Oregon
Tina Kotek, Governor

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MEETING NOTICE

LICENSING, STANDARDS AND COMPETENCY COMMITTEE MEETING

Oregon Board of Dentistry
1500 SW 1st Ave.,
Portland, Oregon 97201

ZOOM MEETING INFORMATION
https://us02web.zoom.us/j/85722873443?pwd=zZ7MeQpBR619TNMqBrlgP18uc3mjwd.1
Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 857 2287 3443 ● Passcode: 254431

September 9, 2026
6:00 p.m. – 7:30 p.m.

Committee Members:
Sharity Ludwig, R.D.H., Chair
Aarati Kalluri, D.D.S
Aaron Tinkle, D.M.D.
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.

AGENDA

Call to Order: Chair, Sharity Ludwig, R.D.H.

1. Review and approve Minutes of April 7, 2026 Committee Meeting.
   - April 7, 2026 Minutes – **Attachment #1**

2. Review, discuss and make possible recommendations from August 21, 2026 Board meeting – Moved request to amend OAR 818-013-0005 to cleanup HPSP rule.
   - OAR 818-013-0005 - Participation in Health Professionals' Services Program – **Attachment #2**

3. Review, discuss and make possible recommendations from April 24, 2026 Board meeting – Moved request to amend continuing education rules to include suicide prevention, mental health awareness, or substance use disorders

This meeting is being held remotely via Zoom. A request for accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.

- Proposal from Dr. Terrence Clark – **Attachment #3**
- OAR 818-021-0060 - Continuing Education – Dentists – **Attachment #4**
- OAR 818-021-0070 - Continuing Education – Dental Hygienists – **Attachment #5**
- OAR 818-021-0076 - Continuing Education – Dental Therapists – **Attachment #6**

4. Review, discuss and make possible recommendations from August 21, 2026 Board meeting – Moved request to amend Minimal Sedation rules to align with updated ADA Sedation Guidelines
    - OAR 818-026-0030 – Requirements for Anesthesia Permits – **Attachment #7**
    - OAR 818-026-0050 – Minimal Sedation Permit – **Attachment #8**
    - OAR 818-026-00XX – Oral Anxiolysis without a Minimal Sedation Permit– **Attachment #9**

5. Review, discuss and make possible recommendations from April 24, 2026 Board meeting – Moved request to amend OAR 818-035-0030 to allow Registered Dental Hygienists to administer Botox.
    - Proposal #1 from Jenna Shanks, RDH – **Attachment #10**
    - Proposal #2 from Jenna Shanks, RDH – **Attachment #11**
    - Discussions and Motions Re: RDH's Administering Botox – **Attachment #12**
    - OAR 818-035-0030 – Additional Functions of Dental Hygienists – **Attachment #13**

6. Review, discuss and make possible recommendations from August 21, 2026 Board meeting – Moved request to amend dental assisting rules for clarity.
    - Letter from the American Association of Orthodontists – **Attachment #14**
    - 818-042-0050 Taking of X-Rays - Exposing of Radiographic Images – **Attachment #15**
    - OAR 818-042-0080 Certification - Expanded Function Dental Assistant (EFDA) – **Attachment #16**
    - OAR 818-042-0110 Certification - Expanded Function Orthodontic Dental Assistant (EFODA) – **Attachment #17**
    - OAR 818-042-0113 Certification - Expanded Function Preventive Dental Assistants (EFPDA) – **Attachment #18**
    - 818-042-0120 - Certification by Credential – **Attachment #19**

7. Review, discuss and make possible recommendations from April 24, 2026 Board meeting – Moved request to make rules in response to HB 4040.
    - Proposal from Justin Jones, DDS – **Attachment #20**
    - HB 4040 and amendments to ORS 679.025 – **Attachment #21**

Any Other Business
Adjourn

This meeting is being held remotely via Zoom. A request for accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.

Draft

LICENSING, STANDARDS AND COMPETENCY COMMITTEE
Held as a Zoom Meeting

Minutes
April 7, 2026

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

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

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

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

MINUTES

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

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

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

OAR 818-042-0113

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

OAR 818-042-0117

Background:

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

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

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

OAR 818-042-0117

Initiation of IV Line and Phlebotomy Blood Draw

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

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

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

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

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

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

Ms. Ludwig moved and Dr. Spaniel seconded that the Committee refer the issue of dental assistants assisting in the administration of nitrous oxide under direct supervision to the

Board for clarification. The motion passed with SK, MA, SL, KL, JS, HK, JL, and KM voting Aye.

Dental Assistant Instructors Signing Off on Proficiency

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

ADEX Merger

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

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

818-035-0072
Restorative Functions of Dental Hygienists

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

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

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

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

847-001-xxxx
Criminal Conviction Determination Process
(1) As used in this rule:
(a) “Applicant” means a person who has applied for a license from the Oregon Board of Dentistry (Board).
(b) “Petitioner” means a person who has requested the Board review their criminal history to determine whether it will prevent them from being granted a license by the Board.
(2) A person who was convicted of a crime may petition the Board for a determination

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

818-001-0087
Fees
(1) The Board adopts the following fees:
(a) Biennial License Fees:
(A) Dental —$490;
(B) Dental — retired — $0;
(C) Dental Faculty — $435;
(D) Volunteer Dentist — $0;
(E) Dental Hygiene —$279;
(F) Dental Hygiene — retired — $0;

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

AI Guidelines

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

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

818-012-0070
Patient Records
(1) Each licensee shall have prepared and maintained an accurate and legible record for each person receiving dental services, regardless of whether any fee is charged. The record shall contain the name of the licensee rendering the service and include:
(a) Name and address and, if a minor, name of guardian;
(b) Date description of examination and diagnosis;
(c) An entry that informed consent has been obtained and the date the informed consent was obtained. Documentation may be in the form of an acronym such as "PARQ" (Procedure, Alternatives, Risks and Questions) or its equivalent.
(d) Date and description of treatment or services rendered;
(e) Date, description and documentation of informing the patient of any recognized treatment
complications;
(f) Date and description of all radiographs, study models, and periodontal charting;
(g) Current health history; and
(h) Date, name of, quantity of, and strength of all drugs dispensed, administered, or prescribed.
(2) Each licensee shall have prepared and maintained an accurate record of all charges and payments for services including source of payments.
(3) Each licensee shall maintain patient records and radiographs for at least seven years from the date of last entry unless:
(a) The patient requests the records, radiographs, and models be transferred to another licensee who shall maintain the records and radiographs;
(b) The licensee gives the records, radiographs, or models to the patient; or
(c) The licensee transfers the licensee's practice to another licensee who shall maintain the records and radiographs.
(4) When a dental implant is placed the following information must be given to the patient in writing and maintained in the patient record:
(a) Manufacture brand;
(b) Design name of implant;
(c) Diameter and length;
(d) Lot number;
(e) Reference number;
(f) Expiration date;
(g) Product labeling containing the above information may be used in satisfying this requirement.
(5) When changing practice locations, closing a practice location or retiring, each

licensee must retain patient records for the required amount of time or transfer the custody of patient records to another licensee licensed and practicing dentistry in Oregon. Transfer of patient records pursuant to this section of this rule must be reported to the Board in writing within 14 days of transfer, but not later than the effective date of the change in practice location, closure of the practice location or retirement. Failure to transfer the custody of patient records as required in this rule is unprofessional conduct.
(6) Upon the death or permanent disability of a licensee, the administrator, executor, personal representative, guardian, conservator or receiver of the former licensee must notify the Board in writing of the management arrangement for the custody and transfer of patient records. This individual must ensure the security of and access to patient records by the patient or other authorized party, and must report arrangements for permanent custody of patient records to the Board in writing within 90 days of the death of the licensee.

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

a licensee may render treatment in a reasonable manner according to community standards.
(12) Use the behavior management technique of Hand Over Mouth (HOM) without first obtaining informed consent for the use of the technique.
(13) Use the behavior management technique of Hand Over Mouth Airway Restriction (HOMAR) on any patient.
(14) Fail to determine and document a dental justification prior to ordering a Cone Beam CT series with field greater than 10x10 cm for patients under 20 years of age where pathology, anatomical variation or potential treatment complications would not be otherwise visible with a Full Mouth Series, Panoramic or Cephalometric radiographs.
(15) Fail to advise a patient of any recognized treatment complications.
(16) Fail to maintain proper storage or handling of medications, including injectables, according to federal regulations, guidelines, standards, and manufacturer recommendations.
(17) Fail to obtain and maintain a written informed consent prior to administering Botulinum Toxin Type A or dermal fillers.

Potential statement on the use of AI

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

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

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

Despite these technological advancements, the Oregon Medical Board will continue to hold licensees responsible for the care they provide to patients and expects licensees to use technology – including AI – responsibly and ethically. Regardless of who introduces AI into the practice, OMB licensees are expected to possess basic AI literacy in order to understand the technology and how to use it, explain its capabilities and limitations, assess the quality of AI outputs, and identify and guard against bias in AI algorithms.

OMB licensees must guard against complacency and not compromise their own medical decision making by becoming overly reliant on AI.

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

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

The meeting adjourned at 7:50 p.m.

BACKGROUND: At the June 14, 2024 Board meeting, the Board voted to withdraw from HPSP effective July 1, 2025, unless funding is available from other sources, and to make plans for continued care for licensees in the program. The Board is not currently participating in HPSP and need to amend OAR 818-013-0005 to reflect that.

MOTION FROM AUGUST 21, 2026 BOARD MEETING

Dr. Kalia moved and Dr. Kalluri seconded that the Board refer Proposed Amendment to OAR 818-013-0005 as presented to the Licensing, Standards and Competency Committee. The motion passed with SK, SL, RS, AK, OS, JT, AT, KS, GJ, and KL voting Aye.

CURRENT PROPOSED RULE CHANGE FOR LICENSING, STANDARDS AND COMPETENCY COMMITTEE TO REVIEW AND DISCUSS:

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

(1) Effective July 1, 2010, the Board **may** participate~~s~~ 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.

MARCH 3, 2026 - EMAIL FROM DR. TERRENCE CLARK

Dear Fellow Board members,

As we have discussed several times, like you, I'm deeply concerned with the issue of mental health, suicide, and substance use disorders within our profession. Once again I'm pleading with you to adopt a resolution regarding mandatory continuing education for dental healthcare provider wellbeing. We've done the work to remove the barriers on paper; now we need to do the work of educating our peers so they know how to find help, how to report safely, and how to manage these challenges for a lifetime of safe practice.

The goal is to bridge the gap between the Board's recent policy shifts and the practical need for licensee education. I move we adopt a resolution requiring mandatory continuing education for dental provider wellbeing, one hour every two year renewal cycle. The fact that every survey shows healthcare providers are afraid to self-report, or to report a colleague, is because they are afraid of the consequences and don't trust the system. This is clear evidence they do not understand the process is rehabilitative, not punitive and that they can truly be part of the solution and not simply enable the problem.

We recently took a major step toward reducing stigma by removing "have you ever" mental health and substance use disorder questions from our licensure applications. However, this policy change without further education leaves a major gap. We have removed the stigmatizing language but have not inspired or motivated any greater reporting. Other states that have also removed the stigmatizing language on their licensee applications have not been able to show any change in greater reporting, either self-reporting or anonymous reporting of a colleague. Without meaningful education, our dental healthcare providers will not self-report, with or without stigmatizing questions. They do not trust the system, as proven by multiple surveys and historically abysmal levels of reporting (close to zero). Education will help bridge the gap, help remove the fear of the unknown, help restore trust, and substantially increase the number of providers reporting. Knowledge is empowering.

You may ask, "Why does it have to be mandatory?" For substance abuse, continuing education must be mandatory to ensure 100% of those at risk (all of us) understand clearly that our system is designed to be rehabilitative, not punitive, and that it's safe, supportive, and has the greatest success at reducing or eliminating the consequences of being "caught" when intervention occurs voluntarily. It has to be taught to everyone because even though the vast majority will not personally have a substance abuse disorder or be at risk of suicide, the vast majority will most likely know someone who does, and they can be a huge part of the solution. It has to be mandatory because we don't know who is at risk of suicide, and even one death is too many. Additionally, most dental healthcare providers in

Oregon are not aware they have a legal statutory requirement to report healthcare providers who they have first-hand knowledge are impaired. We must care enough to help and not be enablers.

You may ask, "Is this really a problem in Oregon?" Yes, studies show that at least 10% of healthcare providers (some studies show as high as 19%) will experience some form of substance abuse disorder. There are currently about 8000 dental healthcare providers in Oregon, thus there are statistically at least 800 providers who may be experiencing a substance abuse disorder. The Board is only aware of less than 10 providers seeking help in any given year, less than 0.0125% of the problem. We have to do better than this. Mandatory education is a major part of the solution.

You may be aware, Oregon ranks 14th in the nation for overall suicide rates, with 888 total suicides reported in 2023 (last year for current data), 38% higher than the national average. Although the statistics don't tell us how many were healthcare providers, their suicide rate is often significantly higher than the general population. We must help identify and help support anyone who is experiencing suicide ideation.

Protecting the public & the profession is what we are about, by statute. As sworn in members of the Board, patient safety is our primary mandate. A provider struggling with untreated substance abuse or a mental health crisis is a risk to the public. By mandating education, we help ensure early intervention, which is the most effective way to prevent harm. We already mandate education for pain management and cultural competency. It is time we prioritize the foundational health of the providers themselves. Like the airlines train passengers to put the mask on themselves before helping others, we too must ensure our healthcare providers are safe and protected first, then we can better help our patients.

Oregon should lead, not lag, in provider wellness. Washington already requires suicide prevention training, and Colorado mandates substance abuse education for dentists. Nearly every state requires some form of continuing education on mental health, substance use disorder, and suicide prevention for physicians. Dentist's lives matter at least as much as our medical colleagues.

This resolution isn't just another statement of support by changing question verbiage; it's a serious commitment to make a meaningful and lasting change in the health, safety, and wellbeing of our dental healthcare providers, and by extension, our patients. This may be the closest thing you will ever do as a member of the Oregon Board of Dentistry to literally be saving lives. Please seriously consider this request and commit to sharing your support for this resolution.

Warmly,

Terry

Terrence A. Clark, DMD

FAQ: PROPOSED CE FOR PROVIDER WELLBEING & IMPAIRMENT, INCLUDING SUICIDE PREVENTION

Q: Why do we need another mandatory CE requirement?
A: While we currently mandate pain management and cultural competency, we lack a requirement for the very issue that most directly threatens a provider's license and patient safety: impairment. This education provides the "missing link" to our recent licensing reforms.

Q: Doesn't the Board already have a process for handling impaired dentists?
A: Yes, but national surveys have shown that many licensees do not understand it and are afraid of retaliation by the system. Many believe the Board only takes punitive action and are unaware of non-disciplinary pathways for recovery. Education ensures they know how to seek help *before* harm occurs.

Q: Will this increase the total number of CE hours required for renewal?
A: No. This requirement can be integrated into the existing 40-hour biennial requirement for dentists (or 24 for hygienists), similar to how the pain management module is currently structured.

Q: Is there evidence that this type of education works?
A: Yes. States like Washington and Colorado utilize these mandates to normalize mental health conversations and increase the use of provider assistance programs. Continuing education will significantly increase the opportunity for early intervention, which is statistically proven to reduce the likelihood of malpractice and board disciplinary actions.

Q: What about mandatory reporting? Is that covered?
A: Yes, this is a key component. Many licensees are unaware of the specific statutory requirements for reporting a colleague. This CE would clarify when a report is required and how to do so in a way that supports the colleague's ability to continue practicing safely. Licensees will learn that reporting is anonymous and can literally save lives.

Q: Who will provide this training?
A: The Board would set standards for Board-approved courses. We expect organizations like the Oregon Wellness Program, the ODA, and OHSU to develop high-quality, Oregon-specific content. However, there are many courses already available nationally and being presented at dental conferences in every state across the country.

At its April 24, 2026 Board meeting, the Board reviewed and discussed Dr. Clark's email.

MOTION FROM APRIL 24, 2026 BOARD MEETING

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

818-021-0060

Continuing Education — Dentists

(1) Each dentist must complete 40 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.

(2) Dentists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dentists is April 1 through March 31.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.

(3) Continuing education includes:

(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.

(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than 12 hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)

(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course provides a certificate of completion to the dentist. The certificate of completion should list the dentist’s name, course title, course completion date, course provider name, and continuing education hours completed.

(d) Continuing education credit can be given for volunteer pro bono dental services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Examinations taken after initial licensure; a recognized specialty examination taken after initial licensure; or test development for clinical dental, dental hygiene or specialty examinations. No more than 6 hours of credit may be in these areas.

(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than four hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.

(5) At each renewal, all dentists licensed by the Oregon Board of Dentistry will 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).

(6) At least two (2) hours of continuing education must be related to infection control.

(7) At least two (2) hours of continuing education must be related to cultural competency (Effective January 1, 2021).

(8) At least one (1) hour of continuing education related to suicide prevention, mental health awareness, or substance use disorders (Effective Month, Date, Year).

(~~8~~**9**) A dentist placing dental implants must complete at least seven (7) hours of continuing education related to the placement and/or restoration of dental implants every licensure renewal period (Effective January 1, 2024).

818-021-0070

Continuing Education — Dental Hygienists

(1) Each dental hygienist must complete 24 hours of continuing education every two years. An Expanded Practice Permit Dental Hygienist shall complete a total of 36 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.

(2) Dental hygienists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dental hygienists is October 1 through September 30.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.

(3) Continuing education includes:

(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.

(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than six hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)

(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course provides a certificate of completion to the dental hygienist. The certificate of completion should list the dental hygienist’s name, course title, course completion date, course provider name, and continuing education hours completed.

(d) Continuing education credit can be given for volunteer pro bono dental hygiene services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Hygiene Examination, taken after initial licensure; or test development for clinical dental hygiene examinations. No more than 6 hours of credit may be in these areas.

(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than two hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.

(5) Dental hygienists who hold a Nitrous Oxide Permit must meet the requirements contained in OAR 818-026-0040(11) for renewal of the Nitrous Oxide Permit.

(6) At least two (2) hours of continuing education must be related to infection control.

(7) At least two (2) hours of continuing education must be related to cultural competency (Effective January 1, 2021).

(8) At least one (1) hour of continuing education related to suicide prevention, mental health awareness, or substance use disorders (Effective Month, Date, Year).

818-021-0076

Continuing Education - Dental Therapists

(1) Each dental therapist must complete 36 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.

(2) Dental therapists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dental therapists is October 1 through September 30.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.

(3) Continuing education includes:

(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.

(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than six hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)

(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course provides a certificate of completion to the dental therapist. The certificate of completion should list the dental therapist’s name, course title, course completion date, course provider name, and continuing education hours completed.

(d) Continuing education credit can be given for volunteer pro bono dental therapy services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Therapy Examination, taken after initial licensure; or test development for clinical dental therapy examinations. No more than 6 hours of credit may be in these areas.

(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than two hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.

(5) At least two (2) hours of continuing education must be related to infection control.

(6) At least two (2) hours of continuing education must be related to cultural competency.

(7) At least one (1) hour of continuing education must be related to pain management.

(8) At least one (1) hour of continuing education related to suicide prevention, mental health awareness, or substance use disorders (Effective Month, Date, Year).

APRIL 20, 2026 - THE AMERICAN DENTAL ASSOCIATION RELEASED UPDATED SEDATION AND ANESTHESIA USE AND TEACHING GUIDELINES.

AT THE AUGUST 21, 2026 BOARD MEETING: The Board discussed the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students.

MOTION FROM AUGUST 21, 2026 BOARD MEETING

Dr. Sharifi moved and Dr. Thompson seconded that the Board refer Proposed Amendment to OAR 818-026-0030 as amended to the Licensing, Standards and Competency Committee. The motion passed with SK, SL, RS, AK, OS, JT, AT, KS, GJ, and KL voting Aye.

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 **dose of an** oral agent to achieve anxiolysis only, no anesthesia permit is required. **The dentist shall follow all rules and requirements listed under OAR 818-026-00XX. 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.

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 documented equipment check is required before each sedation case**:

(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 **Bag Valve Mask (BVM)** facemask**, including appropriate mask sizes, oropharyngeal airways,** 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.

(i) Emergency drills are required to be completed and documented every six (6) months.

(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**. The patient's weight, height, Body Mass Index (BMI), blood pressure, pulse, and respiratory rate is required to be evaluated and documented as part of the pre-operative assessment**;

(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.

(12) A licensee that does not hold a Moderate, Deep Sedation or General Anesthesia Permit may not administer, for purpose of anxiolysis or sedation, Benzodiazepines or narcotics in children under 6 years of age.

(13) A licensee must ensure a written emergency response protocol is in place for all patients undergoing treatment with oral anxiolytic agents, Nitrous Oxide, Minimal Sedation, Moderate Sedation, Deep Sedation, or General Anesthesia.

818-026-00XX
Oral Anxiolysis without a Minimal Sedation Permit

Under the American Dental Association (ADA) guidelines, what was formerly termed "anxiolysis" is officially classified as minimal sedation. A dentist may administer a single dose of an oral agent to achieve anxiolysis only without holding a Minimal Sedation permit if the dentist:

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

(2) Maintains evidence of completion of a comprehensive training program consisting of at least 16 hours of training that 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 16 hours of training that is equivalent to that required in graduate training programs. This training shall cover pharmacology, patient evaluation, sedation, recognition and management of complications and emergency protocols. The dentist will provide initial training and continuing education certificates upon written request of the Board.

(3) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery. A documented equipment check is required before each sedation case:

(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 Bag Valve Mask (BVM) facemask, including appropriate mask sizes, oropharyngeal airway and appropriate connectors

that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

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

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

(h) Emergency drills are required to be completed and documented every six (6) months.

(4) Before inducing minimal sedation with a single oral anxiolytic agent, 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 an oral anxiolytic agent or minimal sedation. The patient's weight, height, Body Mass Index (BMI), blood pressure, pulse, and respiratory rate is required to be evaluated and documented as part of the pre-operative assessment;

(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.

(5) No permit holder shall have more than one person under an oral anxiolytic agent, minimal sedation, or nitrous oxide sedation at the same time.

(6) While the patient is being treated under an oral anxiolytic agent 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 anxiolytic agents calculated and dispensed by a dentist permit holder under the direct supervision of a dentist permit holder.

(7) A patient under an oral anxiolytic or 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.

(8) 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.)

(9) 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.

(10) 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 sedation with an oral anxiolytic agent or minimal sedation except to the care of a responsible third party.

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

(12) When incremental dosing or supplemental dosing of the oral anxiolytic agent is required the patient must be treated by a dentist holding an appropriate minimal sedation permit, moderate sedation permit, deep sedation permit, or general anesthesia permit.

(13) A licensee that does not hold a Moderate, Deep Sedation or General Anesthesia Permit may not administer, for purpose of anxiolysis or sedation, Benzodiazepines or narcotics in children under 6 years of age.

(14) A licensee must ensure a written emergency response protocol is in place for all patients undergoing treatment with oral anxiolytic agents, Nitrous Oxide, Minimal Sedation, Moderate Sedation, Deep Sedation, or General Anesthesia.

AUGUST 11, 2024 EMAIL FROM JENNA SHANKS, RDH

Dear Stephen Prisby,

I hope this message finds you well. I'm writing to propose that dental hygienists in Oregon be authorized to administer Botox and dermal fillers under the indirect supervision of a dentist. With their extensive training, dental hygienists are well-qualified to safely perform these procedures, which would benefit patients and expand dental practice offerings.

Hygienists are already trained in complex techniques like administering local anesthesia, making them well-suited to provide Botox and fillers. These services are low-risk and can be safely administered in the sterile environment of a dental office. Research also shows that patients often feel more comfortable with familiar dental professionals, enhancing their overall experience.

Allowing dental hygienists to perform these procedures would benefit both dentists and patients by expanding services and meeting growing demand. Dentists have been successfully administering Botox and fillers for some time, and extending this privilege to hygienists, with specialized training, is a natural progression.

In addition to aesthetic benefits, dental hygienists could offer treatments for TMJ disorders, migraines, and other therapeutic needs. There is strong professional interest in this expanded scope of practice, and it would align with the trend toward comprehensive patient care.

I believe this proposal would enhance patient care, expand the role of dental hygienists, and meet increasing demand for aesthetic treatments. I respectfully ask the Board to consider this proposal and would welcome further discussion.

Thank you for your time and consideration.

Sincerely,

Jenna Shanks, Registered Dental Hygienist

MOTION FROM AUGUST 23, 2024 BOARD MEETING

Dr. Clark moved and Ms. Simmons seconded that the Board move the issue of dental hygienists administering Botox and dermal fillers to the December 13, 2024 Board meeting for further discussion. The motion passed with RS, AK, SK, TC, MA, OS, KS, GJ and CD voting Aye.

NOVEMBER 20, 2024 EMAIL FROM JENNA SHANKS, RDH

Hello Stephen Prisby,

I hope you're doing well. I've updated my document regarding the proposition to allow dental hygienists to administer Botox in Oregon. I kindly request that this be added to

the agenda for the December 13th meeting, as it was not called to vote at the last meeting.

From: Jenna Shanks <>
Sent: Wednesday, November 20, 2024 7:15 PM
To: PRISBY Stephen * OBD <stephen.prisby@obd.oregon.gov>
Subject: Request to Add Proposal to December 13th Agenda

> You don't often get email from jenna.shanks@aol.com. Learn why this is important

Hello Stephen Prisby,

I hope you're doing well. I've updated my document regarding the proposition to allow dental hygienists to administer Botox in Oregon. I kindly request that this be added to the agenda for the December 13th meeting, as it was not called to vote at the last meeting.

Thank you so much, and have a great night!

Best regards,

Jenna Shanks, RDH

Jenna Shanks

Expanding Scope of Practice: Advocating for Dental Hygienists to Administer Botox Injections in Oregon

Introduction

The integration of Botox into dental practice offers significant benefits for patients with various conditions, including TMJ disorders, bruxism, and excessive gingival display. As trained oral health professionals, dental hygienists possess the foundational knowledge and skills necessary to safely administer Botox under appropriate supervision.

Current Landscape

Currently, only Kansas and Oklahoma allow dental hygienists to administer Botox with direct supervision from a dentist, reflecting a growing recognition of their capability in this area (RDH Magazine, 2023). In Oregon, advocacy is ongoing to broaden these permissions, highlighting the need for updated regulations that reflect the evolving role of dental hygienists in patient care.

Benefits of Allowing Dental Hygienists to Administer Botox

1. **Enhancing Patient Care**: Granting dental hygienists the authority to administer Botox would significantly improve patient care quality and access, particularly for those suffering from TMJ disorders and related issues (Mayo Clinic, 2023).
2. **Leveraging Existing Expertise**: Dental hygienists have extensive training in oral health and anatomy, positioning them well to perform Botox injections safely and effectively (American Dental Association, 2020). Their education prepares them to understand the techniques and considerations necessary for this procedure.
3. **Meeting Increasing Demand**: With the rising popularity of Botox, allowing dental hygienists to provide these injections can help meet patient demand for non-surgical treatment options, ensuring more individuals can access these services (American Society of Plastic Surgeons, 2020).
4. **Broadening Treatment Options**: Enabling dental hygienists to administer Botox can expand the range of treatments available within dental practices, fostering comprehensive care that addresses both aesthetic and medical needs (RDH Magazine, 2023).
5. **Improving Accessibility**: By allowing dental hygienists to perform Botox injections, patients can access these services during their regular dental visits, reducing the need for referrals to outside specialists (Today's RDH, 2023).
6. **Promoting Safe Administration**: With proper training and oversight, dental hygienists can safely administer Botox, thus minimizing the risks associated with injections from inadequately trained providers in less regulated environments (American Academy of Dermatology Association, 2023).

7. **Facilitating Interprofessional Collaboration**: Permitting dental hygienists to administer Botox encourages collaboration between dental and medical professionals, leading to more integrated and holistic patient care (Mayo Clinic, 2023).
8. **Addressing Regulatory Gaps**: Updating regulations to permit dental hygienists to provide Botox aligns Oregon with other states that have successfully integrated this practice, thereby enhancing the competitiveness of dental care in the state (American Dental Association, 2020).
9. **Enhancing Patient Education**: Dental hygienists are well-equipped to educate patients about the risks and benefits of Botox, ensuring informed consent and fostering patient understanding, which enhances overall safety and satisfaction (American Academy of Dermatology Association, 2023).
10. **Adapting to Evolving Roles**: Allowing dental hygienists to administer Botox reflects the evolving landscape of healthcare, recognizing the increasing value of multidisciplinary approaches in providing comprehensive patient care (RDH Magazine, 2023).

Below is a table detailing Botox's therapeutic and cosmetic applications in dentistry, based on information from *Today's RDH*. Offering Botox in dental offices could not only provide valuable treatments but also attract more patients seeking these services. By addressing both pain management and cosmetic goals, dental practices offering Botox can meet a broader range of patient needs and draw in new patients interested in these versatile treatments.

Table 1: Therapeutic and cosmetic uses of Botox in dentistry

Disorder/condition	Outcome/benefit
Migraine	Pain relief. The mechanism is not fully understood, but it appears the reduction of muscle innervation leads to pain relief.
Pathologic clenching and bruxism, leading to trauma, attrition, etc.	Injections into the temporalis and masseter muscles help alleviate the symptomatology of bruxism.
Trigeminal neuralgia	An injection can relieve headaches and pain associated with this condition.
Temporomandibular joint disorders	Injecting with Botox helps ease and reduce pain and relax the muscle, leading to less wear on restorations.
Oromandibular dystonia movement disorder	Improves the function of chewing and speaking.
Masseteric hypertrophy—increased size of muscle; jaw looks swollen or misshapen	A sequence of three injections into the masseter muscle produces selective loss of muscle function.
"Gummy smile" or lip deformities	Injecting into the lip elevator muscles decreases the elevation of the upper lip; more gingiva is covered when smiling.
Sialorrhea	Botox injections can reduce secretions from the salivary gland.
Myofascial pain	Injecting into the painful muscles inhibits muscle contraction.

Currently, the following licensed professionals are authorized to administer Botox, while concerns exist about untrained individuals performing this procedure without medical qualifications:

1. **Nurse Practitioners**: These professionals can administer Botox independently, without the need for physician oversight (American Association of Nurse Practitioners, 2023).

2. **Physician Assistants**: They are permitted to inject Botox but must operate under the supervision of a physician (American Academy of Physician Assistants, 2023).
3. **Aestheticians**: In certain jurisdictions, aestheticians can administer Botox, provided they do so under the supervision of a licensed physician (National Laser Institute, 2023).
4. **Medical Assistants**: Medical assistants are also allowed to administer Botox under the supervision of a physician (American Association of Medical Assistants, 2023).
5. **Registered Nurses**: Registered nurses can perform Botox injections with supervision from a licensed physician or nurse practitioner. They must hold a valid nursing license, graduate from an accredited nursing program, and possess the necessary knowledge and skills to administer the procedure safely. Additionally, specialized training in injectables is often recommended (American Nurses Association, 2023).

However, there is a growing concern regarding individuals without medical training who are performing Botox injections, highlighting the need for stricter regulations and oversight to ensure patient safety.

Nursing vs. Dental Hygiene Curriculum at MHCC

Category	Nursing Courses (NRS)	Dental Hygiene Courses (DH)
Foundations	**Nursing Foundations**	**Clinical Principles**
	NRS110A: Health Promotion - A	DH112: Clinical Dental Hygiene
	NRS110B: Health Promotion - B	DH113: Dental/Oral Anatomy
	NRS111A: Chronic Illness I - A	DH114: Oral Microbiology
	NRS111B: Chronic Illness I - B	DH115: Professionalism and Cultural Competency
Acute Care	**Nursing in Acute Care**	**Clinical Theory and Practice**
	NRS112A: Acute Care I - A	DH121: Dental Hygiene Clinical Theory I
	NRS112B: Acute Care I - B	DH122: Dental Hygiene Clinic I
Chronic Illness & End-of-Life	**Chronic Illness II & End of Life**	**Advanced Oral Studies**
	NRS221A: Chronic Illness II - A	DH123: Oral Histology and Embryology

	NRS221B: Chronic Illness II - B	DH124: Oral Radiology I
	NRS222A: Acute Care II - A	DH125: General Pathology
	NRS222B: Acute Care II - B	DH131: Dental Hygiene Clinical Theory II
Clinical Practicum	**Integrative Practicum**	**Advanced Clinical Skills**
	NRS224A: Practicum I - A	DH132: Dental Hygiene Clinic II
	NRS224B: Practicum I - B	DH134: Oral Radiology II
Pharmacology & Pathophysiology	**Pharmacology & Pathophysiology**	**Specialized Dental Studies**
	NRS230: Clinical Pharmacology I	DH135: Oral Pathology
	NRS231: Clinical Pharmacology II	DH136: Pharmacology
	NRS232: Pathophysiological Processes I	DH137: Head and Neck Anatomy
	NRS233: Pathophysiological Processes II	DH211: Dental Hygiene Clinical Theory III
Expanded Practice & Specialization	**Specialization & Expanded Functions**	**Periodontology, Community Health & Restorative Dentistry**
		DH212: Dental Hygiene Clinic III
		DH213: Expanded Functions
		DH214: Periodontology for Dental Hygienists I
		DH215: Dental Materials
		DH216: Community Dental Health
		DH217: Local Anesthesia
		DH218: Introduction to Restorative Dentistry

		DH219: Nitrous Oxide-Oxygen Sedation
Advanced Clinical Practice	**Advanced Dental Hygiene Theory & Practice**	**Public Health, Management & Ethics**
		DH221: Dental Hygiene Clinical Theory IV
		DH222: Dental Hygiene Clinic IV
		DH223: Public Health and Dental Research
		DH224: Periodontology for Dental Hygienists II
		DH225: Restorative Dentistry Lab
		DH231: Dental Hygiene Clinical Theory V
		DH232: Dental Hygiene Clinic V
		DH233: Ethics and Jurisprudence
		DH234: Practice Management and Dental Hygiene Issues
		DH235: Restorative Dentistry Clinic

Total Credits

- **Nursing**: 60 Credits
- **Dental Hygiene**: 87 Credits

https://catalog.mhcc.edu/courses-az/dh/

https://catalog.mhcc.edu/courses-az/nrs/

Currently, the curricula for nursing and dental hygiene programs differ significantly in their focus areas. Nurses are trained through a broad range of courses that cover various aspects of the human body, emphasizing holistic patient care. In contrast, dental hygienists concentrate primarily on the head and neck region, making their education particularly relevant for administering Botox.

This specialized training equips dental hygienists with a deeper understanding of facial anatomy and the specific skills required for procedures involving Botox. Given their focused coursework and expertise as head and neck specialists, dental hygienists are well-suited to perform Botox injections effectively and safely.

Below is a summary of the requirements dentists must meet to administer Botox. I believe that dental hygienists, with similar training, should be allowed to take the same course and administer Botox as well. This approach could expand services in dental offices and attract more patients interested in cosmetic options offered by trusted dental professionals.

OAR 818-012-0005 (3) and (4):

(3) A dentist may utilize Botulinum Toxin Type A to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in Botulinum Toxin Type A, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (3) by successfully completing training in Botulinum Toxin Type A as part of a CODA accredited program.

(4) A dentist may utilize dermal fillers to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s), in dermal fillers, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (4) by successfully completing training in dermal fillers as part of a CODA accredited program.

The Board also views "cosmetic dentistry" as within the scope of practice, as long as there is a dental justification for the procedure.

Please contact the Board Office if you have any questions or need additional information.

Botox Safety Overview

Botox (Botulinum toxin type A) is considered safe when administered by trained professionals, with an established safety profile from extensive research and therapeutic use.

1. **Safety Profile**
    - **FDA Approval**: Approved for medical (e.g., migraines, hyperhidrosis, spasticity) and cosmetic uses.
    - **Controlled Dosage**: Small, regulated doses are used in procedures, reducing serious risks.
    - **Temporary Effects**: Effects typically last 3-6 months, with muscle function returning gradually.
2. **Common Side Effects**
    - **Local Reactions**: Redness, swelling, and mild pain at the injection site.
    - **Systemic Effects**: Some may experience headaches or flu-like symptoms.
    - **Localized Muscle Weakness**: Rarely, Botox can cause temporary weakness if it spreads beyond the injection area.
3. **Rare Serious Side Effects**
    - **Spread of Toxin Effects**: Larger medical doses can, in rare cases, cause swallowing or breathing difficulties.
    - **Allergic Reactions**: Severe allergies are rare but can include rash or wheezing.

4. **Safety Precautions**
    - **Qualified Practitioners**: It's crucial to have Botox administered by licensed, trained professionals.
    - **Patient Screening**: Pre-screening for contraindications like neurological disorders or pregnancy reduces risks.
5. **Reversal and Long-Term Safety**
    - **Natural Reversal**: Botox naturally wears off within months.
    - **No Direct Antidote**: No specific reversal agent exists; adverse effects are generally managed symptomatically.
    - **Long-Term Use**: Safe for repeated treatments, though rare resistance may develop with high/frequent doses.

Conclusion

Botox is generally safe for medical and cosmetic use, with temporary effects and manageable risks. Receiving treatment from trained professionals is key to minimizing potential complications. In conclusion, dental hygienists in Oregon should be granted the ability to administer Botox. As one of the most progressive states in the country for dental hygiene, Oregon is well-positioned to expand the scope of practice for dental hygienists, especially given the high demand and market for Botox treatments. Allowing hygienists to administer Botox would enhance patient care options, attract more clients to dental offices, and reflect the extensive training and qualifications that hygienists already possess. The arguments presented here demonstrate both the readiness and capability of hygienists to safely and effectively provide Botox, supporting the case for a broader, more versatile practice in Oregon.

Sources:

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Jenna Shanks

Expanding Scope of Practice: Advocating for Dental Hygienists to Administer Botox Injections in Oregon Continued

Complications of Local Anesthesia vs. Botox in Dentistry

Complications associated with Botox are generally minimal compared to those of local anesthesia used in dentistry. Botox complications typically include temporary side effects such as mild bruising, pain at the injection site, headache, rash, or minor facial asymmetry. In rare cases, patients may experience allergic reactions or muscle weakness, particularly if contraindications like neuromuscular disorders are present. Botox treatments are localized and generally have a high safety profile when administered correctly, especially since doses for dental applications are significantly below toxic levels (Ocean State Oral & Maxillofacial Surgery, *What is DAANCE?*, https://www.oceanstateoms.com/files/2011/08/What-is-DAANCE.pdf).

In contrast, complications from local anesthesia in dentistry can be more severe and potentially life-threatening. These include nerve damage leading to persistent paresthesia, trismus, hematoma, allergic reactions, and systemic toxic effects like cardiovascular collapse in cases of overdose. Hemorrhage, broken needles, and infection from improper injection techniques are also risks. Management of these complications often requires more immediate and advanced medical intervention than Botox-related issues. Below is a list of complications associated with local anesthesia:

- **Nerve Damage**: Paresthesia, or prolonged numbness, can result from nerve trauma during the injection process. This is typically temporary but can occasionally be permanent.
- **Hematoma**: Bleeding into surrounding tissues due to vessel puncture can lead to swelling and bruising.
- **Trismus**: Muscle spasms or tissue damage can cause difficulty in opening the mouth.
- **Infections**: Though rare, infections may occur at the injection site if sterilization protocols are not followed.
- **Needle Breakage**: Improper technique or equipment failure can lead to a broken needle, potentially requiring surgical intervention.
- **Systemic Toxicity**: Overdose or inadvertent intravascular injection of anesthetic can result in cardiovascular or central nervous system effects, such as seizures or collapse.
- **Allergic Reactions**: While uncommon, hypersensitivity to the anesthetic or preservatives can cause mild to severe allergic responses, including anaphylaxis.
- **Facial Nerve Paralysis**: Temporary paralysis can occur if the anesthetic is inadvertently administered near a major nerve.

These complications emphasize the importance of proper training and technique for safe administration (Columbia University, 2007, *Complications of Local Anesthesia*; “Understanding the Therapeutic Dental Applications of Botox,” *Today’s RDH*).

Training and Education in Oregon

In Oregon, dental hygienists receive extensive and rigorous training to safely administer local anesthesia. Their education includes comprehensive coursework on the anatomy and physiology of the oral and maxillofacial regions, pharmacology of anesthetic agents, patient assessment, and injection techniques. This is followed by clinical practice under supervision to ensure competence. Hygienists must pass both written and clinical examinations to become certified, ensuring they meet high safety standards and are well-prepared to manage potential complications.

By contrast, dental assistants receive significantly less training. The DAANCE program (Dental Anesthesia Assistant National Certification Examination) is a 36-hour self-study course designed to prepare dental assistants to assist with anesthesia administration under oral and maxillofacial surgeons. While it provides essential skills in patient monitoring and emergency preparedness, it lacks the in-depth anatomical, pharmacological, and hands-on injection training required to directly administer local anesthesia independently (TeacherTina, *LA Cert - Dental Assistant - Oregon*, https://teachertina.thinkific.com/courses/LA-CERT-DENTALASSIST-OREGON).

Comparison of Education and Training

The training required for dental hygienists in Oregon is far more extensive than that for dental assistants. Dental hygienists complete accredited dental hygiene programs that typically span two to four years, covering advanced anatomy, neuroanatomy, pain management, pharmacology, and hands-on clinical practice. This rigorous training equips them with the skills to administer local anesthesia with a high degree of competence and safety (American Association of Oral and Maxillofacial Surgeons, *DAANCE FAQ*, https://aaoms.org/practice/anesthesia/anesthesia-assistants/education/daance/daance-faq/).

In contrast, dental assistants in Oregon undergo a much shorter training period. The Pacific Northwest Dental Assisting School offers a condensed 12-week program for dental assistants, which is far shorter than the two-to-four-year education required for dental hygienists. While the program focuses on speed, it lacks the comprehensive education and hands-on clinical experience necessary to safely administer local anesthesia. This raises questions about whether the brief DAANCE certification is sufficient to prepare dental assistants for the complexity of anesthesia administration (TeacherTina, *LA Cert - Dental Assistant - Oregon*, https://teachertina.thinkific.com/courses/LA-CERT-DENTALASSIST-OREGON).

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Sources:

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2. Columbia University College of Dental Medicine. "Complications of Local Anesthesia." *Columbia University*, 2007, https://www.columbia.edu/itc/hs/dental/d6401/2007/complicationsColor.pdf.
3. Ocean State Oral & Maxillofacial Surgery. *What is DAANCE?* Ocean State OMS, https://www.oceanstateoms.com/files/2011/08/What-is-DAANCE.pdf.
4. TeacherTina. *LA Cert - Dental Assistant - Oregon*. TeacherTina, https://teachertina.thinkific.com/courses/LA-CERT-DENTALASSIST-OREGON.
5. Today's RDH. "Understanding the Therapeutic Dental Applications of Botox." *Today's RDH*, https://www.todaysrdh.com/understanding-the-therapeutic-dental-applications-of-botox/.

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MOTION FROM DECEMBER 13, 2024 BOARD MEETING

Dr. Sharifi moved and Dr. Aldrich seconded that the Board refer the issue of allowing dental hygienists to administer Botox to the Licensing, Standards and Competency Committee. The motion passed with RS, AK, SK, TC, MA, OS, KS, SL, and GJ voting Aye.

MOTION FROM MAY 20, 2025 LICENSING, STANDARDS & COMPETENCY COMMITTEE

Ms. Ludwig moved and Ms. Klobes seconded the Committee direct staff to research other states where registered dental hygienists can administer botox and draft a rule for the Board discussion and review. The motion passed with SK, MA, SL, JS, HK, JL, and KM voting Aye.

At the June 13, 2025 Board meeting the draft rule was presented and other states where Registered Dental Hygienists could administer Botox were discussed.

MOTION FROM JUNE 13, 2025 BOARD MEETING

Dr. Salathe moved and Dr. Kalluri seconded that the Board refer OAR 818-035-0030 as presented to the Rules Oversight Committee. The motion passed with AK, SK, RS, TC, OS, SL, GJ, and KL voting Aye.

DRAFT RULE PRESENTED AT JUNE 13, 2025 BOARD MEETING

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) A dental hygienist with a local anesthesia endorsement may utilize Botulinum Toxin Type A to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s) in Botulinum Toxin Type A, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dental hygienist with a local anesthesia endorsement may meet the requirements of subsection (4) by successfully completing training in Botulinum Toxin Type A as part of a CODA accredited program.

MOTION FROM JULY 17, 2025 RULES OVERSIGHT COMMITTEE MEETING

Ms. Riedman moved and Ms. Harrison seconded that the Committee recommend the Board send OAR 818-035-0030 to a public rulemaking hearing as presented. The motion passed with AK, OS, KS, PM, AR, MH, and RC voting Aye.

MOTION FROM AUGUST 22, 2025 BOARD MEETING

Dr. Kansal moved and Dr. Kalluri seconded that the Board move OAR 818-035-0030 as presented to a public rulemaking period. The motion passed with AK, SK, RS, MA, OS, KS, SL, and GJ voting Aye.

DRAFT RULE PRESENTED AT AUGUST 22, 2025 BOARD MEETING

OAR 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 **after manufacturer required denture preparation** 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.
(5) A dental hygienist with a local anesthesia endorsement may utilize Botulinum Toxin Type A to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s) in Botulinum Toxin Type A, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dental hygienist with a local anesthesia endorsement may meet the requirements of subsection (4) by successfully completing training in Botulinum Toxin Type A as part of a CODA accredited program.

MOTIONS FROM OCTOBER 24, 2025 BOARD MEETING

Dr. Kalluri moved and Dr. Kalia seconded that the Board approve the proposed rule changes to OAR 818-035-0030 as presented to be effective December 1, 2025. The motion failed with AK, RS, TC, MA, OS, KS, SL, and KL voting Nay, and SK voting Aye.

Ms. Ludwig moved and Dr. Aldrich seconded that the Board approve the proposed rule change to OAR 818-035-0030(1)(h) and (4) as presented to be effective December 1, 2025. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, and KL voting Aye.

Ms. Ludwig moved and Dr. Sharifi seconded that the Board refer the issue of dental hygienists' scope of practice, including Botox administration, to be discussed at Strategic Planning. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, and KL voting Aye.

DRAFT RULE PRESENTED AT OCTOBER 24, 2025 BOARD MEETING

OAR 818-035-0030

Additional Functions of Dental Hygienists

(2) 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 **after manufacturer required denture preparation** 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:

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

(d) 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.

(5) A dental hygienist with a local anesthesia endorsement may utilize Botulinum Toxin Type A to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s) in Botulinum Toxin Type A, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dental hygienist with a local anesthesia endorsement may meet the requirements of subsection (4) by successfully completing training in Botulinum Toxin Type A as part of a CODA accredited program.

MOTION FROM APRIL 24, 2026 BOARD MEETING

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

CURRENT PROPOSED RULE CHANGES FOR LICENSING, STANDARDS AND COMPETENCY COMMITTEE TO REVIEW AND DISCUSS:

OAR 818-035-0030

Additional Functions of Dental Hygienists

(3) 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 after manufacturer required denture preparation 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:

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

(f) 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.

(5) A dental hygienist with a local anesthesia endorsement may utilize Botulinum Toxin Type A to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical course(s) in Botulinum Toxin Type A, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dental hygienist with a local anesthesia endorsement may meet the requirements of subsection (4) by successfully completing training in Botulinum Toxin Type A as part of a CODA accredited program.

MAY 26, 2026 LETTER FROM THE AMERICAN ASSOCIATION OF ORTHODONTISTS

Oregon Board of Dentistry
Attn: Haley Robinson, Executive Director
1500 SW 1st Ave., Ste. 770
Portland, OR 97201

Sent via email to information@obd.oregon.gov

Re: Reconsideration and Discussion of OAR 818-042-0110

Dear Dr. Kalluri and Members of the Board:

On behalf of the American Association of Orthodontists (AAO) and the Oregon State Society of Orthodontists (OSSO), we respectfully request that the Board provide review and consider additional discussion on recently finalized rulemaking related to OAR 818-042-0110 during the Board's June 12, 2026 meeting date. We ask the Board to consider additional information regarding the amended rule's potential implications for orthodontic care delivery, particularly in rural and underserved areas of Oregon.

The AAO and OSSO appreciate the Board's ongoing commitment to patient safety and high standards of clinical practice. However, reiterating concerns raised during the rulemaking process, including Dr. Jonathan Yih's public comments to the Board back in October 2025, we remain concerned that the Final Rule's structure—particularly as it has been interpreted to require dental assistants pursuing certain certification pathways to apply for Expanded Function Orthodontic Dental Assistant (EFODA) certification through the Dental Assisting National Board (DANB) within six months of beginning clinical work, and to limit the performance of EFODA duties beyond that six-month window absent certification—may unintentionally constrain workforce capacity in communities that already face provider shortages.

Orthodontic practices, especially those serving rural areas, frequently rely on a "train-from-within" model to build and sustain their workforce. Given the limited availability of formally trained dental assistants in many parts of the state, orthodontists often hire individuals locally and provide hands-on training over time to develop the competencies necessary for EFODA responsibilities. Under the prior interpretation of the rule, this approach was workable, as assistants who were actively progressing toward certification could continue performing EFODA functions while completing their training at the pace appropriate for them and within the practical realities of working within a rural practice.

The revised six-month certification framework, as applied in practice, significantly narrows that flexibility. For rural practices, where recruiting already-certified assistants is often not

feasible, this change may disrupt care delivery by limiting the ability of trained but not yet certified assistants to contribute fully in clinical settings. In turn, this could reduce patient access to orthodontic services, lengthen wait times, and strain already limited provider capacity in underserved regions.

In addition, the rule's different certification pathways do not operate consistently, which has created confusion for licensees. The examination pathway includes a defined six-month period during which assistants can continue performing certain functions while working toward certification. However, other pathways—such as certification under OAR 818-042-0120—require assistants to complete 1,000 hours of qualifying experience but do not clearly explain how those hours may be obtained if the assistant is not yet certified. Many of the duties that would count toward those hours are the same expanded functions associated with EFODA certification, yet the rule does not specify whether, or under what level of supervision, those duties may be performed during the training period. As a result, assistants may have limited ability to gain the experience needed to become certified, and practices are left uncertain about how to structure training in a compliant manner. This creates a practical challenge where experience is required for certification, but the pathway to obtaining that experience is not clearly defined.

These questions remain unresolved for licensees attempting to comply in good faith. In addition, licensees have identified potential inconsistencies between publicly available guidance and the rule text itself, which further contributes to uncertainty in implementation.

For example, licensees have noted that publicly available guidance suggests certification by credential may be limited to assistants already certified in other states, while the rule text in OAR 818-042-0120 appears to provide a broader pathway based on work experience within Oregon. Similarly, it is unclear whether the six-month provisional period applies only to assistants pursuing the examination pathway or more broadly. These inconsistencies make it difficult for practices to determine how to properly train and utilize assistants while remaining in compliance. In addition, licensees have expressed concern that the current framework may unintentionally limit opportunities for dental assistants who develop an interest in orthodontics later in their careers, as the timing and structure of the certification pathways may make it more difficult to transition into expanded function roles.

We respectfully encourage the Board to consider whether additional clarification, flexibility, or implementation guidance may be warranted to ensure that the rule does not inadvertently hinder access to care or create uncertainty in compliance expectations across certification pathways. The AAO and OSSO stand ready to serve as a resource to the

Board and to collaborate on solutions that uphold patient safety while preserving access to high-quality orthodontic care across all communities in Oregon.

Thank you for your consideration.

Sincerely,

Nathan Mich, VP Federal and State Advocacy and Dr. Gemma Hill, Vice President

MOTION FROM AUGUST 23, 2026 BOARD MEETING

Ms. Jorgensen moved and Dr. Kalluri seconded that the Board refer Proposed Amendments to OAR 818-042-0050, 818-042-0080, 818-042-0110, and 818-042-0113 as amended to the Licensing, Standards and Competency Committee. The motion passed with SK, SL, RS, AK, OS, JT, AT, KS, GJ, and KL voting Aye.

CURRENT PROPOSED RULE CHANGES FOR LICENSING, STANDARDS AND COMPETENCY COMMITTEE TO REVIEW AND DISCUSS:

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 (3)(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 12 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 12 months after passage of a required examination in subsection (3)(a). If the expanded function certificate is not obtained within the 12 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 12 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 12 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 12 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 12 months after passage of a required examination in subsection (3)(b). If the expanded function preventive certificate is not obtained within the 12 months, the dental assistant is no longer able to continue to perform expanded function duties under indirect supervision.

(e) 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 12 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.*~~

BACKGROUND: THIS RULE IS BEING INCLUDED BY STAFF TO MAKE IT CLEAR THAT THE 1,000 HOURS IS INTENDED TO BE COMPLETED OUTSIDE OF OREGON.

818-042-0120
Certification by Credential

(1) Dental Assistants who wish to be certified by the Board in Radiologic Proficiency or as Expanded Function Dental Assistants, Expanded Function Orthodontic Dental Assistants, or as Expanded Function Preventive Dental Assistants shall:

(a) Be certified by another state in the functions for which application is made. The training and certification requirements of the state in which the dental assistant is certified must be substantially similar to Oregon's requirements; or

(b) Have worked for at least 1,000 hours in the past two years in a dental office **located outside of Oregon** where such employment involved to a significant extent the functions for which certification is sought; and

(c) Shall be evaluated by a**n Oregon** licensed dentist, using a Board approved checklist, to assure that the assistant is competent in the expanded functions.

(2) Applicants applying for certification by credential in Radiologic Proficiency must obtain certification from the Oregon Health Authority, Center for Health Protection, Radiation Protection Services, of having successfully completed training equivalent to that required by OAR 333-106-0055 or approved by the Oregon Board of Dentistry.

From:	Justin Jones
To:	ROBINSON Haley * OBD
Cc:	OBD Info * OBD
Subject:	Public Comment – Request for Strong Rulemaking on HB 4040 Out-of-State Dental Student Rotations (ORS 679.025)
Date:	Tuesday, March 3, 2026 1:47:54 PM

Dear Interim Executive Director Robinson and Members of the Oregon Board of Dentistry,

My name is Justin Jones, DDS. I am a licensed Oregon dentist and have served as an approved proctor for OHSU dental students. I went through the formal application and credentialing process to become a proctor and have directly supervised students in clinical settings.

I am writing to provide public comment and express serious concerns regarding the implementation of **HB 4040 (Section 12)**, which amends ORS 679.025 to expand unlicensed practice exemptions for out-of-state dental students on community-based or clinical rotations. This change takes effect January 1, 2027, and will require the Board to adopt "minimum requirements" by rule.

While I understand the stated goal of increasing training opportunities, I believe this legislation attempts to fix a problem that does not exist. The current OHSU-supervised system already works effectively and protects patients. Removing the OHSU-specific supervision requirement opens the door for clinics to bring in out-of-state students primarily to perform work rather than to learn under rigorous oversight. This risks subjecting Oregon patients to substandard care and effectively subverts the Board's authority to regulate who practices dentistry in our state.

I am particularly disappointed that this significant expansion was never presented to the licensed dentists of Oregon for input prior to its inclusion in the bill. There was no broad survey, stakeholder meeting, or formal outreach to the practicing dental community or the Oregon Dental Association. In fact, the Board's only public reference to HB 4040 appears in its internal February 27, 2026 board-meeting packet — after the bill had already passed the House — just days prior to the bill's final passage by the full House.

To protect patient safety and maintain the high standards Oregon patients deserve, I respectfully request that the Board adopt the strongest possible rules under ORS 679.025. These rules should at minimum mirror the existing OHSU proctor standards, including:

- A formal faculty/proctor application and approval process,
- Strict indirect-supervision requirements with documented logs and patient consent,
- Limits on student-to-faculty ratios and allowable procedures,
- Mandatory background checks, liability coverage, and adverse-event reporting,
- Clear prohibitions on using students as unpaid or low-cost labor.

I would welcome the opportunity to participate in any stakeholder meetings, rule workshops, or public comment periods as the Board develops these rules. Please let me know how I can contribute.

Thank you for your leadership in protecting the public and upholding the integrity of dental practice in Oregon. I look forward to your response.

MARCH 3, 2026 - EMAIL FROM DR. JUSTIN JONES

At its April 24, 2026 Board meeting, the Board reviewed Dr. Jones's email expressing his concerns re: HB 4040 and asking the Board to support standards mirroring the existing OHSU proctor Standards.

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

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

For additional context, below is a comparison of the dental/dental therapy (ORS 679) and dental hygiene (ORS 680) statutes regarding licensure exemptions:

680.020 Practice of dental hygiene without license prohibited; applicability of dental hygiene license requirement. (1) It is unlawful for any person not otherwise authorized by law to practice dental hygiene or purport to be a dental hygienist without a valid license to practice dental hygiene issued by the Oregon Board of Dentistry.

(2) Subsection (1) of this section does not apply to:

(a) Dental hygienists licensed in another state making a clinical presentation sponsored by a bona fide dental or dental hygiene society or association or an accredited dental or dental hygiene education program approved by the board.

(b) Bona fide students of dental hygiene who engage in clinical studies during the period of their enrollment and as a part of the course of study in an Oregon dental hygiene education program. The program must be accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor agency, and approved by the board. The clinical study may be conducted on the premises of the program or in a clinical setting located off the premises. The facility, the instructional staff and the course of study at the off-premises location must meet minimum requirements prescribed by the rules of the board, and the clinical study at the off-premises location must be performed under the indirect supervision of a member of the faculty.

(c) Bona fide students of dental hygiene who engage in community-based or clinical studies as an elective or required rotation in a clinical setting located in Oregon during the period of their enrollment and as a part of the course of study in a dental hygiene education program located outside of Oregon. The program must be accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency. The community-based or clinical studies must:

(A) Meet minimum requirements prescribed by the rules of the board; and

(B) Be performed under the indirect supervision of a member of the faculty of the Oregon Health and Science University School of Dentistry or another Oregon institution with an accredited dental hygiene education program approved by the board.

(d) Students of dental hygiene or graduates of dental hygiene programs who engage in clinical studies as part of a course of study or continuing education course offered by an institution with a dental or dental hygiene program. The program must be accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency.

(e) Candidates who are preparing for licensure examination to practice dental hygiene and whose application has been accepted by the board or its agent, if the clinical preparation is conducted in a clinic located on premises approved for that purpose by the board and if the procedures are limited to examination only.

(f) Dental hygienists practicing in the discharge of official duties as employees of the United States Government and any of its agencies.

(g) Instructors of dental hygiene, whether full- or part-time, while exclusively engaged in teaching activities and while employed in accredited dental hygiene educational programs.

(h) Dental hygienists who are employed by public health agencies and who are not engaged in direct delivery of clinical dental hygiene services to patients.

(i) Counselors and health assistants who have been trained in the application of fluoride varnishes to the teeth of children and who apply fluoride varnishes only to the teeth of children enrolled in or receiving services from the Women, Infants and Children Program, the Oregon Prenatal to Kindergarten Program or a federal Head Start grant program.

(j) Persons acting in accordance with rules adopted by the State Board of Education under ORS 336.213 to provide dental screenings to students.

(k) Dental hygienists licensed in another state or United States territory and practicing in this state under ORS 676.347. [Amended by 1963 c.266 §2; 1983 c.169 §19; 2003 c.310 §2;

2005 c.504 §2; 2007 c.379 §5; 2009 c.582 §1; 2012 c.80 §2; 2015 c.558 §5; 2017 c.342 §2; 2022 c.62 §6; 2023 c.547 §29]

679.025 License required to practice dentistry; exemptions. (1) A person may not practice dentistry or purport to be a dentist without a valid license to practice dentistry issued by the Oregon Board of Dentistry.

(2) Subsection (1) of this section does not apply to:

(a) Dentists licensed in another state or country making a clinical presentation sponsored by a bona fide dental society or association or an accredited dental educational institution approved by the board.

(b) Bona fide full-time students of dentistry who, during the period of their enrollment and as a part of the course of study in an Oregon accredited dental education program, engage in clinical studies on the premises of such institution or in a clinical setting located off the premises of the institution if the facility, the instructional staff and the course of study to be pursued at the off-premises location meet minimum requirements prescribed by the rules of the board and the clinical study is performed under the indirect supervision of a member of the faculty.

(c) Bona fide full-time students of dentistry who, during the period of their enrollment and as a part of the course of study in a dental education program located outside of Oregon that is accredited by the Commission on Dental Accreditation of the American Dental Association or its successor ~~agency~~ organization, engage in community-based or clinical studies as an elective or required rotation in a clinical setting located in Oregon if the community-based or clinical studies meet minimum requirements prescribed by the rules of the board and are performed under the indirect supervision of a ~~member of the faculty of the Oregon Health and Science University School of Dentistry~~ faculty member of a dental education program accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization.

(d) Candidates who are preparing for a licensure examination to practice dentistry and whose application has been accepted by the board or its agent, if the clinical preparation is conducted in a clinic located on premises approved for that purpose by the board and if the procedures are limited to examination only. This exception shall exist for a period not to exceed two weeks immediately prior to a regularly scheduled licensure examination.

(e) Dentists practicing in the discharge of official duties as employees of the United States Government and any of its agencies.

(f) Instructors of dentistry, whether full- or part-time, while exclusively engaged in teaching activities and while employed in accredited dental educational institutions.

(g) Dentists who are employed by public health agencies and who are not engaged in the direct delivery of clinical dental services to patients.

(h) Persons licensed to practice medicine in the State of Oregon in the regular discharge of their duties.

(i) Persons qualified to perform services relating to general anesthesia or sedation under the direct supervision of a licensed dentist.

(j)(A) Dentists licensed in another country and in good standing, while practicing dentistry without compensation for no more than five consecutive days in any 12-month period, provided the dentist submits an application to the board at least 10 days before practicing dentistry under this subparagraph and the application is approved by the board.

(B) Dentists licensed in another state or United States territory and practicing in this state under ORS 676.347.

(k) Persons practicing dentistry upon themselves as the patient.

(L) Dental hygienists, dental assistants or dental technicians performing services under the supervision of a licensed dentist in accordance with the rules adopted by the board.

(m) A person licensed as a denturist under ORS 680.500 to 680.565 engaged in the practice of denture technology.

(n) An expanded practice dental hygienist who renders services authorized by a permit issued by the board pursuant to ORS 680.200. [1953 c.574 §2; 1955 c.560 §1; 1957 c.552 §4; 1963 c.284 §1; 1971 c.48 §1; 1973 c.390 §1; 1975 c.693 §19; 1979 c.1 §16; 1983 c.169 §2; 1993 c.142 §1; 1997 c.251 §5; 2005 c.504 §1; 2011 c.716 §5; 2012 c.80 §1; 2013 c.114 §1; 2017 c.342 §1; 2022 c.62 §5]

Enrolled
House Bill 4040

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

CHAPTER .....

AN ACT

Relating to health care; creating new provisions; amending ORS 411.447, 414.211, 414.690, 427.191, 442.615, 475A.325, 475A.338, 475A.372, 646A.694, 656.005, 656.214, 656.245, 656.250, 656.252, 656.262, 656.268, 656.325, 656.340, 656.726, 656.797, 657.170, 659A.043, 659A.046, 659A.049, 659A.063, 678.733, 679.025, 685.100, 685.102, 743A.145, 743B.456, 744.702, 750.055 and 750.333 and section 5, chapter 575, Oregon Laws 2015; repealing ORS 743B.221; and declaring an emergency.

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

HOSPITALS

SECTION 1. ORS 442.615 is amended to read:

442.615. (1) As used in this section:

(a) "Financial assistance" includes:

(A) Charity care, as defined in ORS 442.601; or

(B) An adjustment to a patient's costs for care under ORS 442.614 (1)(a).

(b) "Hospital" has the meaning given that term in ORS 442.612.

(2) Using the process prescribed by the Oregon Health Authority under subsection (3) of this section, a hospital licensed under ORS 441.025 shall screen a patient for presumptive eligibility for financial assistance if the patient:

(a) Is uninsured;

(b) Is enrolled in the state medical assistance program; or

(c) Owes the hospital more than [*$500*] **$1,500 for a single hospital encounter**.

(3) The authority shall adopt by rule the process for screening a patient for presumptive eligibility for financial assistance under subsection (2) of this section. The rules and process must:

(a) Prohibit a hospital from requiring a patient to provide documentation or other verification;

(b) Ensure that the process will not cause any negative impact on the patient's credit score;

(c) Require a hospital, before sending a bill to the patient, to conduct the screening and apply any financial assistance for which the patient qualifies to the bill; and

(d) Require the hospital to notify a patient if the patient has been screened and to explain to the patient, in language approved by the authority, how to apply for financial assistance if financial assistance was denied, or how to apply for additional financial assistance above what the patient received.

(4) A patient may apply for financial assistance:

(b) The number of hours of attendant care services provided by parent providers and number of hours of attendant care services provided by nonparent caregivers;

(c) A comparison of the cost per child of providing attendant care services by parent providers under the program with the cost per child of providing attendant care services by nonparent caregivers; and

(d) A report on the adequacy of the direct care workforce in this state to provide services to all children with developmental disability services who are eligible for attendant care services.

DENTAL

SECTION 12. ORS 679.025 is amended to read:

679.025. (1) A person may not practice dentistry or purport to be a dentist without a valid license to practice dentistry issued by the Oregon Board of Dentistry.

(2) Subsection (1) of this section does not apply to:

(a) Dentists licensed in another state or country making a clinical presentation sponsored by a bona fide dental society or association or an accredited dental educational institution approved by the board.

(b) Bona fide full-time students of dentistry who, during the period of their enrollment and as a part of the course of study in an Oregon accredited dental education program, engage in clinical studies on the premises of such institution or in a clinical setting located off the premises of the institution if the facility, the instructional staff and the course of study to be pursued at the off-premises location meet minimum requirements prescribed by the rules of the board and the clinical study is performed under the indirect supervision of a member of the faculty.

(c) Bona fide full-time students of dentistry who, during the period of their enrollment and as a part of the course of study in a dental education program located outside of Oregon that is accredited by the Commission on Dental Accreditation of the American Dental Association or its successor [*agency*] **organization**, engage in community-based or clinical studies as an elective or required rotation in a clinical setting located in Oregon if the community-based or clinical studies meet minimum requirements prescribed by the rules of the board and are performed under the indirect supervision of a [*member of the faculty of the Oregon Health and Science University School of Dentistry*] **faculty member of a dental education program accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization**.

(d) Candidates who are preparing for a licensure examination to practice dentistry and whose application has been accepted by the board or its agent, if the clinical preparation is conducted in a clinic located on premises approved for that purpose by the board and if the procedures are limited to examination only. This exception shall exist for a period not to exceed two weeks immediately prior to a regularly scheduled licensure examination.

(e) Dentists practicing in the discharge of official duties as employees of the United States Government and any of its agencies.

(f) Instructors of dentistry, whether full- or part-time, while exclusively engaged in teaching activities and while employed in accredited dental educational institutions.

(g) Dentists who are employed by public health agencies and who are not engaged in the direct delivery of clinical dental services to patients.

(h) Persons licensed to practice medicine in the State of Oregon in the regular discharge of their duties.

(i) Persons qualified to perform services relating to general anesthesia or sedation under the direct supervision of a licensed dentist.

(j)(A) Dentists licensed in another country and in good standing, while practicing dentistry without compensation for no more than five consecutive days in any 12-month period, provided the dentist submits an application to the board at least 10 days before practicing dentistry under this subparagraph and the application is approved by the board.

(B) Dentists licensed in another state or United States territory and practicing in this state under ORS 676.347.

(k) Persons practicing dentistry upon themselves as the patient.

(L) Dental hygienists, dental assistants or dental technicians performing services under the supervision of a licensed dentist in accordance with the rules adopted by the board.

(m) A person licensed as a denturist under ORS 680.500 to 680.565 engaged in the practice of denture technology.

(n) An expanded practice dental hygienist who renders services authorized by a permit issued by the board pursuant to ORS 680.200.

SECTION 13. (1) The amendments to ORS 679.025 by section 12 of this 2026 Act become operative on January 1, 2027.

(2) The Oregon Board of Dentistry make take any action before the operative date specified in subsection (1) of this section that is necessary to enable the board to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the board by the amendments to ORS 679.025 by section 12 of this 2026 Act.

COMMERCIAL HEALTH INSURANCE

SECTION 14. Section 15 of this 2026 Act is added to and made a part of the Insurance Code.

SECTION 15. (1) A group or individual policy of casualty insurance or health insurance, including a health benefit plan as defined in ORS 743B.005, shall provide coverage for medically necessary anesthesia services, regardless of the duration, for any procedure covered by the policy.

(2) A policy described in subsection (1) of this section may not deny payment or reimbursement for anesthesia services solely because the duration of care exceeded a preset time limit.

SECTION 16. Section 15 of this 2026 Act applies to group or individual policies of casualty insurance or health insurance, including health benefit plans, that are issued, renewed or extended on or after January 1, 2027.

SECTION 17. Sections 18, 20 and 21 of this 2026 Act are added to and made a part of the Insurance Code.

SECTION 18. As used in ORS 743B.456 and sections 20 and 21 of this 2026 Act:

(1) "Dental insurance plan" means a policy or certificate of insurance or other contract that provides only a dental benefit.

(2) "Dental insurer" means an insurer that offers a policy or certificate of insurance or other contract that provides only a dental benefit.

(3) "Dental provider" means a person licensed, certified or otherwise permitted by laws of this state to administer dental services in the ordinary course of business or practice of a profession.

SECTION 19. ORS 743B.456 is amended to read:

743B.456. (1) As used in this section, [*"dental insurer" means an insurer that offers a policy or certificate of insurance or other contract, that provides only a dental benefit*] **"clean claim" means a claim that has no defect or error, is understandable and reasonably legible, includes required substantiating documentation and does not require special treatment that delays timely payment on the claim**.

(2) A dental insurer may pay a claim for reimbursement made by a dental care provider using a credit card or electronic funds transfer payment method that imposes on the provider a fee or similar charge to process the payment if:

(a) The dental insurer notifies the provider, in advance, of the potential fees or other charges associated with the use of the credit card or electronic funds transfer payment method;