



OREGON BOARD *of* DENTISTRY

NEWS

Vol. 28, No. 1

February 2013

PRESIDENTS' MESSAGES

by Patricia Parker, DMD
2012-2013



I ran into a little snag the other day. I realized my CPR card needed to be renewed. I have a nitrous oxide endorsement so I am required to have a current Health Care Provider BLS/CPR certification. It would only be a couple of weeks until I could get it renewed, that isn't so long. But then I would be in violation of the Dental Practice Act. That does not look so good, especially for the President of the Board of Dentistry.

Rather than take that chance, I contacted the staff at the Board and got advice on what to do. They are an incredible resource and always willing to help sort through all the rules and regulations. I found out that I could drop my nitrous endorsement and have my license reissued without it. Once I get re-certified I have one year to request the nitrous be put back on my license without any additional application or requirements. It was a simple fix for my dilemma.

Many of our disciplinary cases are the result of simple things like the example above. Remember: It is your license and your responsibility to keep it current and meet all requirements necessary to maintain it. If you are a dentist you are also

responsible to make certain your hygienist's license is current and that dental assistants are certified for any duty they are performing while in your employ.

You can find contact information and a copy of the Dental Practice Act (click on regulations) on our website: www.oregon.gov/dentistry

I put the address in "favorite links" on my computer for quick reference. If the answer to your question is not there, pick up the phone and call or email your question. I did that even before I was a Board member and always received a prompt and informative response. Sometimes it was not the answer I was hoping for but it was better than finding out I was violating a rule and suffering the consequences involved. ■

by Mary Davidson, MPH, RDH
Immediate Past President



Let us carry this scenario into the dental hygiene arena. If I was employed by Dr. Parker as a dental hygienist and held an active nitrous permit could I provide the use of nitrous for Dr. Parker's patient

if Dr. Parker's nitrous permit was dropped? No! Even though I hold a current nitrous endorsement the dentist who is providing treatment must hold a current Health Care Provider BLS/CPR level certification to allow my administration of nitrous oxide to their patient.

If the supervising dentist does not hold a nitrous oxide permit but has a current BLS/CPR certification then under her/his indirect supervision I may administer nitrous oxide to the patient the dentist is performing dental procedures on. Even if a dentist utilizes a physician anesthesiologist licensed by the Oregon Board of Medical Examiners, another Oregon licensed dentist holding an appropriate anesthesia permit, or a Certified Registered Nurse Anesthetist (CRNA) licensed by the Oregon Board of Nursing, the dentist providing patient treatment must have a current BLS/CPR certification to render treatment regardless of the credentials of the nitrous administrator.

WHAT'S INSIDE

Executive Director	2
Prescription Drug Monitoring.....	3-4
Disciplinary Actions.....	5-13
News	14
Farewell to Board Member	14
Proposed Rule Changes	15
License Renewal Notification	15

(continued on page 2)

2013

by Patrick D. Braatz, Executive Director



An odd numbered year means the start of another regular Oregon Legislative Session.

The 2013 Legislative Session began with a “bang” with the introduction of over 1,200 bills on the very first day of the Legislative Session.

As we all know not all of them will pass and some might never actually see the light of day.

The Oregon Board of Dentistry (OBD) does not have any specific legislative proposals that it has requested for the 2013 Legislative Session with the exception of the 2013-2015 Biennial Budget. The OBD Budget is pretty much a status quo budget as the OBD has not requested any fee increases and the Governor’s Balanced Budget actually reduces some of the OBD’s requests specifically in the area of dealing with PERS which all state agencies have been requested to reduce. The OBD has not raised fees since 2009.

A number of legislative bills have been introduced that will have an impact on all Health Care Professionals as well as many of the Health Care Licensing Boards in Oregon, the Dentistry Board as well. As a Licensee you should be very interested in those proposals.

One proposal would require Health Care Regulatory Boards to implement rules for requiring licensee to complete Cultural Competency Continuing Education Programs as a requirement for licensure starting in 2015 (HB 2611 and SB 530). There are more proposals, however, I do not have sufficient space to write about them here.

The OBD currently has a very large case load, over 170 cases are currently opened for investigation and that large volume is simply too large for the current OBD resources to sustain. Why so many cases? There are a number of reasons, one is that we have seen a dramatic increase in the complexity of cases; patients have not seen just one dentist, but as many as eight!!!! The review of all of those records increase the processing time of the investigation. Senior enforcement staff have earned maximum leave time plus they were burdened with 4 years of furlough days means a lot of lost investigative days. Finally,

the OBD has seen a rise in a number of complaints being encouraged to be filed by other licensees versus a licensee discussing the issue with the original treating licensee and trying to find a solution to the problem with the dental care.

One issue that seems to be on the rise is that dentists are allowing dental assistants to perform duties, which they have not been certified to do. Some of the rules have been in place for over 35 years and we have found licensees who have been violating these rules sometimes for as long as 20 years. This is a problem that needs to stop.

The Board continues to get telephone calls and emails on the “standard of care” regarding radiographs and I encourage you to go to our website www.oregon.gov/dentistry and review the information that we have placed on the site.

You will see in this newsletter that the OBD has once again begun to publish the names of licensees who have been disciplined by the OBD. The OBD used to do this but in 1988 stopped. The Board discussed this last summer and decided to return to publishing the names something that most other Health Care Regulatory Boards in Oregon do, as well as many dental boards throughout the United States.

I urge you to stay informed and to reach out to your Representatives and Senators to tell them your feelings on any proposed legislation that will affect the OBD as well as the Practice of Dentistry and Dental Hygiene.

Please feel free to contact me with your questions, concerns or comments at (971) 673-3200 or by e-mail Patrick.Braatz@state.or.us or by stopping by the OBD office in downtown Portland. ■

PRESIDENTS

(Continued from page 1)

As a dental hygienist with a nitrous permit employed by a dentist who does not have a current BLS/CPR certification I am allowed to administer nitrous oxide to the patient I provide care for under the aforementioned dentist’s indirect supervision.

As a side note, not only can one be recertified for BLS/CPR at many physical locations but Health Care Provider BLS/CPR level certification is available on-line. It is your responsibility to make sure the class taken fulfills the necessary requirements. I echo Dr. Parker’s thoughts and agree that if questions arise refer to the Oregon Board of Dentistry’s website, email or call the Oregon Board of Dentistry. We may want to remember Benjamin Franklin’s saying: “An ounce of prevention is worth a pound of cure.”

OREGON PRESCRIPTION DRUG MONITORING PROGRAM

by Stephen Prisby, Office Manager

At our recent December 14th Board Meeting, it was suggested to review the Prescription Drug Monitoring Program (PDMP) again with our constituents. Senate Bill 355 established the PDMP in Oregon with it going into effect in July 2009. Administrative Rules 410-121-4000 explain the purpose and operational processes of the PDMP in Oregon. There is a \$50 fee for Oregon Dental Licensees added to the total fees to be licensed to practice dentistry in Oregon. The fee is used to fund this program. Examples at the Board meeting were shared where the PDMP was effectively utilized to prevent prescription drug abuse and prevent dentists from over prescribing. The Board believes the PDMP is a great program and an excellent tool to for dentists to utilize in preventing prescription abuse and/or other illegal activity.

The Oregon Prescription Drug Monitoring Program (PDMP) is a tool to help healthcare providers and pharmacists provide patients better care in managing their prescriptions. It contains information provided by Oregon-licensed retail pharmacies.

Pharmacies submit prescription data to the PDMP system for all Schedules II, III and IV controlled substances dispensed to Oregon residents. The protected health information is

collected and stored securely.

Only Oregon-licensed healthcare providers and pharmacists may be authorized for an account to access information from the PDMP system. By law their access is limited to patients under their care.

The program was started to support the appropriate use of prescription drugs. The information is intended to help people work with their healthcare providers and pharmacists to determine what medications are best for them.

For more information, questions or concerns, browse the website, www.orpdmp.com, and Fact Sheet or email or call the PDMP staff.

What will the program do? Oregon's Prescription Drug Monitoring Program (PDMP) is a program developed to promote public health and welfare and help improve patient care. The information will aid healthcare providers and pharmacists to better manage patients' prescriptions to improve quality of care. It will also support the appropriate use of prescription drugs.

When will the Oregon PDMP system start? Data upload procedures began on June 1, 2011. This is when pharmacies were able to create accounts and begin submitting data. Healthcare providers and pharmacists can apply for accounts to access patient information from the PDMP website.

Why is my prescription data being collected? The data is being collected so that your provider can give you better health care.

Why was this program started? The number of deaths related to poisoning in Oregon has increased five-fold since 1990. This increase is mainly due to deaths associated with controlled substance prescription drugs. From 1999 - 2008, more than 1,300 Oregonians died from prescription drug poisonings. For these reasons, Oregon Senate Bill 355 established a PDMP in Oregon when the governor signed the bill into law in July, 2009.

What prescription information is collected? The information includes: the patient's name, address, and date of birth, pharmacy and prescriber

(continued on page 4)

BOARD MEMBERS

<p>Patricia Parker, DMD President <i>Hillsboro</i> Term expires 2014</p> <p>•</p> <p>Jonna Hongo, DMD Vice President <i>Portland</i> Term expires 2016</p> <p>•</p> <p>Darren Huddleston, DMD <i>Grants Pass</i> Term expires 2013</p> <p>•</p> <p>Jill Mason, MPH, RDH, EPP <i>Portland</i> Term expires 2013</p> <p>•</p> <p>Mary Davidson, MPH, RDH, EPP <i>Portland</i> Term expires 2014</p>	<p>Brandon Schwindt, DMD <i>Tigard</i> Term expires 2013</p> <p>•</p> <p>Alton Harvey, Sr. <i>Public Member, Beaverton</i> Term expires 2014</p> <p>•</p> <p>Norman Magnuson, DDS <i>Eugene</i> Term expires 2014</p> <p>•</p> <p>Julie Ann Smith, DDS, MD <i>Portland</i> Term expires 2015</p> <p>•</p> <p>Vacant Seat Public Board Member</p>
---	--

DRUG MONITORING (Continued from page 3)

information, and specific prescription information including the drug name and dosage, when it was prescribed, and when it was dispensed. This is only for prescriptions that are classified as controlled substances (Schedules II, III and IV).

Which drugs does the Oregon PDMP monitor? The Oregon PDMP collects data on Schedules II, III and IV controlled substances. For a list of these medications and more information, go to www.deadiversion.usdoj.gov/schedules/.

Will the program limit access to prescription drugs? No. The program is not intended to prevent people from obtaining needed drugs nor is it intended to prevent healthcare providers from prescribing needed drugs to their patients.

Who is required to report data to the Oregon PDMP? Pharmacies licensed with the Oregon Board of Pharmacy that dispense controlled substances in the state of Oregon, or to an address in the state, are required to electronically report prescription data. Neither hospital inpatient dispensing data nor data from veterinarians is collected.

Who can access information in the system? Healthcare providers can access the system, but only for information regarding their own patients. Pharmacists can access the system, but only for information regarding their own customers.

Are providers or pharmacists required to access the database? No. Prescribers and pharmacists are not required to use the system.

Will law enforcement be looking up my information? Law enforcement agencies will not have direct access to the system, but law enforcement officials may request information from the Oregon Health Authority if they have a valid court order based on probable cause for an authorized drug-related investigation of an individual.

Will the system be used to monitor my prescribing practices? No. Licensing boards may request information from the system, but only related to an investigation of a licensee related to licensure, renewal or disciplinary action.

Will my PDMP information be safe? The information being gathered is health information protected by Oregon law and is safeguarded in both its collection and distribution. Access to the database is limited to authenticated users who

agree to terms and conditions to assure the confidentiality of patient data. Reasonable efforts are made to keep your information private and secure.

Are providers permitted to share information? Yes. However, this is limited to a healthcare provider sharing information with another healthcare provider who is engaged in an individual patient's care.

What if I suspect system information is accessed or used inappropriately? Improper access or disclosure of information should be reported in writing to the Oregon Health Authority (OHA). The notification should include what information you suspect was inappropriately accessed or used, when and by whom, and why the action is considered inappropriate. OHA's Information Security Office will investigate the matter.

Can I get a copy of my own prescription information? Yes. To request a free copy of their report, a patient needs to fill out a record request form and mail it to the program along with a copy of a government-issued photo ID.

What if I find an error in a patient record? Errors should be reported to the program in writing. The notification should identify the error and any other relevant information. Staff will check to make sure it is not a system error. If it is a system error, the record will be corrected. If it is not a system error, the record will be flagged to indicate the error. Patients or healthcare providers then will need to request from the pharmacy that submitted the data to correct the error since the information was originated by the pharmacy.

Do other states have a similar program? Currently 42 states have laws that authorize the establishment and operation of a PDMP, and 34 of these states' programs are up and running.

Who is paying for the system? Healthcare providers and pharmacists are the ones paying for the system. OBD licensees pay a \$50 annual fee along with all of their other licensing fees. No general state funds are used. The rationale is that this will be a tool used by health care providers and pharmacists to help provide better patient care. ■

PDMP Information provided by and posted on Oregon Health Authority website at www.orpdmp.com

DISCIPLINARY ACTIONS TAKEN BETWEEN OCTOBER 1, 2011 AND DECEMBER 31, 2012

The following reports of Board actions have been edited for clarity and brevity. The actual documents may be viewed on the Board's website.

Unacceptable Patient Care ORS 679.140(1)(e)

Case #2010-0098 The Board issued a Notice of Proposed Disciplinary Action alleging that Teemu J. Scarborough, D.D.S., failed to document a dental justification for providing treatment and failed to document obtaining informed consent, seated 14 crowns with various defects, and failed to obtain periodontal probing depths. In a Consent Order, Dr. Scarborough agreed to make a restitution payment of \$24,050.00 to the patient and to complete at least 30 hours of hands-on continuing education in crown and bridge and at least three hours of continuing education in record keeping.

Case #2011-0012 The Board issued an Amended Notice of Proposed Disciplinary Action alleging that James W. Ridley, D.D.S., fabricated a lower complete denture that did not meet the minimum acceptable standards of construction. In a Consent Order, Dr. Ridley agreed to be reprimanded and to make a restitution payment of \$800.00 to the patient.

Case #2011-0103 The Board issued a Notice of Proposed Disciplinary Action alleging that Raymond L. Frye, D.M.D., allowed a person to expose patients to x-rays when that person was not certified by the Board to do so. In a Consent Order, Dr. Frye agreed to be reprimanded.

Case #2011-0090 The Board issued an Amended Notice of Proposed Disciplinary Action alleging that Jack G. Garvin, D.M.D., on numerous occasions, failed to document obtaining informed consent; failed to document a dental diagnosis and dental justification prior to providing treatment; failed to diagnose and document open margins on crowns that were seated; failed to diagnose and document a separated instrument that

occurred while performing endodontic therapy; provided nitrous oxide sedation without documenting the patient's vital signs and the amount of nitrous oxide administered; and initiated endodontic therapy in a tooth but failed to complete the endodontic treatment of the tooth before preparing the tooth for a crown, and then permanently cementing a new crown on the tooth. In a Consent Order, Dr. Garvin agreed to be reprimanded, to make a restitution payment of \$1,179.50 to the patient, to submit radiographs and treatment notes to the Board for all patients who receive endodontic therapy, and to retire his dental license at the time of the sale of his dental practice or by March 31, 2012, whichever was the earlier date.

Case #2011-0021 The Board issued an Amended Notice of Proposed Disciplinary Action alleging that Ruston R. Munk, D.M.D., billed the ODS companies for non-intravenous conscious sedation of a patient when he actually provided anxiolysis for the patient. In a Consent Order, Dr. Munk agreed to pay a \$1,000.00 civil penalty.

Case #2011-0132 The Board issued a Notice of Proposed Disciplinary Action alleging that Stephen E. Waldram, D.M.D., completed endodontic therapy in a tooth but failed to document in the patient records the taking of a final fill radiograph; completed endodontic therapy in a tooth but failed to document a separated instrument in the mesial canal of the tooth and the patient was not informed of the event; completed endodontic therapy in a tooth but failed to keep the working length and final fill radiographs with the patient records; completed endodontic therapy in a tooth, left a separated instrument in the mesial canal of the tooth, and then failed to refer the patient to an endodontist; failed to document a dental diagnosis of a separated instrument evident on radiographs that was present in the mesial canal of a tooth; and failed to document obtaining informed consent. In a Consent Order, Dr. Waldram agreed to be reprimanded.

(continued on page 6)

DISCIPLINARY ACTIONS (Continued from page 6)

Case #2010-0029 The Board issued a Notice of Proposed Disciplinary Action alleging that Nathan G. Dustin, D.M.D., failed to document the strength of epinephrine in the local anesthetics administered to a patient; failed to document obtaining informed consent; failed to document the name of, quantity of, and strength of local anesthetic administered to patient; failed to document a dental justification prior to restoring two teeth; and between January 1, 2010, and January 27, 2011, failed to install an amalgam separator. In a Consent Order, Dr. Dustin agreed to pay a \$1,000.00 civil penalty.

Case #2010-0177 and 2011-0057 The Board issued two Notices of Proposed Disciplinary Action alleging that Sharen Strong, D.M.D., on numerous patients, misrepresented the need for scaling and root planing when billing insurance companies and collecting fees from patients; on numerous patients, billed, collected fees for, and documented that she placed direct pulp caps, when there was no documentation of a pulpal exposures or justification for placing direct pulp caps on teeth; failed to document in the patient record that informed consent was obtained prior to providing nitrous oxide, and failed to document the patient's condition upon discharge; failed to document a diagnosis and dental justification for treatment planning and referring a patient for the extraction of a tooth; failed to document the name of the premedication a patient had taken prior to each appointment; failed to document the name of, quantity of, and strength of the medication that was prescribed for a patient; and collected fees for a future bridge, then prepared teeth #'s 2 and 4 for the bridge, but when the patient subsequently refused to have the completed bridge seated, the licensee refused to refund any portion of the fees for that bridge. In a Consent Order, Dr. Strong agreed to be reprimanded; to pay a \$10,000.00 civil penalty; to make restitution payments totaling \$3,093.50 to various patients; to make restitution payments totaling \$863.00 to various dental insurance companies; and to complete 10 hours of Board approved CE in ethics, six hours of Board approved CE in periodontics, and three hours of Board approved CE in record keeping.

Case #2010-0008 and 2010-0014 The Board issued two Notices of Proposed Disciplinary Action alleging that Rick A. Warf, D.M.D., failed to document a dental diagnosis of caries evident on radiographs on numerous teeth, in numerous patients; failed to document a dental justification prior to providing various treatments for numerous patients; failed to obturate and clean numerous canals in numerous teeth for numerous patients; failed to diagnose and document dental pathology evident on radiographs taken on numerous patients; failed to document treatment that was provided to various patients; failed to document the strength of dosages and amounts of medications that were prescribed; failed to document obtaining informed consent; utilized Nitrous Oxide Sedation but failed to document the patient's vital signs and the patient's condition upon discharge; failed to document a dental diagnosis of defective margins evident on radiographs of crowns and other restorations in various patients. In a Consent Order, Dr. Warf agreed to be reprimanded; to make a \$4,275.00 restitution payment to a patient; to complete 20 hours of Board approved CE in endodontics, of which 15 hours would be hands-on, 16 hours of Board approved CE in diagnosis and treatment planning and periodontics, and three hours of Board approved CE in record keeping; and to not provide root canal therapy treatment until the CE course in endodontics was completed.

Case #2011-0031 The Board issued a Notice of Proposed Disciplinary Action alleging that E. Eric Webster, D.D.S., while providing minimal sedation to a patient, failed to monitor the patient with pulse oximetry and failed to document the patient's condition upon discharge; and failed to confirm with the patient what medication the patient had taken immediately prior to the appointment. In a Consent Order, Dr. Webster agreed to be reprimanded.

Case #2010-0252 The Board issued a Notice of Proposed Disciplinary Action alleging that Robert D. Grew, D.M.D., allowed a dental hygienist to practice dental hygiene without an active license between October 1, 2008 and June 10, 2010. In a Consent Order, Dr. Grew agreed to pay a \$2,000.00 civil penalty.

(continued on page 7)

DISCIPLINARY ACTIONS (Continued from page 6)

Case #2010-0132 The Board issued an Amended Notice of Proposed Disciplinary Action alleging that Thomas N. Barrett, D.M.D., failed to document a description of the type of material used for filling the root canals in two teeth; failed to accurately document the date and description of all radiographs taken of a tooth; and filled the canal of a tooth 4-6 mm short of the apex. In a Consent Order, Dr. Barrett agreed to be reprimanded, to make a restitution payment of \$390.00 to a patient, to make a restitution payment of \$360.00 to a dental insurance company, and to pay a \$1,000.00 civil penalty.

Case #2012-0084 The Board issued a Notice of Proposed Disciplinary Action alleging that Brad S. King, D.M.D., allowed a dental assistant without certification to expose dental radiographs on patients between 1987 and 2011. In a Consent Order, Dr. King agreed to be reprimanded.

Case #2012-0056 The Board issued a Notice of Proposed Disciplinary Action alleging that Mark L. Harris, D.M.D., allowed a dental hygienist to practice dental hygiene without an active license on October 3, 2011. In a Consent Order, Dr. Harris agreed to be reprimanded and to pay a \$2,000.00 civil penalty.

Case #2012-0056 The Board issued a Notice of Proposed Disciplinary Action alleging that Stephen McLean, D.M.D., allowed a dental hygienist to practice dental hygiene without an active license on October 3, 2011. In a Consent Order, Dr. McLean agreed to be reprimanded and to pay a \$2,000.00 civil penalty.

Case #2012-0088, 2012-0122, and 2012-0127 The Board issued an Order of Immediate Emergency License Suspension to Bongmin An, D.D.S., on findings that Dr. An provided dental treatment to various patients but failed to maintain chart notes for any patient that was treated; when chart notes were requested to validate dental insurance claims, Dr. An fabricated chart notes; Dr. An obtained marijuana for his personal use and stored the marijuana in a freezer in his office; Dr. An

provided altered and incomplete records for patients in response to the Board's request for records; and Dr. An changed treatment dates on claims sent to dental insurance companies so that patients would receive benefits they were not entitled to receive. In a Consent Order, Dr. An subsequently agreed to resign his license to practice dentistry and to not seek future licensure from the Board.

Case #2010-0039 The Board issued a Notice of Proposed Disciplinary Action alleging that John D. Summer, D.D.S., failed to document and describe all radiographs taken and failed to document the teeth that were treated involving a bridge; failed to document the name quantity and strength of anesthetic used; failed to accurately document the results of periodontal exams; failed to seek a consultation with a patient's periodontist before providing treatment; failed to complete 17 of the 40 hours of required continuing education; and failed to install and maintain an amalgam separator between January 1, 2010, and July 29, 2011. In a Consent Order, Dr. Summer agreed to be reprimanded, to pay a \$2,000.00 civil penalty, and to complete three hours of Board approved CE in record keeping.

Case #2012-0066 The Board issued a Notice of Proposed Disciplinary Action alleging that Russell C. Teasdale, D.M.D., allowed a dental hygienist to practice dental hygiene without an active license for four days. In a Consent Order, Dr. Teasdale agreed to be reprimanded and to pay a \$2,000.00 civil penalty.

Case #2011-0055 The Board issued a Notice of Proposed Disciplinary Action alleging that Craig D. Johnson, D.D.S., failed to install and maintain an amalgam separator between January 1, 2010, and September 12, 2011. In a Consent Order, Dr. Johnson agreed to pay a \$1,000.00 civil penalty.

Case #2010-0145 The Board issued a Notice of Proposed Disciplinary Action alleging that Charles Q. Belusko, D.M.D., failed to document obtaining informed consent; failed to document a dental justification prior to restoring two teeth

(continued on page 8)

DISCIPLINARY ACTIONS (Continued from page 7)

and doing a pulpotomy; and failed to diagnose document the presence of retained roots following the extraction of a tooth. In a Consent Order, Dr. Belusko agreed to be reprimanded and to complete three hours of Board approved CE in record keeping.

Case #2012-0072 The Board issued a Notice of Proposed Disciplinary Action alleging that James E. Hodson, D.M.D., allowed a dental hygienist to practice dental hygiene without an active license for one day. In a Consent Order, Dr. Hodson agreed to pay a \$2,000.00 civil penalty.

Case #2011-0190 The Board issued a Notice of Proposed Disciplinary Action alleging that Keith R. Larson, D.M.D., failed to complete three hours of continuing education related to medical emergencies in a dental office; failed to follow infection control guidelines when he removed a syringe tip from the garbage and placed it in a patient's mouth; and failed to document obtaining informed consent. In a Consent Order, Dr. Larson agreed to be reprimanded and to pay a \$2,000.00 civil penalty.

Case #2011-0206 The Board issued a Notice of Proposed Disciplinary Action alleging that Paul M. Madden, D.M.D., initiated endodontic therapy in a tooth without first doing diagnostic testing. In a Consent Order, Dr. Madden agreed to be reprimanded and to make a restitution payment of \$1,130.00 to the patient.

Case #2011-0015 The Board issued a Notice of Proposed Disciplinary Action alleging that Dennis A. Burri, R.D.H., failed to document obtaining informed consent prior to providing treatment; while treating a patient utilizing Nitrous Oxide Sedation failed to document the patient's vital signs; while treating a patient utilizing Nitrous Oxide Sedation failed to document the patient's pre-treatment vital signs; while treating a patient, initiated or engaged in behavior that had sexual connotations, specifically, sexual relations. In a Consent Order, Mr. Burri agreed to be reprimanded and to complete three hours of

a Board approved continuing education course in record keeping and three hours of a Board approved continuing education course in boundary issues concerning relationships between medical providers and patients.

Case #2012-0090 The Board issued a Notice of Proposed Disciplinary Action alleging that Dennis T. Adair, D.M.D., failed to install and maintain an amalgam separator between January 1, 2010 and December 15, 2011; failed to document a patient's ASA status prior to inducing sedation for a patient; failed to document in the patient record a discharge entry following sedation of a patient; failed to maintain his Healthcare Provider CPR after May 14, 2010; and failed to obtain the required replacement ACLS certification until October 3, 2010. In a Consent Order, Dr. Adair agreed to be reprimanded, to complete three hours of a Board approved continuing education course in record keeping, and to pay a \$1,000.00 civil penalty.

Case #2012-0023 The Board issued a Notice of Proposed Disciplinary Action alleging that Bradley C. Oliver, D.M.D., performed an alveoplasty on the mandible of a patient that failed to remove adequate height of bone for subsequent implant placement; placed implants that were located too far buccally in the sites of teeth numbers 6, and 12, and too high vertically in the site of tooth number 28 on a patient; placed maxillary and mandibular dentures over implants that were inadequate to retain and support the dentures; relined the maxillary and mandibular dentures for a patient and placed them over implants that were inadequate to retain and support the dentures; and placed abutments on improperly located implants in sites of teeth numbers 6, 12, and 28. In a Consent Order, Dr. Oliver agreed to pay a \$2,500.00 civil penalty, to make a restitution payment of \$15,678.00 to the patient, and to complete 21 hours of Board approved continuing education in implantology, of which seven hours must be hands-on.

(continued on page 9)

DISCIPLINARY ACTIONS (Continued from page 9)

Case #2011-0114 The Board issued a Notice of Proposed Disciplinary Action alleging that David N. Carothers, D.D.S., failed to diagnose and document the presence of a large radiolucency in the periapical area of teeth #'s 2 and 3, although the patient's radiographs showed the presence of the radiolucency; and extracted teeth #'s 1, 16, 17, and 32 but failed to have current radiographs showing the periapical regions of the teeth that were extracted. In a Consent Order, Dr. Carothers agreed to be reprimanded, to pay a \$3,000.00 civil penalty, to complete four hours of Board approved continuing education in radiographic diagnosis and interpretation, and to make a restitution payment of \$2,000.00 to the patient.

Case #2011-0071 The Board issued a Notice of Proposed Disciplinary Action alleging that Dix C. Densley, D.D.S., induced Conscious Sedation without first obtaining a Conscious Sedation permit; induced Conscious Sedation without documenting the name, dosage, and amount of medication that the patient had taken; failed to document that the patient's vital signs were taken; failed to continuously monitor the patient utilizing pulse oximetry; failed to document the patient's condition upon discharge; failed to document the name of the responsible party to whom the patient was discharged; failed to document that impressions were taken for the fabrication of a night guard; and failed to document that four bitewing radiographs were taken. In a Consent Order, Dr. Densley agreed to be reprimanded and to pay a \$500.00 civil penalty.

Case #2011-0219 The Board issued a Notice of Proposed Disciplinary Action alleging that Lilia Herrera, D.D.S., failed to diagnose, document, and inform a patient that there was a recurrent carious lesion at the gingival margin of an existing restoration a carious lesion evident in radiographs that were taken; failed to diagnose, document, and inform a patient that there was an open gingival margin on the restoration previously placed at the distal of tooth #20, an open margin evident in radiographs that were taken; and permitted a dental assistant to seat a stainless steel temporary crown on a tooth, but failed to examine and approve the

crown prior to releasing the patient. In a Consent Order, Dr. Herrera agreed to be reprimanded and to pay a \$2,000.00 civil penalty.

Case #2011-0213 The Board issued a Notice of Proposed Disciplinary Action alleging that Kelly J. Blodgett, D.M.D., failed to diagnose, document, and inform a patient that there were carious lesions on the distal surface of tooth #6 and the mesial surface of tooth #31, carious lesions evident in radiographs that were taken; and between April 1, 2009 and March 31, 2011, failed to maintain complete records of the 40 hours of continuing education required during his licensing period. Dr. Blodgett failed to request a hearing in a timely manner, so, in a Final Default Order, Dr. Blodgett was reprimanded, ordered to pay a \$1,000.00 civil penalty, ordered to complete six hours of Board approved continuing education in orofacial radiology, and ordered to submit documentation verifying completion of 40 hours continuing education for the next two licensing periods.

Case #2012-0149 The Board issued a Notice of Proposed Disciplinary Action alleging that Peter Schwarzer, D.M.D., allowed a dental assistant without certification to expose dental radiographs on patients between December 2002 and January 2011. In a Consent Order, Dr. Schwarzer agreed to be reprimanded.

Case #2011-0186 The Board issued a Notice of Proposed Disciplinary Action alleging that Michael C. Hazel, D.M.D., seated a crown with open margins and failed to cover a patient with antibiotic premedication. In a Consent Order, Dr. Hazel agreed to be reprimanded and to make a \$772.00 restitution payment to the patient.

Case #2012-0133 The Board issued a Notice of Proposed Disciplinary Action alleging that Stephen E. Hull, D.M.D., allowed a dental hygienist to practice dental hygiene without an active license between October 1, 2010 and February 17, 2012. In a Consent Order, Dr. Hull agreed to be reprimanded and to pay a \$2,000.00 civil penalty.

(continued on page 10)

DISCIPLINARY ACTIONS (Continued from page 10)

Case #2012-0171 The Board issued a Notice of Proposed Disciplinary Action alleging that Bradford J. Rhodes, D.M.D., mechanically perforated into the furcation areas of two teeth while doing pulp-tomies in the teeth and then placed alloy restorations in the teeth that extended into the furcation areas of the teeth; failed to diagnose a large distal overhang on an existing restoration in a tooth evident in radiographs that were taken; while doing a pulpotomy in a tooth, placed an alloy restoration directly over the pulpal stumps of the tooth; and while doing a pulpotomy in a tooth, failed to completely remove pulpal tissue from the distal one half of the pulp chamber of the tooth. In a Consent Order, Dr. Rhodes agreed to be reprimanded, to pay a \$8,000.00 civil penalty, and to make a \$1,262.00 restitution payment to the patient.

Case #2010-0197 The Board issued a Notice of Proposed Disciplinary Action alleging that Neil M. Walle, D.D.S., permitted his assistants to place separators; permitted his assistant to expose dental radiographs without holding a current Certificate of Radiologic Proficiency; permitted his assistants to acid etch patients' teeth prior to placing brackets; and permitted his assistant to place an elastic chain on a patient. In a Consent Order, Dr. Walle agreed to be reprimanded and to complete two, pro bono, fully banded orthodontic cases, pre-approved by the Board, from referrals made by Advantage Smiles for Kids.

Case #2011-0117 The Board issued a Notice of Proposed Disciplinary Action alleging that Thomas M. Bell, D.D.S., allowed a dental hygienist to practice dental hygiene without an active license between October 1, 2010 and January 26, 2011. In a Consent Order, Dr. Bell agreed to be reprimanded and to pay a \$2,000.00 civil penalty.

Case #2011-0229 The Board issued a Notice of Proposed Disciplinary Action alleging that Ken W. Waddell, D.M.D., failed to document a diagnosis to justify preparing a tooth for a crown; failed to obtain written informed consent prior to the administration of minimal sedation to a patient; failed to document the prescribing or dispensing

of two tablets of Halcion 0.25mg that a patient had taken immediately prior to an appointment; and while holding a Deep Sedation anesthesia permit, failed to hold current Advanced Cardiac Life Support (ACLS) Certification. In a Consent Order, Dr. Waddell agreed to be reprimanded and to pay a \$5,000.00 civil penalty.

Case #2012-0113 The Board issued a Notice of Proposed Disciplinary Action alleging that Kris M. Blodgett, D.M.D., prior to performing extensive surgical procedures on a medically compromised patient, failed to seek a medical consultation for the patient. In a Consent Order, Dr. Blodgett agreed to be reprimanded and to make a \$2,738.00 restitution payment to the patient.

Case #2011-0068 The Board issued a Notice of Proposed Disciplinary Action alleging that Anne H. Dennehy, D.D.S., failed to document obtaining informed consent; failed to document a diagnosis and dental justification for doing pulp-tomies and extracting teeth; when administering moderate sedation to one patient, failed to obtain written informed consent for the sedation; and on two occasions, failed to document the name of the responsible party to whom the patient was released. In a Consent Order, Dr. Dennehy agreed to be reprimanded to complete three hours of Board approved continuing education in record keeping.

Case #2011-0078 The Board issued a Third Amended Notice of Proposed Disciplinary Action alleging that a Emine C. Loxley, D.M.D., immediately prior to allowing a dental assistant to dispense and administer to the patient 1.0 mg of Xanax, failed to obtain a medical history that would have disclosed all medications that the patient had taken that would have affected the level of sedation that was produced. In a Consent Order, Dr. Loxley agreed to be reprimanded and to pay a \$2,000.00 civil penalty.

Case #2012-0150 The Board issued a Notice of Proposed Disciplinary Action alleging that Peter Garcia, D.M.D., allowed a dental hygienist to practice dental hygiene without an active

(continued on page 11)

DISCIPLINARY ACTIONS (Continued from page 10)

license between October 1, 2010 and March 7, 2012. In a Consent Order, Dr. Garcia agreed to be reprimanded and to complete 50 hours of Board approved pro bono community service.

Case #2011-0013 and 2012-0117 The Board issued two Notices of Proposed Disciplinary Action alleging that Raymond L. Frye II, D.M.D., while treating multiple patients, failed to provide the Board with the complete records of the patients; failed to document a dental diagnosis to justify treatment provided to the patients; and failed to document all the treatment that was provided to the patients. In a Consent Order, Dr. Frye agreed to be reprimanded, to complete a Board approved three hour course in record keeping, and to pay a \$10,000.00 civil penalty.

Case #2011-0059 The Board issued a Notice of Proposed Disciplinary Action alleging that Richard W. Davenport, D.M.D., seated crowns with short or deficient margins on eight teeth. In a Consent Order, Dr. Davenport agreed to be reprimanded and to make a \$6,600.00 restitution payment to the patient.

Case #2012-0018 The Board issued a Notice of Proposed Disciplinary Action alleging that Roger C. Dow, D.M.D., failed to document obtaining informed consent; failed to document in the patient records a diagnosis to justify initiating of endodontic therapy in teeth and placing restorations in teeth; applied medication to the pulp of teeth, but failed to document the name of the medication that was applied; while utilizing Nitrous Oxide Sedation on a patient, failed to take and document the patient's vital signs and document the patient's condition upon discharge; failed to document a diagnosis of a short margin on the crown on a tooth and distal overhangs on the crown on a tooth although the patient's radiographs that were taken showed those deficiencies. In a Consent Order, Dr. Dow agreed to be reprimanded and to complete a Board approved three hour course in record keeping.

**Practicing Dentistry Without a License
ORS 679.020**

Case #2010-0216 The Board issued a Notice of Proposed Disciplinary Action alleging that Prashant Gagneja, B.D.S., practiced dentistry without a license between January 1, 2008 and December 31, 2009. In a Consent Order, Dr. Gagneja agreed to be reprimanded and if he ever applied for and subsequently received an Oregon dental license, he would provide 250 hours of pro-bono surgical treatment, defined as treatment requiring deep sedation or general anesthesia in an appropriate setting.

**Practicing Dental Hygiene Without a
License ORS 680.020**

Case #2012-0056 The Board issued an Amended Notice of Proposed Disciplinary Action alleging that Marisa D. Hunt, R.D.H., practiced dental hygiene without a license on October 3, 2009. In a Consent Order, Ms. Hunt agreed to be reprimanded and to pay a \$2,500.00 civil penalty.

Case #2012-0066 The Board issued a Notice of Proposed Disciplinary Action alleging that Jamie M. Smith, R.D.H., practiced dental hygiene without a license for four days. In a Consent Order, Ms. Smith agreed to be reprimanded and to pay a \$2,500.00 civil penalty.

Case #2012-0072 The Board issued a Notice of Proposed Disciplinary Action alleging that Janice L. Railton, R.D.H., practiced dental hygiene without a license for four days. In a Consent Order, Ms. Railton agreed to be reprimanded and to complete 40 hours of Board approved pro bono community service.

(continued on page 12)

DISCIPLINARY ACTIONS (Continued from page 12)

Case #2012-0133 The Board issued a Notice of Proposed Disciplinary Action alleging that Judy J. Hull, R.D.H., practiced dental hygiene without a license between October 1, 2010 and February 17, 2012. In a Consent Order, Ms. Hull agreed to be reprimanded and to pay a \$2,000.00 civil penalty, and the Board agreed to reinstate Ms. Hull's dental hygiene license following completion of her license application process.

Case #2012-0150 The Board issued a Notice of Proposed Disciplinary Action alleging that Alene Garcia, R.D.H., practiced dental hygiene without a license between October 1, 2010 and March 7, 2012. In a Consent Order, Ms. Garcia agreed to be reprimanded and to complete 50 hours of Board approved pro bono community service.

Unprofessional Conduct (Drug and/or Alcohol Abuse) ORS 679.140(2)(e)

Case #2009-0105 The Board issued an Order of Immediate Emergency License Suspension for Shelly R. Huser, R.D.H., based on the nature and history of Ms. Huser's alcohol abuse; false statements made in order to deceive the Board; violation of the terms of a Board Order for Examination, dated June 5, 2012; the diagnosis of alcohol dependence by a Board approved provider; Ms. Huser's continued denial of an alcohol problem; and the failure of Ms. Huser to enter a recommended treatment regimen.

Unprofessional Conduct ORS 679.140(1)(c)

Case #2011-0066 The Board issued a Notice of Proposed License Revocation alleging that Whitney S. Kang, D.D.S., failed to respond to the Board's request for information within 10 days of a written request. When Dr. Kang failed to request a hearing in a timely manner the Board issued a Default Order revoking Dr. Kang's dental license.

Case #2010-0059 The Board issued an Amended Notice of Proposed Disciplinary Action

alleging that Ralph K. Duffin, D.D.S., failed to respond to the Board's request for information within 10 days of a written request and failed to maintain the records and radiographs of a patient for at least seven years from the date of the last entry. When Dr. Duffin failed to request a hearing in a timely manner the Board issued a Default Order reprimanding Dr. Duffin and ordering Dr. Duffin to pay a \$5,000.00 civil penalty.

Case #2011-0147 The Board issued a Notice of Proposed Disciplinary Action alleging that Cynthia M. Grehn, R.D.H., failed to respond to the Board's requests for information within 10 days of written request. In a Consent Order, Ms. Grehn agreed to be reprimanded, to pay a \$1,000.00 civil penalty, to provide 40 hours of pro bono community service, and to submit documentation verifying completion of 24 hours continuing education for the next two licensing periods.

Violation of an Order Issued by the Board ORS 679.140(1)(d)

Case #2007-0150 The Board issued a Notice of Proposed License Suspension alleging that K. Donald Larson, D.M.D., failed to complete ordered continuing education and failed to respond to the Board's request for information within 10 days of a written request. In an Amended Consent Order, Dr. Larson agreed to be reprimanded.

Case #2010-0085 The Board issued a Second Amended Notice of Proposed License Suspension alleging that Rachele N. Stiffle, R.D.H., failed to submit documentation verifying completion of 30 hours of community service per a Consent Order, dated August 22, 2010, and failed to submit documentation verifying completion of 24 hours of continuing education for the licensure period October 1, 2009 to September 30, 2011, per a Consent Order, dated August 22, 2010. In an Amended Consent Order, the Second Amended Notice of Proposed License Suspension was withdrawn, and Ms. Stifle agreed to be reprimanded and to complete 10 hours of Board approved pro bono community service.

(continued on page 13)

DISCIPLINARY ACTIONS (Continued from page 13)

Case #2011-0087 and 2011-0156 The Board issued a Notice of Proposed License Suspension alleging that Paul K. Kami, D.M.D., failed to pay a \$5,000 civil penalty and failed to respond to written requests for information from the Board and then the Board issued an Amended Notice of Proposed License Suspension alleging that Paul K. Kami, D.M.D., practiced dentistry in violation of a Board Final Order, dated August 19, 2011, when his license to practice dentistry in Oregon was suspended. The Board filed a Motion for Summary Determination that was subsequently granted and the Board then revoked Dr. Kami's license to practice dentistry.

Prohibited Practices (Making False Written or Oral Statements) ORS 679.170(5)

Case #2010-0102 The Board issued an Amended Notice of Proposed Disciplinary Action alleging that Brook A. Derenzy, D.D.S., placed a misleading advertisement in two newspapers and made an untrue statement during an interview with an agent of the Board. In a Consent Order, Dr. Derenzy agreed to be reprimanded and to pay a \$1,000.00 civil penalty.

Case #2011-0188 The Board issued a Notice of Proposed Denial of Application for License Disciplinary Action alleging that Alexander S. Olea, D.D.S., in an application for licensure in Oregon, falsely claimed working the number of clinical hours needed to gain licensure in Oregon. In a Consent Order, Dr. Olea withdrew his application for licensure and agreed to not apply for an Oregon dental license at any time in the future.

Case #2012-0119 The Board issued a Notice of Proposed Disciplinary Action alleging that Jamsheed J. Shamloo, D.M.D., on his License and Permit Renewal Application for 2012-2014, failed to disclose that a \$25,500.00 settlement payment was made to a patient. Dr. Shamloo failed to request a hearing in a

timely manner, so in a Final Default Order, Dr. Shamloo was reprimanded and ordered to pay a \$5,000.00 civil penalty. ■

by Harvey Wayson, Investigator

38

On January 9, 2013, a pharmacist in a small Willamette Valley community called the Board to report a suspected drug seeker. The pharmacist had queried the State's **Prescription Drug Monitoring Program (PDMP)** and discovered the pharmacy customer had prescriptions written for controlled drugs by 38 dentists in the area. The prescriptions were filled by 17 different pharmacies.

50

If you are a dentist reading this, \$50 of your \$315 license renewal fee goes to support the State's **PDMP**. As a healthcare provider you finance this program and have access to the **PDMP** with respect to your own patients.

You may use the **PDMP** as a tool to assist in exposing drug seekers. It can also assist in managing your patients' care when you know of legitimate prescriptions ordered by another provider.

WWW.ORDMP.COM

In order to access the **PDMP**, you must establish a user account at the www.orpdmp.com website. Go there and click on "Healthcare Provider" to begin the process.

RADIOGRAPHS

The Standard of Care in Oregon requires that current radiographs are available prior to providing treatment to a patient. If a patient without a medical justification refuses to allow radiographs to be taken, even with the offer to sign a waiver, then providing treatment to that patient would violate the Standard of Care in Oregon.

BOARD STAFF

Patrick D. Braatz, *Executive Director*
Patrick.Braatz@state.or.us

Paul Kleinstub, DDS, MS
Dental Director and Chief Investigator
Paul.Kleinstub@state.or.us

Stephen Prisby, *Office Manager*
Stephen.Prisby@state.or.us

Teresa Haynes
Licensing and Examination Manager
Teresa.Haynes@state.or.us

Harvey Wayson, *Investigator*
Harvey.Wayson@state.or.us

Daryll Ross, *Investigator*
Daryll.Ross@state.or.us

Lisa Warwick, *Office Specialist*
Lisa.Warwick@state.or.us

The Board office is open from 7:30 a.m. to 4:00 p.m., Monday through Friday, except State and Federal holidays.
 Phone: 971-673-3200 Fax: 971-673-3202

FAREWELL TO BOARD MEMBER

We wish to extend a great big “Thank you” to David Smyth of Wallowa for his eight plus years of dedicated service to the Board of Dentistry and the citizens of Oregon. Mr. Smyth served on the Enforcement and Discipline Committee of the Board for numerous years and as Board President from 2007-2008.

Mr. Smyth’s common sense and practical knowledge will be missed by his fellow Board members and staff and we wish him well in his future endeavors. ■

SCHEDULED BOARD MEETINGS

2013

- April 19, 2013
- June 21, 2013
- August 16, 2013
- October 18, 2013
- December 20, 2013

PRACTICING WITHOUT AN ACTIVE LICENSE

The Oregon Board of Dentistry has recently developed a protocol that if a licensee fails to renew their license and continues to practice, they will be subject to disciplinary action by the Board. The Board feels that this is a very serious matter as all licensees are aware of the date that their license expires. Dental Licenses expire March 31 and Dental Hygiene Licenses expire September 30 of the respective years.

Dentists

Notices of Proposed Disciplinary Action will be issued and Consent Orders offering a Reprimand and \$5,000 Civil Penalty.

Dental Hygienists

Notices of Proposed Disciplinary Action will be issued and Consent Orders offering a Reprimand and \$2,500 Civil Penalty.

QUESTIONS? Call the Board office at 971-673-3200 or e-mail your questions to us at information@oregondentistry.org.

FAILING TO RELEASE PATIENT RECORDS

818-012-0030 Unprofessional

Conduct The Board finds that in addition to the conduct set forth in ORS 679.140(2), a licensee engages in unprofessional conduct if the licensee does or permits any person to:

- (9)(a) Fail to provide a patient or patient’s guardian within 14 days of written request:
 - (A) Legible copies of records; and
 - (B) Duplicates of study models and radiographs, photographs or legible copies thereof if the radiographs, photographs or study models have been paid for.

PROPOSED RULE CHANGES

At recent Board Meetings, the Board voted to send the following to a Rulemaking Hearing. The Board has tentatively scheduled the Rulemaking Hearing for April 18th. Due to space constraints in this newsletter, the rules that will be reviewed at the rule hearing are listed, and a brief description of the change is included.

More details and information will be available at: www.oregon.gov/dentistry/

818-001-0002 Definitions

Clarification of existing language added.

818-001-0087 Fees

Clarifying fee payments.

818-012-0005 Scope of Practice

Replace current rule, re-letter and clarify the use of Botulinum Toxin Type A.

818-026-0000 Purpose

Remove language.

818-026-0020 Presumption of Degree of Central Nervous System Depression

Clarification of permit language.

818-026-0060 Moderate Sedation Permit

Adding additional equipment requirement.

818-026-0065 Deep Sedation Permit

Delete words and add additional language.

818-026-0065(2)(h) & (7)(a) Deep Sedation Permit

Adding additional equipment requirement.

818-026-0070 General Anesthesia Permit

Adding additional equipment requirement.

818-035-0020 Authorization to Practice

Clarifies the duties a hygienist may perform.

818-035-0066 Additional Populations for Expanded Practice Dental Hygiene Permit Holders

Delete words and add an additional population for expanded practice dental hygiene permit holders.

818-035-0072 Restorative Functions of Dental Hygienists

Delete the word “anterior” from rule.

818-042-0090 Additional Functions of EFDAs

Allow hygienists to authorize EFDAs to apply sealants and soft relines.

818-042-0095 Restorative Functions of Dental Assistants

Delete the word “anterior” from rule.

818-042-0110 Certification – Expanded Functions Orthodontic Assistant

Clarification of on the job training requirement.



OREGON BOARD OF DENTISTRY DENTAL LICENSE RENEWAL NOTIFICATION

Renew Online:

To access your renewal online, use the link below and enter your last name, license number and the last four digits of your social security number.

Please go to www.oregon.gov/dentistry and select the renewal link.

If you have any questions, please contact the OBD at 971-673-3200.

Remember:

If your dental license (not dental hygiene) expires on March 31, 2013, and has not been renewed, then you cannot practice on April 1st.

OREGON BOARD OF DENTISTRY
1600 SW 4th Avenue, Suite 770
Portland, OR 97201-5519

IT'S THE LAW!

You must notify the OBD within 30 days of any change of address. An on-line Address Change Form is on the OBD's website at www.oregon.gov/dentistry. All address changes must be made in writing by fax, mail or e-mail.

Our Mission: *The mission of the Oregon Board of Dentistry is to protect the public by assuring that the citizens of Oregon receive the highest possible quality oral health care.*



Licensees are required to report any change of address within 30 days.

CHANGE OF ADDRESS FORM

Licensee Name: _____
Print Name Phone

Licensee Number: _____

New Mailing Address: _____

New Email Address: _____

Above is designated as my mailing address: Home Office Other

Mail or Fax to: OREGON BOARD OF DENTISTRY
1600 SW 4th Avenue, Suite 770
Portland, OR 97201-5519
Phone: (971) 673-3200
Fax: (971) 673-3202