazards
  - Ventilation requirements
  - First-aid measures
  - Storage recommendations

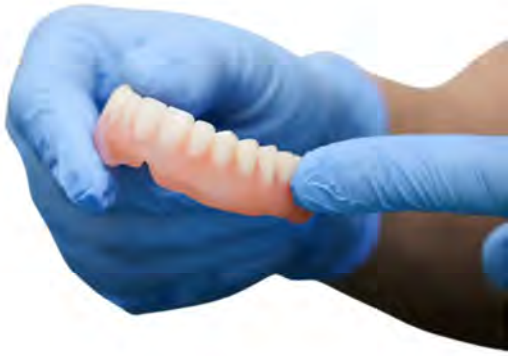
TEMPORARY SOFT RELINE
PROCEDURE SET UP



- Soft reline material
- Lubricant
- Cup and spatula for mixing or mixing tips if using a silicone reline material
- Trimming tools such as #15 blade and/or tissue scissors
- Slow speed handpiece with acrylic burs (as needed)
- Patients denture (cleaned, disinfected, and rinsed)

TEMPORARY SOFT RELINE
PROCEDURE STEPS

1. Dentist prescribes soft reline and may roughen the surface or create a lip on flanges to prevent peeling of the reline.
2. Discuss procedure and cost with patient, answer any questions
3. Examine patients mouth for factors that may impact treatment and check patients centric occlusion
4. Prepare the denture (remove old material if needed, clean with denture brush, disinfect, rinse, and dry)



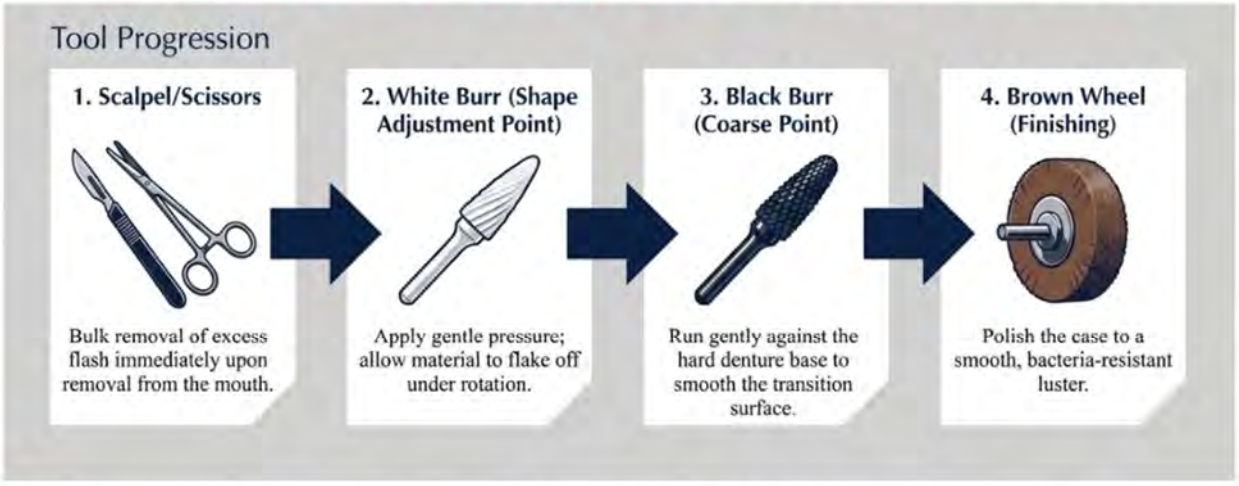
TEMPORARY SOFT RELINE
PROCEDURE STEPS

5. Coat labial and buccal surfaces with lubricant, avoiding 3 mm of peripheral border
6. Mix and apply product according to manufacturer's instructions. *If using Coe-Soft, mix 11g powder/8ml liquid and mix for 30 seconds (do not whip or overmix to avoid bubbles)*
7. Spread mixture evenly over denture intaglio
8. Seat denture into centric occlusion (posterior first to avoid gag reflux) and ask patient to bite lightly

TEMPORARY SOFT RELINE
PROCEDURE STEPS

9. After 3 minutes, ask patient to move lips and cheeks to obtain muscle periphery
10. Remove denture and rinse with cold water
11. Trim excess with tissue scissors and/or #15 blade
12. Re-seat denture and ask patient to bite firmly for 5 minutes
13. Rinse again with cold water and complete finishing touches to achieve a smooth edge and patient comfort
14. Dentist or Hygienist MUST check completed reline prior to dismissal

TEMPORARY SOFT RELINE
FINISHING TOUCHES FOR SILICONE BASED MATERIALS



NOTE: If using a polymer/monomer material, a hot spatula may be used to smooth edges if needed

TEMPORARY SOFT RELINE
PATIENT INSTRUCTIONS

- Use cold water only to rinse dentures, ideally after every meal
- Use a soft cloth to gently wipe the liner clean (the rigid acrylic portion can be cleaned with a brush)
- Avoid commercial chemical cleaners
- If pressure points cause irritation or ulcerations, patients should return for post-insertion adjustments
- DO NOT:
  - brush the soft liner
  - use abrasive toothpaste or rough brushes
  - use hot water

TEMPORARY SOFT RELINE
DOCUMENTATION

- Complete necessary procedure codes and document the following:
- Patient Concerns (complaint, symptoms, or functional impact)
- Name of provider who completed reline
- Materials used (brand name)
- Instructions provided to the patient
- Final verification: Final fit and occlusion checked and approved by the dentist prior to patient dismissal.
- Follow-up plan

EFDA Exam Prep: Core Takeaways

Supervision:
Soft relines require Indirect Supervision (Dentist prescribes, checks before dismissal).

Nature of Fix:
Soft relines are a temporary solution, not a permanent rebase.

Chemistry:
Materials are chemically-activated and self-curing (no light).

Patient State:
Unlike hard relines, the patient is never without their denture.

Maintenance:
NEVER use hot water or hard brushes to clean the reline.

Packaging:
Materials generally come as a powder/liquid or 2-2-paste system.

THANK YOU!

With any questions, please reach out to
alyssa.kobylinsky@clackamas.edu

Temporary Soft Reline Certification Exam

The examination will be administered and documented within the Learning Management System (LMS). Students will have two attempts to complete the exam and must earn a score of at least 80% to successfully pass.

I. Legal Requirements

1. According to OAR 818-042-0090, which level of supervision is required for an EFDA to apply temporary soft relines?
   A) General Supervision B) Direct Supervision C) Indirect Supervision D) Personal Supervision

2. When can an EFDA legally dismiss a patient after completing a soft reline?
   A) Immediately after the final set of the material B) Only after a dentist or dental hygienist has checked the procedure C) Once the patient confirms they are comfortable D) After providing home care instructions

II. Purpose, Indications, and Contraindications

3. What is the primary objective of using a temporary soft reline?
   A) To permanently replace the denture base B) To allow irritated or inflamed tissues to heal and provide comfort C) To change the shade of the denture teeth D) To increase the weight of the prosthesis for stability

4. Which of the following is a recognized clinical indication for a soft reline?
   A) Recent oral surgery or extractions B) Significant patient weight loss C) Alveolar ridge resorption D) All of the above

5. Why are chairside soft relines categorized as "temporary" solutions?
   A) The material is highly porous and can harbor microorganisms B) The material loses its resiliency and adhesion over time C) They are only intended for tissue conditioning or short-term relief D) All of the above

6. Which factor would be a direct contraindication for performing a soft reline procedure?
   A) The patient is a clencher or grinder B) The patient has a known allergy to the reline material or monomer C) The patient has immediate dentures D) The patient is homebound

III. Patient Assessment and History

7. When assessing a patient's medical history, why are immunocompromised states (such as those resulting from chemotherapy or long-term corticosteroid use) considered significant *risk factors for soft reline procedures?*
   A) These conditions prevent the reline material from polymerizing or setting correctly. B) There is an increased risk of infection and delayed healing because soft reline materials are porous and can harbor microorganisms. C) Patients with these conditions are unable to maintain the required centric occlusion for the final set. D) The chemical monomers in the reline material will cause an immediate systemic allergic reaction in these patients.

8. Which anatomical feature should be identified during the clinical exam to prevent discomfort?
    A) The size of the patient's tonsils B) The presence of palatal tori or sore spots C) The color of the soft palate D) The length of the uvula

9. Beyond immediate physical discomfort, how do poorly fitting dentures affect the long-term facial appearance and skeletal structure of a patient?
    A) They stimulate the growth of new alveolar bone. B) They cause uneven pressure that accelerates bone resorption (shrinkage), leading to facial sagging and a prematurely aged appearance. C) They have no long-term impact on the jawbone or facial aesthetics. D) They cause the jawbone to become denser and more resistant to future changes

10. Why is the presence of an active infection, such as oral candidiasis, considered a direct contraindication for the application of a soft reline?
    A) The infection will prevent the polymer and monomer from achieving a chemical bond. B) The medication used to treat the infection will dissolve the reline material. C) Soft reline materials are porous and can harbor microorganisms, which may trap the fungi and exacerbate the infection D) The infection causes the oral tissues to become too slippery for the denture to be seated in centric occlusion.

IV. Materials and Safety

11. Where must a dental assistant look to find specific information on the chemical hazards and first aid for reline monomers?
    A) The office's employee handbook B) The Safety Data Sheets (SDS) C) The Oregon Board of Dentistry website D) The patient's clinical record

12. If a chemical splash to the eye occurs during mixing, what is the first action an assistant should take?
    A) Finish the procedure before seeking help B) Rinse the eye with a neutralizing agent C) Alert someone immediately, review the MSDS, and follow emergency rinse protocols D) Rub the eye vigorously to remove the powder particles

13. Which pieces of PPE are required when placing denture soft reline? Choose all that apply.
    A) long sleeved gown or lab coat B) gloves C) Protective eyewear D) A face shield

14. What is the primary purpose of applying lubricant to the plastic teeth and external surfaces of the denture?
    A) To make the denture taste better for the patient B) To prevent the reline material from adhering to areas where bonding is not desired C) To speed up the chemical polymerization process D) To help the dentist check the bite

15. Which of the following is NOT a standard item in the armamentarium for a soft reline?
    A) A slow-speed handpiece with acrylic burs B) A curing light C) A #15 scalpel blade D) Mixing containers and spatulas

16. What are the two primary chemical components found in a standard chairside soft reline kit?
    A) Resin and Catalyst B) Base and Accelerator C) Powder (Polymer) and Liquid (Monomer) D) Etchant and Bonding agent

V. Clinical Procedure: Mixing to Finishing

17. When mixing Coe-Soft reline material, what is the maximum recommended spatulation time?
    A) 10 seconds B) 30 seconds C) 60 seconds D) 2 minutes

18. When seating the loaded denture, how should it be placed to avoid expressing material into the throat?
    A) Anterior portion first, rocking toward the posterior B) Posterior portion first, rocking toward the anterior C) Seat both sides simultaneously with heavy pressure D) Have the patient seat it themselves

19. In which occlusal relationship must the patient hold firmly while the material achieves its final set?
    A) Protrusive Occlusion B) Lateral Occlusion C) Centric Occlusion D) Open-mouth position

VI. Patient Education and Home Care

20. How should a patient be instructed to clean the soft lining of their denture?
    A) Vigorous brushing with whitening toothpaste B) Soaking in boiling water daily C) Wiping with wet cotton and rinsing with cold tap water D) Scrubbing with a hard-bristled denture brush

21. Why should patients avoid commercial chemical cleansers (like Efferdent) on soft relines?
    A) They can change the color of the denture teeth B) They can deteriorate or harden the material prematurely C) They are too expensive for temporary relines D) They interfere with the patient's sense of taste

22. What is the generally expected lifespan of a temporary soft reline or tissue conditioner?
    A) 1 to 2 days B) 2 weeks to 3 months C) 1 to 2 years D) It is a permanent solution

VII. Documentation

23. Which of the following must be included in the patient's chart entry for a soft reline?
    A) The brand of material used B) The name of the person who performed the reline C) A statement that home care instructions were provided D) All of the above

24. Whose name must be documented as having prescribed and checked the final fit of the reline?
    A) The Office Manager B) The Lead Assistant C) The Dentist and/or Dental Hygienist D) The Lab Technician

25. List 2 temporary soft reline brands (open ended)

Exam Answer Key

1. Indirect Supervision
2. Only after a dentist or dental hygienist has checked the procedure
3. To allow inflamed tissues to heal and provide a cushion for comfort
4. All of the above
5. The material is porous, can harbor bacteria, and loses its resiliency/adhesion over time
6. Known allergy to the reline material/monomer
7. There is an increased risk of infection and delayed healing because soft reline materials are porous and can harbor microorganisms.
8. Tori or sore spots
9. They cause uneven pressure that accelerates bone resorption (shrinkage), leading to facial sagging and a prematurely aged appearance.
10. Soft reline materials are porous and can harbor microorganisms, which may trap the fungi and exacerbate the infection
11. Material Safety Data Sheets (MSDS)
12. Ask for help immediately, review MSDS, and follow specific emergency rinse instructions
13. Protective eyewear
14. To prevent the reline material from adhering to areas where bonding is not desired
15. Curing Light
16. Powder (Polymer) and Liquid (Monomer)
17. 30 seconds
18. The posterior portion (rocking toward the anterior)
19. Centric Occlusion
20. Wiping with wet cotton and rinsing with cold tap water
21. These agents can deteriorate or harden the porous material prematurely
22. 2 weeks to 3 months (depending on material and care)
23. All of the above
24. The Dentist and/or Dental Hygienist
25. Open ended (will encourage assistants to share what they use in their office)

Soft Reline Lab Proficiency Sheet

Student Name _____ Date _____
Lab Partner _____Soft reline material_____

Step 1: Complete the following tasks with a lab partner using soft reline material provided. Verbal questions may be discussed with partner.
Step 2: Once the reline procedure is successfully completed with a lab partner at 100% competency, remove the reline from the denture and demonstrate the competency again with the instructor for final sign-off. Score of 100% is required to pass.

Task: Soft Reline for Full Denture	Partner Initial	Instructor Initial
1. *Verbally list a few factors that would indicate a temporary soft reline.*		
2. Student has reviewed product instructions.		
3. All necessary materials to complete the entire task assembled, including but not limited to: reline material, basic set-up, scissors or #15 blade, etc.…		
4. Appropriate PPE is worn, including gloves, glasses, mask, and gown.		
5. Try denture in. *What is something you would look for when trying the denture in?*		
6. Denture is cleaned and dried thoroughly		
7. Any existing reline material is removed (using slow-speed handpiece and lab bur if needed)		
8. Tissue surface is roughened to enhance material adhesion using slow-speed handpiece and lab bur.		
9. Vaseline or lubricant applied to labial and buccal surfaces,		

avoiding 3 mm from peripheral border.		
10. Material measured and mixed properly		
11. Reline material is spread on tissue surface of denture that is to be relined		
12. Denture is applied to model, applying firm pressure to replicate centric occlusion.		
13. Denture is removed from model after 3 minutes (or when set on model) and rinsed under cool water		
14. Reline is evaluated and excess material is trimmed away using a scissors or #15 blade		
15. Denture is remounted onto model firm pressure applied (to replicate centric occlusion) again for another 5 minutes		
16. Denture removed for a final rinse under cold water		
17. Final adjustments are made to denture.		
18. Instructor evaluate denture for accuracy of material placement. (In clinic setting, Dr. or Hyg. must evaluate)		
19. Verbal answer: What are the post op instructions?		
20. Verbal answer: What must be documented?		

Student correctly applied soft reline material: PASS

Student did not correctly apply soft reline material: FAIL

Instructor Initials:_____Date_____

Course Evaluation

Course: Temporary Soft Relines course for Oregon EFDA

Instructor: _____ Date: _____

Please indicate if the course effectively covered the following learning objectives:

Objective	Yes	No
Explanation of legal requirements (OAR 818-042-0090)		
Ability to distinguish between rebase, hard reline, soft reline, and tissue conditioner		
Understanding material chemistry, OSHA Standards, and MSDS protocols.		
Proficiency in assessing patient medical history, indications, and contraindications.		
Step-by-step clinical procedure (mixing, seating, and trimming).		
Techniques for trimming, finishing, and verifying final fit and occlusion.		
Providing clear post-operative home care instructions to patients.		
Accurate documentation and chart entry requirements.		

Please evaluate the training by responding to the following statements.

(5 = Excellent, 4 = Very Good, 3 = Good, 2 = Fair, 1 = Poor, 0 = N/A)

1. Instructor's knowledge and grasp of the subject matter:
2. Instructor's effectiveness in clinical demonstrations and lab guidance:
3. Quality of educational materials (PowerPoints, Syllabus, Handouts):
4. Usefulness and clinical applicability of the training to your role:
5. Hands-on lab session effectiveness in preparing you for live patients:
6. Overall administration and scheduling of the course:

Open Feedback

General comments or suggestions for improvement:

_____

_____

Request for Approval of a Local Anesthesia Course for Oregon Local Anesthesia Functions Certificate (LAFC) for Dental Assistants – Sam Boehm, R.D.H.

The Board has received a request for approval of a Local Anesthesia Course – for Oregon dental assistants. The course would be provided to Expanded Practice Dental Assistants so the EFDAs could apply for and obtain a certificate from DANB

Relevant Rule:

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.

August 6th, 2026

Oregon Board of Dentistry

Dear Members of the Oregon Board of Dentistry,

I am writing to request the Board's review and approval of a curriculum I have developed for Expanded Function Dental Assistants seeking endorsement in the administration of local anesthesia.

The course has been specifically designed to provide dental assistants with the education, knowledge, and clinical training necessary to safely and competently perform local anesthesia within the scope of practice established by the Oregon Board of Dentistry.

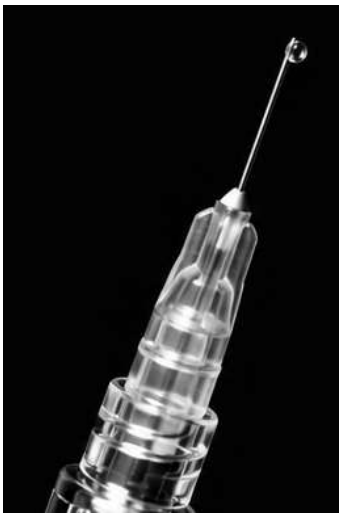
Thank you for your time and consideration. I look forward to working with the Oregon Board of Dentistry to ensure the curriculum meets all applicable educational and regulatory standards.

Sincerely,

Samantha Boehm, CDA, RDH, BSDH
(541)890-8598

2026
PRAXIA DENTAL EDUCATION

LOCAL ANESTHESIA FOR THE DENTAL ASSISTANT



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1. COURSE DESCRIPTION

Praxia Dental Education has organized this course to review concepts of pain management with the use of local anesthetic agents. Participants in this course will review pharmacology of anesthetic solutions, dosages, vasoconstrictors, drug interactions, neural physiology, anatomical structures, health history evaluation, contraindications of local anesthesia and management of medical emergencies and adverse reactions.

2. COURSE PREREQUISITES

Participants of this course must provide proof of:

- One year of work experience as a dental assistant
- EFDA certification from the Oregon Board of Dentistry
- BLS for Healthcare Providers certification
- Professional liability insurance

3. COURSE REQUIREMENTS

To successfully complete this course, participants must:

- Obtain a 75% or above in the lecture exam
- Participate in all lecture modules, laboratories and clinics
- Demonstrate competency for each required injection

Course hours (minimum of 65 hours):

- 35+ hours of lecture
- 15+ hours of laboratory
- 15+ hours of clinical

4. RESOURCES

Bassett, KB, DiMarco, AC, Naughton, DK. Local Anesthesia for Dental Professionals 2nd ed. 2015. Pearson: Upper Saddle River, NJ.

5. COURSE OBJECTIVES

Participants will be able to:

- Explain pain physiology and mechanisms of local anesthesia.
- Describe head and neck neuroanatomy related to anesthesia.
- Discuss pharmacology of local anesthetics and vasoconstrictors.
- Calculate maximum recommended dosages safely.
- Perform comprehensive patient assessment prior to anesthesia.
- Demonstrate proper armamentarium setup and infection control.
- Administer all required maxillary and mandibular injection techniques safely.
- Select supplemental injection techniques when indicated.
- Recognize and manage local anesthetic emergencies and complications.
- Modify treatment for medically compromised pediatric and anxious patients.
- Apply legal, ethical, and documentation standards.

6. COURSE OUTLINE

Course length: 11 weeks.

Module I: Course Orientation, Perspectives, Pain Management and Treating the Fearful Patient (Chapter 1,2 and 18)

- Topics:
  - Course orientation and expectations
  - Oregon EFDA local anesthesia certification requirements
  - The role of local anesthesia in modern dentistry
  - Pain perception and pain management principles
  - Dental anxiety and fear
  - Communication strategies for anxious patients
  - Behavioral management techniques
  - Building patient trust and confidence
- Learning Objectives:
  - Identify a variety of dental local anesthesia providers in North America.
  - Discuss the responsibilities of local anesthesia providers.
  - Discuss the value of pain as a protective response.
  - Discuss factors that can contribute to an individual's response to a painful experience.
  - Discuss the three general types of pain.
  - Differentiate between acute and chronic pain.
  - Explain the differences between pain perception and nociception.
  - Discuss the physiological reactions of the sympathetic nervous system related to pain.
  - Discuss anxiety and fear as they relate to successful anesthesia.
  - Give examples of strategies that can help patients cope with fear and anxiety.
  - Discuss the influence of previous pain experiences on the ability to administer local anesthetic injections.
  - Differentiate between the terms fear, anxiety and phobia.
  - Explain the etiology and development of fear as it relates to pain and pain management.
  - Discuss the primary sources for recognizing and assessing fears.
  - Apply the fundamental concepts of treatment for fearful and anxious patients.
  - Relate a patient's sense of control to his or her experienced level of fear or anxiety.
  - Explain four useful types of control for anxious patients receiving injections.
  - Discuss and demonstrate physical relaxation and coping skills.
  - Teach physical relaxation and coping skills to patients.
  - Apply appropriate fear management strategies and coping feedback.
  - Explain benefits and techniques for testing local anesthetic effectiveness.
  - Describe the management of anesthetic failure, including psychological management of the patient and technical reassessment.
- Laboratory Assignment: (2 hours) Patient communication and anxiety management
  - Objective: Develop communication skills for introducing local anesthesia to patients.
  - Assignment:

        - Create a 2–3-minute script explaining local anesthesia to a nervous patient.
        - Include: Why anesthesia is needed, what the patient should expect, how discomfort will be minimized, post-anesthetic instructions. Record yourself delivering script.
    - Deliverable: Video submission (3-5 minutes). Self-reflection paragraph. Upload on website.
- Weekly quiz.

Module II: Head and Neck Anatomy Review (Instructor- provided anatomy material/PowerPoint review)

- Topics:
    - Basic anatomy review
    - Osteology of the skull
    - Maxilla and mandible
    - Cranial foramina
    - Muscles of mastication
    - Muscles of facial expression
    - Cranial nerves
    - Trigeminal nerve
    - Blood supply
    - Soft tissue landmarks
    - Clinical anatomy related to local anesthesia
    - Surface landmarks for injections
- Learning Objectives:
    - Identify all anatomical landmarks required for local anesthesia.
    - Trace the branches of the trigeminal nerve.
    - Correlate anatomy with injection techniques.
    - Locate important foramina and soft tissue landmarks.
- Laboratory assignment: (2 hours)
    - Objective: Reinforce anatomical landmarks
    - Assignment: Using instructor provided skull diagrams, students will label:
        - Maxillary landmarks
        - Mandibular landmarks
        - Trigeminal nerve branches
        - Injection landmarks
    - Students are to create a one-page study guide identifying:
        - Landmarks
        - Clinical importance
        - Associated injection(s)
    - Deliverable: Upload on website with self-reflection paragraph.
- Weekly quiz.

Module III: Neurophysiology and Pharmacology Basics (Chapter 3 and 4)

- Topics:
    - Structure of neurons

    - Nerve impulse transmission
    - Pain pathways
    - Mechanism of action of local anesthetics
    - Basic pharmacologic principles
    - Drug absorption
    - Distribution
    - Metabolism
    - Elimination
    - Factors influencing anesthetic effectiveness
- Learning Objectives:
    - Explain the normal mechanisms of nerve impulse generation and conduction
    - Define the events in successful nerve impulse generation, including the resting rate, slow depolarization, firing threshold, rapid depolarization and recovery.
    - Explain the significance of Schwann cell sheaths and nodes of Ranvier on the ability of local anesthetic agents to block nerve impulses.
    - Describe the significance of the anatomical differences between sensory and motor neurons.
    - Discuss the different types of nerve fibers related to pain perception.
    - Identify the nerve fibers that normally transmit pain sensations from dental and periodontal structures.
    - Differentiate anatomically and functionally between myelinated and unmyelinated nerves.
    - Discuss what is meant by anatomic barriers to the diffusion of anesthetic solutions and those that present the greatest challenges to diffusion.
    - Describe the location of the structures in the dental neural plexus.
    - Discuss the actions and effects of local anesthetic drugs on neural membranes.
    - Analyze, evaluate, and be prepared to discuss the pharmacologic properties of local anesthetic drugs and vasoconstrictors.
    - Evaluate the differences between the specific receptor theory and the membrane expansion theory and explain why neither theory accounts for local anesthetic effects on nerve membranes.
    - Explain why tissue inflammation affects the success of local anesthesia.
    - Evaluate the relationships between pH and pKa and discuss the clinical relevance of both.
    - Discuss the pharmacodynamics and pharmacokinetics of local anesthetic drugs.
    - Evaluate the signs and symptoms of and discuss the effects of local anesthetics on the central nervous system (CNS).
    - Evaluate the signs and symptoms of and discuss the effects of local anesthetics on the cardiovascular system (CVS).
    - Examine and discuss the biotransformation pathways of amides and esters and the concept of elimination half-life.
- Laboratory Assignment: Pain Pathway Flowchart
    - Objective: Visualize nerve conduction
    - Assignment: Students to create a flow chart showing:

        - Pain stimulus->
        - Peripheral nerve ->
        - Action potential->
        - Trigeminal nerve->
        - Brain interpretation->
        - Site where local anesthetic interrupts transmission
        - Include: Sodium channels, depolarization (two phases), repolarization.
    - Deliverable: Illustrated flowchart and self-reflection paragraph. Upload on website.
- Weekly quiz.

Module IV: Local Anesthetic Agents (Chapter 5, 6, 7, 8)

- Topics:
    - Classification of dental local anesthetics
    - Clinical indications
    - Vasoconstrictor selection
    - Medical considerations
    - Maximum recommended doses
    - Dose calculations
    - Topical anesthetics
    - Clinical drug selections
- Learning Objectives:
    - Discuss similarities and differences between dental local anesthetic drugs.
    - Explain how similarities and differences between dental local anesthetic drugs promote clinically safe and successful local anesthesia.
    - Select appropriate local anesthetic and/or vasoconstrictor drugs for various types of clinical situations.
    - Discuss and determine situations in which specific drugs are indicated or contraindicated.
    - Discuss which local anesthetic solutions are effective without vasoconstrictors.
    - Explain why local anesthetic solutions without vasoconstrictors are more effective in certain clinical situations.
    - Explain when and why solutions with epinephrine and levonordefrin are indicated or contraindicated in clinical situations.
    - Discuss the overall similarities and differences between vasoconstrictors.
    - Discuss and identify clinical situations in which the choice of vasoconstrictor may directly affect anesthetic success.
    - Discuss and determine situations in which specific vasoconstrictors may be indicated or contraindicated.
    - Describe the difference in potency between epinephrine and levonordefrin.
    - Distinguish between clinical signs and symptoms of vasoconstrictor overdose and anxiety/fear responses.
    - Define and discuss the significance of the maximum recommended dose of a drug.
    - List maximum recommenced doses for each local anesthetic drug and vasoconstrictor.

    - Identify and discuss the relevant information and mathematical operations required to calculate drug doses.
    - Identify relevant information necessary to compute recommended drug doses.
    - Calculate the recommended doses for local anesthetic drugs and vasoconstrictors in clinical situations.
    - Calculate the recommended doses when multiple drugs with differing concentrations are administered.
    - Discuss recommended dose modifications for vasoconstrictors in patients with significant cardiovascular compromise.
    - Calculate the recommended doses for the local anesthetic drugs and vasoconstrictors for patients with significant cardiovascular compromise.
    - Calculate the recommended doses for the local anesthetic drugs for children using Clark's Rule and Young's Rule.
    - Demonstrate and discuss the most common methods of application of topical anesthetic drugs.
    - Identify and discuss indications and contraindications of topical anesthetic drugs.
    - Discuss dose and application considerations when maximum recommended doses of topical anesthetics are not provided by manufacturers.
    - Describe and recognize the signs and symptoms of adverse topical anesthetic drug reactions, both local and systemic.
    - Discuss the properties of eutectic mixtures that determine their effectiveness.
    - Discuss the FDA guidelines for formulation and use of compounded drugs.
- Laboratory assignment (2 hours)
    - Students complete a comparison table including:
        - Drug
        - Concentration
        - Vasoconstrictor
        - Onset
        - Duration
        - Maximum dose
        - Clinical indications
        - Contraindications
    - Deliverable: upload on website with self-reflection paragraph.
- Weekly quiz.

Module V: Patient assessment and evaluation (Chapter 10)

- Topics:
    - Medical history review
    - ASA classifications
    - Vital signs
    - Contraindications
    - Medical consultations
    - Risk assessment

    - Treatment modifications
    - Documentation
    - Informed consent
- Learning Objectives:
    - Identify and discuss the responsibilities associated with the delivery of regional anesthesia.
    - Describe the ASA (American Society of Anesthesiologists) Physical Status Classification System categories I-IV (P1-P6).
    - Discuss patient assessment tools for the evaluation of physical and psychological tolerance to local anesthesia.
    - Analyze and discuss the implications of patient evaluation in obtaining informed consent.
    - Identify and apply contraindications to the use of local anesthesia.
    - Identify and evaluate treatment modifications that can be made to increase patient safety and comfort with local anesthesia.
    - Evaluate situations that require a medial consultation before treatment.
    - Define functional capacity and describe activities to meet the 4 metabolic equivalent of task (MET) / level.
    - Describe the dose limitation with a vasoconstrictor when cardiovascular disease is reported.
    - Identify signs and symptoms of undiagnosed medical conditions that can affect local anesthetic administration.
    - Discuss the importance of postanesthetic care.
- Laboratory Assignment (2 hours): Patient Assessment Case Studies
    - Students review five mock patient charts. For each patient determine:
        - ASA classification
        - Medical concerns
        - Appropriate anesthetic
        - Vasoconstrictor recommendation
        - Maximum dosage
        - Need for physician consultation
    - Student to provide rationale for every decision
    - Deliverable: upload on website with self-reflection paragraph.
- Weekly quiz.

Module VI: Local Anesthetic Delivery Systems (Chapter 9)

- Topics:
    - Syringes
    - Needles
    - Cartridges
    - Needle gauges and lengths
    - Assembly
    - Safety devices
    - Infection control

    - Sharps management
    - Operator positioning
    - Ergonomics
- Learning Objectives:
    - List and explain the purpose of each item in the basic armamentarium for anesthetic injections.
    - List and discuss the different types of syringes available for local anesthetic injections.
    - Identify and explain the function of each component of a local anesthetic syringe.
    - Identify the components of a needle.
    - Discuss the factors to consider when selecting needles.
    - Describe the components of a local anesthetic cartridge.
    - List and describe the purpose of the contents in a cartridge.
    - Identify local anesthesia cartridges according to the American Dental Association (ADA) color system.
    - Discuss and demonstrate safe needle recapping and disposal procedures.
- Laboratory Assignment (2 hours): Armamentarium and delivery device lab
    - Students assemble a “mock tray” using printed photos.
    - Identify:
        - Syringe
        - Needle gauge
        - Needle length
        - Local anesthesia cartridge
        - Topical anesthetic
        - Cotton applicators
        - Gauze
    - The student is to photograph their setup and an equipment identification worksheet.
    - Deliverable: upload photographs, worksheets and self-reflection paragraph on website.
- Weekly quiz.

Module VII: Fundamentals for Administering Local Anesthesia (Chapter 11)

- Topics:
    - Patient positioning
    - Operator positioning
    - Tissue preparation
    - Needle insertion
    - Aspiration
    - Injection rate
    - Patient monitoring
    - Documentation
    - Basic injection principles
- Learning Objectives:
    - Identify and discuss the general principles and elements of informed consent.

    - Identify and discuss key factors that impact the successful delivery of local anesthetic agents.
    - Identify and discuss stress and anxiety factors that impact both patients and clinicians during the delivery of local anesthetic injections.
    - Discuss the impact of clinician/patient communications before, during and after the delivery of local anesthetic injections.
    - Differentiate between the three basic types of injections.
    - List, describe, and apply the basic steps involved in the delivery of local anesthetic injections.
    - Identify, demonstrate, and apply the general principles of ergonomics during the delivery of local anesthetic injections.
- Laboratory Assignment: Injection Sequence Checklist (2 hours)
    - Students create step-by-step checklist for
        - Preparing equipment
        - Greeting patient
        - Medical review
        - Positioning
        - Tissue preparation
        - Injection sequence
        - Aspiration
        - Injection rate
        - Documentation
        - Post-operative instructions
    - Deliverable: upload on website with self-reflection paragraph.
- Weekly quiz.

Module VIII: Maxillary Injection Techniques (Chapter 12, 13)

- Topics:
    - Supraperiosteal infiltration
    - Posterior superior alveolar nerve block
    - Middle superior alveolar nerve block
    - Anterior superior alveolar nerve block
    - Greater Palatine nerve block
    - Nasopalatine nerve block
    - Clinical indications
    - Anatomical landmarks
    - Troubleshooting
- Learning Objectives:
    - Describe and discuss the indications, relevant anatomy and technique features of the injections discussed in this chapter.
    - Describe the basic steps for safe and effective administration for the following injections:
        - Infiltrations
        - Field blocks

        - Anterior superior alveolar nerve block
        - Middle superior alveolar nerve block
        - Infraorbital nerve block
        - Posterior superior alveolar nerve block
        - Nasopalatine nerve block
        - Anterior middle superior alveolar nerve block
        - Greater palatine nerve block
- Laboratory Assignment: Maxillary Injection Planning (2 hours)
    - For each maxillary injection students complete:
        - Target nerve
        - Teeth anesthetized
        - Soft tissue anesthetized
        - Landmark
        - Needle length
        - Needle gauge
        - Depth of penetration
        - Angle of insertion
        - Recommended volume
        - Common complications
    - Students to include illustrations to reinforce landmarks.
    - Deliverable: upload images, paper/worksheet and self-reflection paragraph on website.
- Weekly quiz.

Module IX: Mandibular Injection Techniques (Chapter 14)

- Topics:
    - Inferior Alveolar
    - Long Buccal
    - Mental
    - Incisive
    - Clinical considerations
- Learning Objectives:
    - Describe and discuss the indications, relevant anatomy and technique features of the injections discussed in this chapter.
    - Describe the basic techniques for safe and effective administration for the following injections:
        - Inferior alveolar nerve block
        - Lingual nerve block
        - Buccal nerve block
        - Mental nerve block
        - Incisive nerve block
- Laboratory Assignment: Mandibular Injection Planning (2 hours)
    - For each mandibular injection students complete:
        - Target nerve

        - Teeth anesthetized
        - Soft tissue anesthetized
        - Landmark
        - Needle length
        - Needle gauge
        - Depth of penetration
        - Angle of insertion
        - Recommended volume
        - Common complications
    - Students to include illustrations to reinforce landmarks.
    - Deliverable: upload images, paper/worksheet and self-reflection paragraph on website.
- Weekly quiz.

Module X: Troubleshooting and Complications (Chapter 16 and 17)

- Topics:
    - Failed anesthesia
    - Reinjection strategies
    - Hematoma
    - Trismus
    - Needle breakage
    - Facial paralysis
    - Toxicity
    - Allergic reactions
    - Syncope
    - Medical emergencies
    - Emergency preparedness
- Learning Objectives:
    - Discuss the primary reasons for inadequate local anesthesia.
    - Describe the physiological and anatomical bases of inadequate anesthesia.
    - Develop critical thinking skills to help overcome frustrating anesthesia challenges.
    - Develop and apply strategies for addressing inadequate anesthesia.
    - Identify and discuss the most common adverse local events that may occur during and after local anesthetic drug administrations.
    - Identify and discuss the categories of adverse systemic events that may occur during and after local anesthetic drug administrations.
    - Evaluate and discuss appropriate responses and management of adverse local events.
    - Evaluate and discuss appropriate responses and management of adverse systemic events.
    - Evaluate and discuss protocols for the management of overdose and allergic events.
    - Define idiosyncratic events and analyze their management.
    - Discuss and apply appropriate preventive strategies to avoid local anesthesia complications.
- Weekly quiz.

Module XI: Intensive Injection Clinic (2 day-10 hours)
DAY ONE:

- Morning:
  - Equipment review
  - Infection control
  - Delivery devices
  - Injection principles
  - Patient positioning
- Afternoon:
  - Supraperiosteal
  - PSA
  - MSA
  - ASA
  - Greater Palatine
  - Nasopalatine
  - Documentation
  - Faculty competency evaluation/remediation

DAY TWO:

- Morning:
  - Mandibular anatomy review
- Afternoon:
  - Inferior Alveolar
  - Long Buccal
  - Mental
  - Incisive
  - Comprehensive competency examination
  - Clinical scenarios
  - Documentation
  - Practical evaluation
  - Course wrap-up and preparation for Oregon Board certification

7. CO-FOUNDERS AND EDUCATORS

SAMANTHA BOEHM

CDA, RDH

CLINICAL AND DIDACTIC INSTRUCTOR AT ROGUE COMMUNITY COLLEGE

CLINICAL INSTRUCTOR AT OREGON TECH

RICHARD BRADSHAW

DMD

CLINICAL AND DIDACTIC INSTRUCTOR AT ROGUE COMMUNITY COLLEGE

BOARD MEMBER OF SOUTHERN OREGON DENTAL ASSISTING EDUCATION

PREPARED BY

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REGISTERED DENTAL HYGIENIST AND EDUCATOR

SAM BOEHM, CDA, RDH

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PROFESSIONAL LICENSURE AND CERTIFICATION

- Oregon licensed dental hygienist
- BLS certified through the American Heart Association
- Nitrous oxide endorsement
- Local anesthesia endorsement
- Certified dental assistant

TEACHING EXPERIENCE

2026 – present

PRAXIOM DENTAL EDUCATION

Co-Founder and Curriculum Developer

- Educates and mentors dental assistants through didactic instruction and clinical supervision.
- Develop approved curriculum to prepare expanded function dental assistants for local anesthesia certification.
- Grade and assess students on required competencies.
- Create professional development goals for the academic year and align with course learning objectives.
- Analyze course learning objectives and adjust curriculums accordingly.
- Calibrate and collaborate with colleagues to promote alignment.

2023 – present

ROGUE COMMUNITY COLLEGE

Didactic and Clinical Adjunct Instructor

- Educates and mentors future dental hygienists through didactic instruction and clinical supervision.
- Develop curriculum for Head and Neck Anatomy, Dental Materials, Local Anesthesia and Pre-Dental Hygiene.
- Grade and assess students on required competencies.
- Provide feedback and coaching in clinical settings.
- Create professional development goals for the academic year and align with course learning objectives.
- Analyze course learning objectives and adjust curriculums accordingly.
- Calibrate and collaborate with colleagues to promote alignment in curriculum.

2016 – 2017

OREGON INSTITUTE OF TECHNOLOGY

Clinical Adjunct Instructor

- Instructed students in Local Anesthesia, Community Health, Clinicals, Dental Materials and Radiology.
- Graded students on CODA required competencies.
- Implemented technological learning tools to increase student engagement and promote positive learning outcomes.
- Provided student feedback and coaching.
- Provided additional learning resources.

CLINICAL EXPERIENCE

2017 – present

PREMIER CARE DENTAL

Registered Dental Hygienist

- Perform comprehensive individualized preventive and therapeutic services.
- Provide and maintain thorough electronic health records.
- Obtain digital radiographs and CBCTs and interpret findings.
- Create and review individualized treatment plans.
- Educate diverse patient populations on oral hygiene instruction, nutrition, tobacco cessation and disease prevention.

EDUCATION

2016

OREGON INSTITUTE OF TECHNOLOGY

Bachelor of Science in Dental Hygiene

PROFESSIONAL MEMBERSHIPS

AMERICAN DENTAL EDUCATION ASSOCIATION (ADEA)

AMERICAN DENTAL HYGIENE ASSOCIATION (ADHA)

OREGON BOARD OF DENTISTRY

THIS PORTION FOR MAILING PURPOSES ONLY

SAMANTHA D. BOEHM
505 Splendida Dr.
MEDFORD OR 97504

THIS LICENSE MUST BE POSTED IN A CONSPICUOUS PLACE IN PLAIN SIGHT OF LICENSEE'S PATIENTS

H7270
License Number

OREGON BOARD OF DENTISTRY

2026/2028 Hygiene License

SAMANTHA D. BOEHM R.D.H.

Permits:
Nitrous Oxide
Endorsements:
Local Anesthesia

Restrictions:
None

Expires: 09/30/2028

THIS LICENSE MUST BE POSTED IN A CONSPICUOUS PLACE IN PLAIN SIGHT OF LICENSEE'S PATIENTS

2026
PRAXIA DENTAL EDUCATION

LOCAL ANESTHETIC PERFORMANCE CHECK-OFF

Oregon Expanded Function Dental Assistant — Local Anesthesia Functions Certificate (LAFC)

Clinical Skills Competency Evaluation

Student Name: _____
Instructor/Evaluator: _____
Course/Program: _____
Date: _____ **Clinical Site:** _____
Student Oregon EFDA Certificate #: _____
Supervising Dentist: _____

PURPOSE

This performance evaluation is designed to document the student's successful demonstration of clinical competency in local anesthetic functions within the scope authorized for an Oregon dental assistant holding the appropriate certification.

Important: Completion of this check-off does not independently confer Oregon certification. Eligibility, course approval, certification, and scope of practice are governed by the Oregon Board of Dentistry and applicable Oregon Administrative Rules.

PERFORMANCE EVALUATION KEY

C = Competent / Meets Standard
R = Remediation Required
N/O = Not Observed
N/A = Not Applicable

Critical Safety Items

A **critical safety error** involving patient identification, informed consent, medication verification, allergy screening, infection control, aspiration/safety technique, sharps handling, recognition of an adverse event, or failure to appropriately respond to an emergency requires remediation and repeat demonstration before competency can be awarded.

I. PRE-PROCEDURE PREPARATION

Skill / Performance Criteria	C	R	N/O	N/A
1. Verifies patient identity using appropriate identifiers	☐	☐	☐	☐
2. Reviews the dentist's treatment plan and anesthetic authorization	☐	☐	☐	☐
3. Reviews relevant medical and dental history	☐	☐	☐	☐
4. Identifies medical conditions or medications requiring consideration before anesthetic administration	☐	☐	☐	☐
5. Confirms allergies and previous adverse reactions to local anesthetics	☐	☐	☐	☐
6. Confirms appropriate patient age, weight, and treatment considerations	☐	☐	☐	☐
7. Verifies anesthetic agent, concentration, vasoconstrictor, dilution, expiration date, and integrity of cartridge/vial	☐	☐	☐	☐
8. Identifies appropriate anesthetic and vasoconstrictor considerations based on dentist's treatment plan and patient factors	☐	☐	☐	☐
9. Calculates/verifies maximum recommended dose according to the course protocol and applicable manufacturer guidance	☐	☐	☐	☐
10. Prepares required armamentarium and emergency equipment	☐	☐	☐	☐
11. Performs appropriate hand hygiene and uses required PPE	☐	☐	☐	☐
12. Establishes an appropriate clean/aseptic field	☐	☐	☐	☐
13. Explains the procedure to the patient using understandable language	☐	☐	☐	☐

Skill / Performance Criteria	C	R	N/O	N/A
14. Confirms patient questions have been addressed and dentist-directed consent requirements have been met	☐	☐	☐	☐

Evaluator Initials: _____

II. SYRINGE, NEEDLE & ANESTHETIC PREPARATION

Skill / Performance Criteria	C	R	N/O	N/A
15. Selects appropriate syringe and needle for the planned injection	☐	☐	☐	☐
16. Inspects needle for integrity and appropriate size/gauge/length	☐	☐	☐	☐
17. Loads cartridge appropriately and maintains aseptic technique	☐	☐	☐	☐
18. Secures needle appropriately and verifies syringe function	☐	☐	☐	☐
19. Identifies anesthetic cartridge correctly before administration	☐	☐	☐	☐
20. Maintains appropriate control and visibility of the syringe	☐	☐	☐	☐
21. Uses appropriate topical anesthetic technique when indicated	☐	☐	☐	☐
22. Demonstrates safe handling of needles and sharps throughout the procedure	☐	☐	☐	☐

Evaluator Initials: _____

III. PATIENT POSITIONING & INJECTION PREPARATION

Skill / Performance Criteria	C	R	N/O	N/A
23. Positions patient appropriately for the planned injection	☐	☐	☐	☐
24. Positions operator and patient to maintain visibility and control	☐	☐	☐	☐
25. Uses appropriate retraction and tissue stabilization	☐	☐	☐	☐
26. Identifies appropriate anatomical landmarks for the selected technique	☐	☐	☐	☐
27. Demonstrates understanding of relevant anatomy and structures to be avoided	☐	☐	☐	☐
28. Establishes appropriate needle insertion site	☐	☐	☐	☐
29. Communicates with the patient throughout the procedure	☐	☐	☐	☐

Evaluator Initials: _____

IV. LOCAL ANESTHETIC ADMINISTRATION

A. Infiltration / Supraperiosteal Injection

Skill / Performance Criteria	C	R	N/O	N/A
30. Identifies appropriate indication for infiltration	☐	☐	☐	☐
31. Identifies appropriate anatomical landmarks	☐	☐	☐	☐
32. Positions needle appropriately	☐	☐	☐	☐
33. Advances needle using controlled technique	☐	☐	☐	☐
34. Aspirates when required by the technique/course protocol	☐	☐	☐	☐
35. Administers anesthetic slowly and in a controlled manner	☐	☐	☐	☐
36. Withdraws, recaps and disposes of needle safely	☐	☐	☐	☐
37. Evaluates anesthetic effectiveness appropriately	☐	☐	☐	☐

Evaluator Initials: _____

B. Mandibular Block / Regional Injection

Skill / Performance Criteria	C	R	N/O	N/A
38. Identifies appropriate indication for regional anesthesia	☐	☐	☐	☐
39. Identifies relevant anatomical landmarks	☐	☐	☐	☐
40. Positions patient and operator appropriately	☐	☐	☐	☐

Skill / Performance Criteria	C	R	N/O	N/A
41. Retracts/stabilizes tissues appropriately	☐	☐	☐	☐
42. Establishes appropriate needle path and insertion point	☐	☐	☐	☐
43. Advances needle using controlled technique and appropriate depth awareness	☐	☐	☐	☐
44. Aspirates appropriately according to course protocol	☐	☐	☐	☐
45. Administers anesthetic slowly and safely	☐	☐	☐	☐
46. Withdraws, recaps, and disposes of needle safely	☐	☐	☐	☐
47. Assesses anesthetic effectiveness and recognizes need for additional direction	☐	☐	☐	☐

Evaluator Initials: _____

V. SAFETY & COMPLICATION MANAGEMENT

Skill / Performance Criteria	C	R	N/O	N/A
54. Recognizes signs/symptoms of an adverse reaction	☐	☐	☐	☐
55. Recognizes signs/symptoms of local anesthetic systemic toxicity	☐	☐	☐	☐
56. Recognizes signs/symptoms of vasovagal syncope	☐	☐	☐	☐
57. Recognizes signs/symptoms of allergic reaction/anaphylaxis	☐	☐	☐	☐
58. Recognizes signs/symptoms of hematoma or other injection-related complication	☐	☐	☐	☐
59. Recognizes signs/symptoms of trismus or nerve-related complications	☐	☐	☐	☐
60. Stops procedure and appropriately alerts the supervising dentist when indicated	☐	☐	☐	☐
61. Initiates appropriate emergency response within the student's training and scope	☐	☐	☐	☐
62. Demonstrates knowledge of emergency equipment and emergency medications available in the clinical setting	☐	☐	☐	☐
63. Demonstrates appropriate response to a simulated local anesthetic emergency scenario	☐	☐	☐	☐

Evaluator Initials: _____

VI. NEEDLE SAFETY & INFECTION PREVENTION

Skill / Performance Criteria	C	R	N/O	N/A
64. Maintains appropriate aseptic technique	☐	☐	☐	☐
65. Avoids unsafe needle handling	☐	☐	☐	☐
66. Does not bend, break, or manipulate contaminated needles inappropriately	☐	☐	☐	☐
67. Demonstrates appropriate needle recapping technique when necessary	☐	☐	☐	☐
68. Immediately disposes of contaminated sharps in an approved sharps container	☐	☐	☐	☐
69. Manages contaminated materials appropriately	☐	☐	☐	☐
70. Performs appropriate post-procedure hand hygiene	☐	☐	☐	☐

Evaluator Initials: _____

VII. POST-PROCEDURE PATIENT MANAGEMENT

Skill / Performance Criteria	C	R	N/O	N/A
71. Evaluates patient condition immediately following injection	☐	☐	☐	☐
72. Confirms appropriate anesthetic effect before proceeding with treatment	☐	☐	☐	☐
73. Provides dentist-directed post-anesthetic instructions	☐	☐	☐	☐
74. Warns patient to avoid biting/chewing while tissues remain numb if appropriate	☐	☐	☐	☐
75. Gives age-appropriate instructions to parent/guardian when applicable	☐	☐	☐	☐
76. Documents anesthetic agent, concentration, vasoconstrictor used and dilution, amount, site/technique, and relevant patient response	☐	☐	☐	☐
77. Documents complications or adverse events and appropriate follow-up	☐	☐	☐	☐

Evaluator Initials: _____

VIII. COMPETENCY SCENARIO

Student must successfully complete a comprehensive clinical case demonstrating the ability to:

☐ Review patient history and identify contraindications/precautions
☐ Verify dentist authorization and treatment plan
☐ Select appropriate anesthetic and armamentarium
☐ Calculate/verify maximum recommended dosage
☐ Explain procedure and obtain/confirm required consent
☐ Prepare patient and injection site
☐ Identify anatomical landmarks
☐ Perform appropriate injection technique
☐ Demonstrate appropriate aspiration and controlled deposition
☐ Recognize and respond appropriately to patient discomfort or unexpected response
☐ Demonstrate appropriate sharps safety
☐ Complete post-procedure instructions
☐ Complete accurate clinical documentation
☐ Identify when immediate dentist intervention is required

Scenario Result:

☐ PASS
☐ REMEDIATION REQUIRED

Evaluator Comments:

IX. FINAL COMPETENCY DETERMINATION

Minimum Course Standard

The student must demonstrate **safe, consistent, and clinically appropriate performance of all critical skills** and successfully remediate any identified deficiencies before final competency is awarded.

Overall Performance:

☐ **COMPETENT — PASS**
☐ **COMPETENT WITH REMEDIATION COMPLETED**
☐ **NOT YET COMPETENT — ADDITIONAL TRAINING REQUIRED**

Skills Requiring Remediation

Skill/Item	Deficiency Identified	Remediation Completed	Recheck Date
_____	_____	☐	_____
_____	_____	☐	_____
_____	_____	☐	_____
_____	_____	☐	_____

STUDENT ATTESTATION

I attest that I have received instruction in the local anesthesia functions evaluated on this form and that I have demonstrated the competencies documented above. I understand that successful completion of this

evaluation does not, by itself, confer Oregon certification and that I may perform only those functions authorized by my current Oregon certification, applicable law/rule, and the supervising dentist.

Student Signature: _____

Date: _____

INSTRUCTOR / EVALUATOR ATTESTATION

I attest that I directly observed and evaluated the student's performance and that the student demonstrated the competencies indicated above according to the standards of this course.

Evaluator Name: _____

Credentials: _____

Signature: _____

Date: _____

SUPERVISING DENTIST VERIFICATION

I have reviewed the students' clinical performance evaluation and acknowledge the competency determination documented above.

Supervising Dentist Name: _____

Oregon License #: _____

Signature: _____

Date: _____

COURSE RECORD

Didactic Hours Completed: _____

Laboratory/Simulation Hours Completed: _____

Clinical Hours Completed: _____

Number of Successful Demonstrations: _____

Number of Remediation Attempts: _____

Final Course Grade/Competency: _____

Certificate Issued: ☐ Yes ☐ No

Date Certificate Issued: _____

DOCUMENT CONTROL

Course Name: _____

Document Title: Local Anesthetic Performance Check-Off

Version: _____

Effective Date: _____

Review Date: _____

Approved By: _____

Approval Date: _____

Related Oregon Rule: OAR 818-042-0096 — Local Anesthesia Functions of Dental Assistants

Note: This form should be reviewed against the current Oregon Board of Dentistry rules, the specific Board-approved curriculum for the course, current manufacturer instructions, and the course's adopted clinical protocols before implementation.

Exam for Licensure

1. What is the primary purpose of local anesthetic in dental practice?
    a. To sedate the patient for the entire appointment
    b. To eliminate the patient's memory of the procedure
    c. To block pain perception in a localized area so treatment can be performed comfortably
    d. To reduce bacterial contamination at the surgical site
2. Establishing trust with a nervous patient prior to administering local anesthesia primarily helps to:
    a. Reduce the total dose of anesthetic required
    b. Eliminate the need for informed consent
    c. Improve patient cooperation and reduce perceived pain and anxiety
    d. Increase the effective duration of the anesthetic
3. Which of the following is an example of appropriate informed consent prior to local anesthesia?
    a. Proceeding directly to injection site local anesthesia is considered routine
    b. Explaining the purpose, risk, benefits, and alternatives, and confirming the patient's understanding and agreement
    c. Providing consent forms only for surgical procedures, not injections
    d. Obtaining consent after the injection is completed
4. A patient exhibiting signs of dental fear (ie: gripping armrest, rapid breathing) is best managed by:
    a. Ignoring the behavior and proceeding as planned
    b. Acknowledging the anxiety, using calm reassurance, and adjusting pace as needed
    c. Administering anesthesia as quickly as possible without explanation
    d. Recommending the patient reschedule indefinitely
5. Which cranial nerve provides sensory innervation to the teeth and surrounding structures of the maxilla and mandible?
    a. Facial nerve (CN VII)
    b. Trigeminal nerve (CN V)
    c. Glossopharyngeal nerve (CN IX)
    d. Hypoglossal nerve (CN XII)
6. The three main branches of the trigeminal nerve are:
    a. Ophthalmic, maxillary, mandibular
    b. Buccal, lingual, palatine
    c. Superior, middle, interior alveolar
    d. Anterior, middle, posterior
7. The greater palatine foramen is typically located:
    a. Directly behind the maxillary central incisors
    b. In the posterior hard palate, near the junction with the soft palate, medial to the maxillary second/third molar
    c. On the buccal surface of the maxillary tuberosity
    d. At the midline of the incisive papilla
8. Which teeth do the anterior superior alveolar nerve innervate?
    a. Mandibular molars unilaterally
    b. Maxillary premolars unilaterally
    c. Mandibular anterior unilaterally
    d. Maxillary anterior unilaterally
9. Which region is the chin located in?
    a. Oral
    b. Frontal
    c. Mental
    d. Occipital
10. What is the major salivary gland that is the biggest consideration for local anesthetic nerve blocks?
    a. Sublingual salivary gland
    b. Submandibular salivary gland
    c. Parotid salivary gland
    d. None of these are a concern
11. What teeth are anesthetized by the greater palatine nerve block?
    a. Maxillary anterior
    b. Mandibular posterior
    c. Maxillary posterior
    d. None
12. Local anesthetics achieve their effect primarily by:
    a. Destroying the nerve fiber permanently
    b. Blocking voltage-gated sodium channels, preventing nerve depolarization and impulse propagation
    c. Increasing potassium to hyperpolarize the neuron
    d. Stimulating GABA receptors in peripheral nerves
13. Local anesthetics are chemically classified as weak:
    a. Acids
    b. Bases
    c. Ionizers
    d. Oxidizers
14. Two major chemical classes of local anesthetics used in dentistry are:

a. Esters and amides
b. Opioids and NSAIDS
c. Alkaloids and glycosides
d. Barbiturates and benzodiazepines

15. Ester local anesthetics are metabolized primarily by:
    a. Hepatic microsomal enzymes
    b. Renal filtration
    c. Hydrolysis via plasma pseudocholinesterase
    d. Salivary amylase
16. Elimination half-life refers to which one of the following?
    a. The time it takes for a drug to be half-metabolized
    b. The time it takes for half of a drug to be out of the system
    c. The time it takes for half of a drug to be out of the circulation
    d. The time it takes for a drug to be out of half of the circulation
17. CNS toxicity occurs because of:
    a. The expected response of neurons in the CNS to the drug dose
    b. Frank neural tissue damage due to the excessive dose
    c. Compromised vascular supply in the CNS due to vasoconstrictor dose
    d. None of the above
18. The definition of maximum recommended dose (MRD) of a drug best fits which one of the following definitions?
    a. A safe dose to administer in all situations
    b. A dose that a 150-lb individual can have
    c. A dose that cannot be exceeded under any circumstance
    d. A safe guideline when administering local anesthetic drugs
19. You are treating a patient with cardiovascular compromise who suffers from liver damage. Which one of the following drugs would be most appropriate for this patient when you are anesthetizing the maxillary right quadrant?
    a. 2% lidocaine, 1:100,000 epinephrine
    b. 3% mepivacaine plain
    c. 4% articaine, 1:200,000 epinephrine
    d. 0.5% bupivacaine, 1:200,000 epinephrine
20. Methemoglobinemia is a life-threatening condition that may be precipitated by which one of the following drugs?
    a. Lidocaine
    b. Mepivacaine
    c. Prilocaine
    d. Bupivacaine
21. The primary reason a vasoconstrictor is added to a local anesthetic is to:
    a. Speed up drug metabolism
    b. Constrict blood vessels at the injection site, slowing systemic absorption and prolonging anesthesia
    c. Reduce the total volume of anesthetic needed
    d. Neutralize the anesthetic's acidity
22. The most commonly used epinephrine concentration paired with lidocaine for routine restorative dentistry is:
    a. 1:50,000
    b. 1:100,000
    c. 1:20,000
    d. 1:1,000
23. For a medically compromised cardiac patient, current guidance generally recommends limiting epinephrine to approximately:
    a. No limit is necessary
    b. 0.04mg per appointment
    c. 0.02mg per appointment
    d. Epinephrine must never be used
24. The standard cartridge of 2% lidocaine (1.8mL) contains approximately how many mL of drug?
    a. 18 mg
    b. 36 mg
    c. 72 mg
    d. 180 mg
25. Topical anesthetics applied before an injection are used primarily to:
    a. Replace the need for injectable anesthesia
    b. Numb the surface mucosa and reduce discomfort of needle penetration
    c. Disinfect the injection site
    d. Increase the duration of the injectable anesthetic
26. The ASA physical status classification system is used to:
    a. Determine dental insurance eligibility
    b. Assess a patient's overall systemic health and anesthesia-related risk
    c. Measure the patient's pain tolerance
    d. Classify the type of dental restoration needed
27. An ASA III classification describes a patient with:
    a. No systemic disease
    b. Mild, well-controlled systemic disease

c. Severe systemic disease that limits activity but is not immediately life-threatening
d. A patient with life-threatening systemic disease

28. Prior to administering local anesthesia, a thorough medical history review is essential primarily to:
    a. Satisfy insurance documentation requirements
    b. Identify contraindications, drug interactions, and needed treatment modifications
    c. Determine the length of needle needed
    d. Calculate the dental fee
29. Which of the following would generally require medical consultation before proceeding with elective local anesthesia?
    a. Well-controlled seasonal allergies
    b. A blood pressure reading of 180/110
    c. Recent dental cleaning
    d. Diabetes controlled with medication
30. Complete and accurate documentation of local anesthetic administration should include all of the following EXCEPT:
    a. Drug name, concentration and vasoconstrictor used
    b. Total dose/number of cartridges used
    c. The tooth being worked on
    d. Patient response and any complications
31. A standard dental local anesthetic cartridge in North America contains approximately:
    a. 1.7 mL
    b. 1.8 mL
    c. 1.9 mL
    d. 2.0 mL
32. A higher needle gauge number indicates:
    a. A thicker diameter needle
    b. A thinner diameter needle
    c. A longer needle
    d. A shorter needle
33. For an inferior alveolar nerve block, which needle is generally recommended due to the depth of penetration required?
    a. Short needle
    b. Long needle
    c. Side-vented needle
    d. No needle; a topical gel is sufficient
34. Aspiration prior to injecting anesthetic solution is performed to:
    a. Mix the anesthetic with vasoconstrictor
    b. Confirm the needle tip is not within a blood vessel
    c. Warm the solution to body temperature
    d. Unplug the needle
35. Proper sharps disposal after an injection requires:
    a. Recapping the needle by hand using both hands for control
    b. Placing the used needle directly into a puncture-resistant sharps container
    c. Rinsing the needle and reusing it for the next patient
    d. Disposing of the needle in the trash
36. To minimize discomfort and reduce the risk of complications, local anesthetic solution should generally be deposited:
    a. As rapidly as possible
    b. Slowly, at a controlled rate
    c. In a single rapid bolus
    d. As the needle is being inserted
37. Prior to needle insertion, the tissue at the injection site should be:
    a. Left untouched
    b. Dried and a topical anesthetic applied
    c. Massaged vigorously
    d. Cooled with ice for five minutes
38. Appropriate patient monitoring during and after anesthetic administration includes observing for:
    a. Signs of adverse reaction such as tachycardia, pallor, or syncope
    b. Complaints of a bitter taste
    c. The color of the anesthetic cartridge
    d. Watery eyes
39. If aspiration yields blood, the clinician should:
    a. Proceed with injection as planned
    b. Withdraw slightly, reposition, and re-aspirate before proceeding
    c. Inject half the intended dose only
    d. Replace the needle
40. The correct sequence after needle insertion and before depositing anesthetic is to:
    a. Withdraw the needle completely
    b. Aspirate to check for blood
    c. Immediately inject the full cartridge
    d. Remove the syringe and re-insert at a new angle.
41. The middle superior alveolar (MSA) nerve, when present, anesthetizes:
    a. Maxillary premolars and the mesiobuccal root of the first molar

b. Only the maxillary central incisors
c. The entire maxillary arch
d. Mandibular premolars

42. A well- known complication associated with the PSA injection, due to the surrounding pterygoid venous plexus, is:
    a. Trismus
    b. Hematoma
    c. Facial paralysis
    d. Nasal congestion
43. Which maxillary injection is most appropriate for anesthetizing soft tissue during a procedure involving the maxillary molars on the palatal side?
    a. Greater palatine nerve block
    b. Mental nerve block
    c. Incisive nerve block
    d. Long buccal nerve block
44. The mental nerve block anesthetizes:
    a. Mandibular molar pulp tissue
    b. Buccal soft tissue anterior to the mental foramen the injected side
    c. The entire mandibular arch, including teeth
    d. The tongue and floor of the mouth
45. The key anatomical landmark for the inferior alveolar nerve block is the:
    a. Incisive papilla and central incisors
    b. Zygomatic arch and frenum
    c. Infraorbital foramen and tragus
    d. Pterygomandibular raphe and internal oblique ridge
46. A common cause of a “failed” inferior alveolar nerve block is:
    a. Injecting too slowly
    b. Incorrect needle height/placement relative to anatomical landmarks, or anatomical variation
    c. Using too much topical anesthetic
    d. Excessive patient hydration
47. True allergic reactions to local anesthetic systemic toxicity most often first involves which system?
    a. Central nervous system
    b. Musculoskeletal system
    c. Integumentary system
    d. Renal system
48. If a needle breaks during an injection, the clinician should:
    a. Instruct the patient to close their mouth immediately
    b. Keep the patient calm and their mouth open, attempt safe retrieval if the fragment is visible, and refer for imaging/surgical retrieval if needed
    c. Ignore it since dental needles rarely break
    d. Probe deeply into the tissue to locate the fragment
49. Trismus following a mandibular block injection may result from:
    a. Trauma to the medial pterygoid muscle or hematoma formation
    b. Not aspirating prior to depositing anesthetic
    c. Use of an amide anesthetic instead of an ester
    d. Injecting too slowly
50. Transient facial paralysis following an IA nerve block is most likely caused by:
    a. Damage to the trigeminal nerve
    b. Anesthetic solution inadvertently deposited into the parotid gland, affecting the facial nerve
    c. An allergic reaction to the vasoconstrictor
    d. Overdose of local anesthetic