PUBLIC PACKET

OREGON BOARD OF DENTISTRY

BOARD MEETING
MARCH 30, 2022

Oregon
Kate Brown, Governor

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

NOTICE OF REGULAR MEETING

PLACE: **VIRTUAL VIA ZOOM**

DATE: **March 30, 2022**

TIME: **5:00 p.m. – 7:30 p.m.**

Call to Order – Alicia Riedman, R.D.H., President **5:00 p.m.**

OPEN SESSION (Via Zoom)
https://us02web.zoom.us/j/84415824818?pwd=bHNQaTJWZ2hmNmpYQWJwNU0zNnFOUT09
Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 844 1582 4818 ● Passcode: 688541

Review Agenda

1. Approval of Minutes
   - February 25, 2022 Board Meeting Minutes

NEW BUSINESS

2. Committee and Liaison Reports
   - Anesthesia Committee Meeting, 3.18.2022 – Chair Reza Sharifi, DMD
     - o Dental Therapy Rule Recommendations from 3.18.22 Anesthesia Committee Meeting
   - Dental Therapy Rules Oversight Committee Meeting #5, 2.23.2022 – Chair Yadira Martinez, RDH
     - o Dental Therapy Rules Oversight Committee Meeting Minutes – Draft
   - Dental Therapy Rules Oversight Committee one-page overview

3. Executive Director's Report
   - Memo – Proposed Dental Therapy rulemaking steps and timeline
   - FIS for HB 2528 as bill was going through legislative process
   - Memo & Documentation to support initiating new Dental Therapy Fees
   - OBD Tribal Relationship & Cooperation Policy

4. Rules – Dental Therapy
   - Review and Consider Dental Therapy Application Rules - Comparison
   - Dental Therapy Education Program Definition – Staff Recommendation
   - Recommendation from Dental Therapy Rules Oversight Committee – Master Rules Document
   - Draft Collaborative Agreement
   - Draft Dental Therapy Licensure by Examination Application
   - Testing Agency information and dental therapy clinical examination overview
     - o CRDTS
     - o WREB-CDCA
   - NPAIHB OHA DPP#100 Extension request 2022

5. ORS 679 – updated with Dental Therapy Statutes

6. CODA Accreditation Standards for a dental therapy education program

7. Public Comment
   - Invitation to Tribal Communities to address dental therapy rules and other important issues

Notes:
(1) The meeting location is accessible to persons with disabilities. A request for an interpreter for the hearing impaired or for other accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.

- Open Comment Period – Anyone is welcome to address the Board as time permits

ADJOURN **7:30 p.m.**

Notes:
(1) A working lunch will be served for Board members at approximately 12:00 p.m.
(2) The meeting location is accessible to persons with disabilities. A request for an interpreter for the hearing impaired or for other accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.
(3) The Board may from time to time throughout the meeting enter into Executive Session to discuss matters on the agenda for any of the reasons specified in ORS 192.660. Prior to entering into Executive Session, the Board President will announce the nature of and authority for holding the Executive Session. No final action will be taken in Executive Session.

APPROVAL OF MINUTES

DRAFT 1

OREGON BOARD OF DENTISTRY
MINUTES
FEBRUARY 25, 2022

MEMBERS PRESENT:	Alicia Riedman, R.D.H., President Jose Javier, D.D.S., Vice President Reza Sharifi, D.M.D. Jennifer Brixey Sheena Kansal, D.D.S. Gary Underhill, D.M.D Yadira Martinez, R.D.H. Chip Dunn Aarati Kalluri, D.D.S.
STAFF PRESENT:	Stephen Prisby, Executive Director Winthrop "Bernie" Carter, D.D.S., Dental Director/ Chief Investigator Angela Smorra, D.M.D., Dental Investigator Haley Robinson, Office Manager (portion of meeting) Shane Rubio, Investigator (portion of meeting) Samantha VandeBerg, Examination and Licensing Manager (portion of meeting) Ingrid Nye, Investigator (portion of the meeting) Kathleen McNeal, Office Specialist
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT VIA TELECONFERENCE*:	Jen Lewis-Goff, Oregon Dental Association (ODA); Mary Harrison, Oregon Dental Assistants Association (ODAA); Teresa Haynes, Barry Taylor, D.M.D., Richael Cober – CRDTS, Jennifer Coyne, Alicia Michelson, Lisa Kihs, Matthew Sinnott, Kari Kuntzelman

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

Call to Order: The meeting was called to order by the President at 8:00 a.m. at the Board office; 1500 SW 1st Ave., Suite 770, Portland, Oregon.

President Alicia Riedman, R.D.H., welcomed everyone to the meeting and had the Board Members, Lori Lindley, and Stephen Prisby introduce themselves.

NEW BUSINESS

Approval of Minutes

Ms. Martinez moved and Dr. Javier seconded that the Board approve the minutes from the December 17, 2021 Board Meeting as presented. The motion passed unanimously.

ASSOCIATION REPORTS

Oregon Dental Association (ODA)
Ms. Lewis-Goff reported that the Oregon Dental Conference would be held April 7-9, 2022. The conference would be hybrid, with some courses online and some in-person. She encouraged dental professionals to register for the conference. Ms. Lewis-Goff outlined ways the ODA was involved in the 2022 legislative session surrounding dental benefits for veterans and addressing the dental assisting shortage.

Oregon Dental Hygienists' Association (ODHA)
Nothing to report

Oregon Dental Assistants Association (ODAA)
Ms. Harrison reported that the ODAA was working with the ODA in regard to the shortage of dental assistants and were excited to hear about potential scholarships. ODAA established a Mary Jenkins grant scholarship fund for dental assistants looking to enter the profession. Mary Jenkins, an active ODAA member, passed away and her family donated money to create the scholarship program.

COMMITTEE AND LIAISON REPORTS

Dental Therapy Rules Oversight Committee Report
Ms. Martinez reported that the meeting was held on February 23, 2022 and that a future meeting was not scheduled. The meeting materials could be found on the website.

ADEX Liaison Report
Nothing to report

CDCA–WREB Report
CDCA-WREB Annual Meeting was held virtually on January 6-7, 2022. The CDCA-WREB merger will be complete in August 2022. In 2023, CDCA-WREB-CITA will universally administer ADEX Dental and Dental Hygiene examinations simplifying licensure examination standards and processes for candidates and dental boards nationally for the oral health professions. This means that every dental school in the US will be offering the ADEX dental licensure examination in 2023, as well as candidates in Canada, Puerto Rico, Jamaica, and Mexico.

Discussion on CRDTS Dental Therapy Exam
The Board discussed Dental Therapy exam requirements. Richael 'Shellie' Cobler from CRDTS stated the CRDTS designed the Dental Therapy exam specifically for Oregon and it could be modified as the Board sees fit. Jen Lewis-Goff from the ODA added comments. Executive Director Prisby scheduled a special Board meeting for March 30, 2022 to focus on Dental Therapy.

EXECUTIVE DIRECTOR'S REPORT

Board and Staff Updates
Most OBD Staff were acclimated to a Hybrid Work Model effective February 1, 2022. The flexible work schedule was adopted by six staff members and they seemed to enjoy the

flexibility of it. They worked two days remotely and three days on-site at the downtown Portland Office.

OBD Budget Status Report
Mr. Prisby presented the latest budget report. This report, which was from July 1, 2021 through December 31, 2021, showed revenue of $907,046.64 and expenditures of $810,854.32.

Customer Service Survey
Mr. Prisby presented the legislatively mandated survey results from July 1, 2021 – January 31, 2022. The results of the survey showed that the OBD continued to receive positive ratings from the majority of those that submitted a survey.

Board and Staff Speaking Engagements
Ingrid Nye and Samantha Vanderberg gave a licensee application Zoom presentation to the graduating students for OIT Klamath Falls and Salem classes on February 4, 2022.

Mr. Prisby reported that OBD Staff would be presenting at the ODA's Oregon Dental Conference in early April. One presentation would be virtual and one in-person. All details could be found on the ODA's website. Mr. Prisby appreciated the invitation and opportunity to provide information and updates at the well attended forum.

2022 Dental License Renewal
The dental license renewal was progressing and would conclude March 31, 2022. Mr. Prisby reminded everyone that audits would be conducted after the renewal closes this year for both dentists and dental hygienists (this fall) renewing their licenses. The Board adopted a new audit scheme to monitor CE compliance, safe practices and also to align staff resources with work load.

License Statistics
Mr. Prisby included a snapshot of licensee data as of January 1, 2022.The initial preparation for the 2023 -2025 OBD Budget would start in March 2022. Licensee data would be used to help make revenue projections, estimates and plans for the next 2- year budget.

OBD Strategic Planning
Mr. Prisby reported that the Board would review the final draft of the OBD's 2022 – 2025 Strategic Plan at the February 25, 2022 Board Meeting. He thanked Board Members, staff and the OBD attorney for their work and on the important endeavor. The feedback from OBD Licensees and others helped inform the Board on the strategic priorities outlined in the new plan which was included in Tab 7 of the meeting packet.

2022 Legislative Session
The short session began Feb 1 and Mr. Prisby could not run longer than 35 days. He attached a report on legislation he was tracking on behalf of the OBD.

Affirmative Action Representative Meeting

Mr. Prisby attended the December Affirmative Action Representative Meeting on behalf of the OBD. The Affirmative Action Office had some staff turnover and transitions, but was now back on track. These meetings would be scheduled every other month going forward.

Council of State Governments - Dental Compact Dec 2021 Meetings
The Council provided some excellent information and resources to give an overview of the work they were undertaking.

AADA & AADB 2022 Mid-Year Meetings
Mr. Prisby reported that both the American Association of Dental Administrators (AADA) and the American Association of Dental Boards (AADB) mid-year meetings would be held virtually. The AADA's would be on April 7. The AADB's would be on April 8 & 9.

Newsletter
Mr. Prisby announced that the OBD published a December 2021 Newsletter which could be accessed with past newsletters on the OBD website. OBD staff intended to publish a summer OBD Newsletter capturing the 2022 legislative session bills impacting the OBD, dental therapy information, new Board member biographies and other fun facts.

UNFINISHED BUSINESS AND RULES
Ms. Martinez moved and Dr. Sharifi seconded that the Board approve the December 8, 2021 DTRO recommendation and move discussion to the March 18, 2022 Anesthesia Committee for further review. The motion passed unanimously.

COORESPONDENCE
Ms. Martinez moved and Mr. Dunn seconded that the Board approve the American Board of Oral Medicine Specialty Examination for Limited Specialty License. The motion passed unanimously.

OTHER ISSUES

Request for Board Approval of OBD 2022-2025 Strategic Plan
Ms. Martinez moved and Ms. Brixey seconded that the Board approve the OBD 2022-2025 Strategic Plan. The motion passed unanimously.

Request for Board Approval of OBD Tribal Relationship and Cooperation Policy
Ms Brixey moved and Ms. Martinez seconded that the Board approve the OBD Tribal Relationship and Cooperation Policy with an amendment to strike UIHP in favor of IHS. The motion passed unanimously.

EXECUTIVE SESSION: The Board entered into Executive Session pursuant to ORS 192.606 (1)(2)(f), (h) and (L); ORS 676.165; ORS 676.175 (1), and ORS 679.320 to review records exempt from public disclosure, to review confidential investigatory materials and investigatory information, and to consult with counsel

OPEN SESSION: The Board returned to Open Session at 12:55 p.m.

CONSENT AGENDA
2022-0073, 2022-0078, 2022-0083, 2022-0087, 2022-0071, 2022-0062, 2022-0063, 2022-0031

Dr. Javier moved and Mr. Dunn seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed unanimously.

COMPLETED CASES

2022-0060, 2022-0003, 2022-0050, 2022-0074, 2021-0092, 2022-0054, 2022-0066, 2021-0149, 2022-0061, 2022-0052, 2022-0081

Dr. Javier moved and Ms. Martinez seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed unanimously.

2022-0056
Ms. Martinez moved and Dr. Javier seconded that the board move to issue Respondent #1 a strongly worded Letter of Concern reminding licensee to ensure that she does not allow individuals to perform duties they are not licensed to perform and for Respondent #2, move to issue the licensee a strongly worded Letter of Concern reminding licensee to renew her license in a timely manner, to refrain from practicing dental hygiene if her license is not active, to complete at least one additional hour of CE related to infection control to address the hour she missed in the 2019 renewal cycle, and to complete all the required CE for each renewal cycle. The motion passed with Ms. Riedman, Ms. Martinez, Dr. Sharifi, Dr. Kansal, Dr. Javier, Mr. Dunn, Dr. Underhill and Dr. Kalluri voting aye. Ms. Brixey recused.

2021-0182
Mr. Dunn moved and Dr. Javier seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that she 1) conducts weekly biological testing of sterilization devices, and 2) engage all referring Licensees to continually improve the processes of effective and timely professional communication, preferably in written form, to minimize any “dental misadventures” during treatment procedures performed for patients between the specialty and referring offices. The motion passed unanimously.

CHADWICK, DOUGLAS A., D.D.S.; 2022-0015
Ms. Brixey moved and Dr. Sharifi seconded that the Board move to issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a $6000 civil penalty, two hours of Board approved continuing education in the area of infection control within six months, and monthly submission of spore testing results for a period of one year from the effective date of the Order. The motion passed unanimously.

COOMBS, CALEB VERNON, D.M.D.; 2021-0162
Dr. Sharifi moved and Mr. Dunn seconded that the Board move to issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order Incorporating a reprimand. The motion passed unanimously.

HAYMORE, THOMAS L., D.M.D.; 2021-0109 and 2021-0176
Dr. Kalluri moved and Dr. Sharifi seconded that the Board move to combine with case 2021-0176 and issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order to incorporate a reprimand, a $5,000.00 civil penalty, unconditionally pass the PROBE: Ethics and

Boundaries Course and agree to not practice dentistry on any coworkers at Licensees place of employment. The motion passed unanimously.

HORACEK, RICHARD S., D.D.S.; 2021-0122
Dr. Kansal moved and Dr. Underhill seconded that the Board move to issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, prohibit Licensee from the placement of endosseous implants without direct supervision of an OAGD Board approved mentor until further order of the Board, a $2500.00 civil penalty to be paid within 3 months, completion of 8 hours of Board approved CE related to dental occlusion within 4 months, and completion of 24 hours of Board approved hands on CE related to planning, appropriate case selection, potential complications, and the surgical placement of dental implants to be completed within 12 months. The motion passed unanimously.

2022-0034
Dr. Underhill moved and Ms. Martinez seconded that the Board move to close the case with a Letter of Concern reminding licensee to assure all staff follow proper infection control protocols and autoclaves are tested with a biological monitoring system on a weekly basis. The motion passed unanimously.

2022-0193
Ms. Martinez moved and Dr. Javier seconded that the Board move to close the case with a Letter of Concern reminding Licensee to assure he (1) utilize best practices to minimize extrusion of endodontic irrigation materials, sealers, and other materials into the peri-radicular tissue during endodontic treatment, and (2) perform weekly biological monitoring of sterilizers. The motion passed unanimously.

2022-0038
Mr. Dunn moved and Dr. Javier seconded the Board move to close the matter with a Letter of Concern reminding Licensee to assure that biological testing is conducted on a weekly basis. The motion passed unanimously.

2021-0192
Ms. Brixey moved and Ms. Maritinez seconded that the Board move to close the matter with a Letter of Concern reminding Licensee to assure periapical radiographic findings are documented and diagnosed in the patient record. The motion passed unanimously.

2022-0042
Dr. Kalluri moved and Dr. Javier seconded that the Board move to close the matter with a Letter of Concern reminding Licensee to assure that all CE completion certificates are maintained for a period of four years. The motion passed unanimously.

2021-0080
Dr. Sharifi moved and Ms. Martinez seconded that the Board move to close the matter with a Letter of Concern reminding Licensee to assure that the proper tooth is identified prior to treatment. The motion passed unanimously.

2022-0012
Dr. Kansal moved and Dr. Javier seconded that the Board move to close the matter with a Letter of Concern reminding Licensee to assure that he makes timely referral of all patients exhibiting post-surgical tooth extraction paresthesia to an oral surgeon or appropriate medical provider. The motion passed unanimously.

2022-0004
Dr. Sharifi moved and Dr. Javier seconded that the Board move to close the matter with a Letter of Concern reminding Licensee to assure that he documents his radiographic images as required by the Dental Practice Act, and documents his administration of local anesthetics as required by the Dental Practice Act. Additionally, Licensee is reminded to assure that he conducts weekly biological testing of sterilization devices. The motion passed unanimously.

PREVIOUS CASES REQUIRING BOARD ACTION

WENDY L BEDNARIK, R.H.D., 2022-0035
Dr. Underhill moved and Dr. Javier seconded that the Board move to accept Licensee's proposal and issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action and close the matter with a Letter of Concern reminding Licensee to assure that a valid Healthcare Provider BLS/CPR certification is maintained while licensed. The motion passed unanimously.

RICHARD PAO-YUAN HSU, D.M.D., 2020-0033
Ms. Martinez moved and Dr. Javier seconded that the Board accept Licensee's request and offer Licensee an Amended Consent Order removing stipulation #4(e),and allowing Licensee to apply for a DEA registration. Licensee will be restricted to sedation in a hospital setting and will be required to use a qualified provider for twelve months from the date of DEA registration issuance. The motion passed unanimously.

JUDD R. LARSEN, D.D.S., 2021-0125
Mr. Dunn moved and Dr. Javier seconded a move that the Board deny licensees request and affirm the prior Board action. The motion passed unanimously.

LICENSE & EXAMINATION ISSUES

Request for Non-Resident Permit - Ehfad Shah, DMD
Ms Brixey moved and Ms. Martinez seconded that the Board approve the non-resident permit. The motion passed unanimously.

Request for Non-Resident Permit – Farah Divanbeigi, D.D.S.
Dr. Sharifi moved and Dr. Javier seconded that the Board approve the non-resident permit limited to the Comprehensive Training in Parenteral IV Sedation Course. The motion passed unanimously.

RATIFICATION OF LICENSES

Dr. Kalluri moved and Dr. Underhill seconded that the Board ratify the licenses presented in tab 16. The motion passed unanimously.

Request for Approval of Soft Relines Course - Lindsay Chronicle
Dr. Kansal moved and Dr. Javier seconded that the Board ratify the course presented. The motion passed unanimously.

Request for Approval of Soft Relines Course – Trina Lepper
Dr. Underhill moved and Ms. Martinez seconded that the Board ratify the course presented. The motion passed unanimously.

Dr. Javier moved and Dr. Underhill seconded a move to direct staff to issue Dr. Chandra a letter stating that he does not meet the requirements for faculty licensure as stated in ORS.679, and to reiterate that the Board does not have the authority to waive the requirements that are sent in statue by the Oregon Legislature

ADJOURNMENT

The meeting was adjourned at 2:15 p.m. Ms. Riedman stated that the next Board Meeting would take place on April 22, 2022.

_____
Alicia Riedman, R.D.H.
President

COMMITTEE REPORTS

Oregon Board of Dentistry
Anesthesia Committee Meeting
Held as a Zoom Meeting

Minutes
March 18, 2022

MEMBERS PRESENT:	Reza Sharifi, D.M.D., Chair Sheena Kansal, D.D.S. Julie Ann Smith, D.D.S., M.D., M.C.R. Mark Mutschler, D.D.S. Michael Doherty, D.D.S. Brandon Schwindt, D.M.D. Normund Auzins, D.M.D. Eric Downey, D.D.S. Ryan Allred, D.M.D.
STAFF PRESENT:	Stephen Prisby, Executive Director Bernie Carter, D.D.S., Dental Director/Chief Investigator Angela Smorra, D.M.D., Dental Investigator Ingrid Nye, Investigator Haley Robinson, Office Manager
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT:	Jen Lewis-Goff – Oregon Dental Association, Emily Coates, Thomas Kolodge, D.D.S., Carolyn Muckerheide, Philip Mann, D.D.S.

Call to Order: The meeting was called to order by Dr. Sharifi at 3:45 p.m.

MINUTES
Dr. Smith moved and Dr. Doherty seconded that the minutes of the November 28, 2018 Anesthesia Committee meeting be approved as amended with the minor corrections noted by staff. The motion passed unanimously.

Dr. Schwindt and Dr. Mutschler joined the meeting

CORRESPONDENCE

Review OBD January 2019 Anesthesia Survey
The committee reviewed and discussed results from the anesthesia survey the Board conducted in 2019.

OAR 818-026-0010 – Definitions
Dr. Allred moved and Dr. Kansal seconded that the Committee recommend that the Board send OAR 818-026-0010 to the Rules Oversight Committee as amended. The motion passed unanimously.

818-026-0010
Definitions
As used in these rules:
(1) "Anesthesia Monitor" means a person trained in monitoring patients under sedation and capable of assisting with procedures, problems and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.
(2) "Anxiolysis" means the diminution or elimination of anxiety.
(3) “General Anesthesia” means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
(4) “Deep Sedation” means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
(5) “Moderate Sedation” means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
(6) “Minimal Sedation” means minimally depressed level of consciousness, produced by non-intravenous **and/or non-intramuscular** pharmacological methods, that retains the patient’s ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous **and/or non-intramuscular** pharmacological method is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single non-intravenous **and/or non-intramuscular** pharmacological method in minimal sedation.
(7) “Nitrous Oxide Sedation” means an induced, controlled state of minimal sedation, produced solely by the inhalation of a combination of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.
(8) “Maximum recommended dose” (MRD) means maximum Food and Drug Administration (FDA) recommended dose of a drug, as printed in FDA approved labeling for unmonitored use.
(9) “Incremental Dosing” means during minimal sedation, administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).
(10) “Supplemental Dosing” means during minimal sedation, supplemental dosing is a single additional dose of the initial drug that is necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.
(11) “Enteral Route” means administration of medication via the gastrointestinal tract. Administration by mouth, sublingual (dissolving under the tongue), intranasal and rectal administration are included.
(12) “Parenteral Route” means administration of medication via a route other than enteral. Administration by intravenous, intramuscular, and subcutaneous routes are included.
(13) American Society of Anesthesiologists (ASA) Patient Physical Status Classification System.
(a) ASA I “A normal healthy patient”.
(b) ASA II “A patient with mild systemic disease”.
(c) ASA III “A patient with severe systemic disease”.
(d) ASA IV “A patient with severe systemic disease that is a constant threat to life”.
(e) ASA V “A moribund patient who is not expected to survive without the operation”.
(f) ASA VI “A declared brain-dead patient whose organs are being removed for donor purposes".

(14) "Recovery" means the patient is easily arousable and can independently and continuously maintain their airway with stable vital signs. Once this has occurred, the patient can be monitored by a qualified anesthesia monitor until discharge criteria is met.

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

Dr. Smith moved and Dr. Allred seconded that the Committee recommend that the Board keep OAR 818-026-0020 as presented, not allowing more than one person to be under nitrous oxide sedation at the same time, and to add "under Nitrous Oxide" to 818-026-0050(4) for clarification. The motion passed unanimously.

818-026-0020
Presumption of Degree of Central Nervous System Depression
(1) In any hearing where a question exists as to the degree of central nervous system depression a licensee has induced (i.e., general anesthesia, deep sedation, moderate sedation, minimal sedation or nitrous oxide sedation), the Board may base its findings on, among other things, the types, dosages and routes of administration of drugs administered to the patient and what result can reasonably be expected from those drugs in those dosages and routes administered in a patient of that physical and psychological status.
(2) The following drugs are conclusively presumed to produce general anesthesia and may only be used by a licensee holding a General Anesthesia Permit:
(a) Ultra short acting barbiturates including, but not limited to, sodium methohexital, thiopental, thiamylal;
(b) Alkylphenols — propofol (Diprivan) including precursors or derivatives;
(c) Neuroleptic agents;
(d) Dissociative agents — ketamine;
(e) Etomidate; and
(f) Volatile inhalational agents.
(3) No permit holder shall have more than one person under any form of sedation or general anesthesia at the same time exclusive of recovery.
(4) 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.
(5) A licensee must ensure a written emergency response protocol is in place for all patients undergoing nitrous oxide, minimal sedation, moderate sedation, deep sedation or general anesthesia.

OAR 818-026-0050 – Minimal Sedation Permit

Dr. Smith moved and Dr. Allred seconded that the Committee recommend that the Board send OAR 818-026-0050 to the Rules Oversight Committee as amended. The motion passed unanimously.

818-026-0050
Minimal Sedation Permit
Minimal sedation and nitrous oxide sedation.
(1) The Board shall issue a Minimal Sedation Permit to an applicant who:
(a) Is a licensed dentist in Oregon;
(b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and
(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the current ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or

(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.
(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:
(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;
(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;
(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;
(g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff; and
(h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants.
(3) Before inducing minimal sedation, a dentist permit holder who induces minimal sedation shall:
(a) Evaluate the patient and document, using the American Society of Anesthesiologists (ASA) Patient Physical Status Classifications, that the patient is an appropriate candidate for minimal sedation;
(b) Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;
(c) Certify that the patient is an appropriate candidate for minimal sedation; and
(d) Obtain written informed consent from the patient or patient's guardian for the anesthesia. The obtaining of the informed consent shall be documented in the patient's record.
(4) No permit holder shall have more than one person under minimal sedation **or nitrous oxide sedation** at the same time.
(5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be present in the room in addition to the treatment provider. The anesthesia monitor may be the dental assistant. After training, a dental assistant, when directed by a dentist permit holder, may administer oral sedative agents or anxiolysis agents calculated and dispensed by a dentist permit holder under the direct supervision of a dentist permit holder.
(6) A patient under minimal sedation shall be visually monitored at all times, including recovery phase. The record must include documentation of all medications administered with dosages, time intervals and route of administration. The dentist permit holder or anesthesia monitor shall monitor and record the patient's condition.
(7) Persons serving as anesthesia monitors for minimal sedation in a dental office shall maintain current certification in BLS for Healthcare Providers Basic Life Support (BLS)/Cardio Pulmonary Resuscitation (CPR) training, 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.

OAR 818-026-0055 – Dental Hygiene, Dental Therapy, and Dental Assistant Procedures Performed Under Nitrous Oxide or Minimal Sedation

Dr. Mutschler moved and Dr. Schwindt seconded that the Committee send OAR 818-026-0055 to the March 30, 2022 Board Meeting for discussion as presented. The motion passed unanimously.

818-026-0055
Dental Hygiene, Dental Therapy and Dental Assistant Procedures Performed Under Nitrous Oxide or Minimal Sedation
(1) Under indirect supervision, dental hygiene procedures may be performed for a patient who is under nitrous oxide or minimal sedation under the following conditions:
(a) A licensee holding a Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; or
(c) If a dental hygienist with a nitrous oxide permit administers nitrous oxide sedation to a patient and then performs authorized procedures on the patient, an anesthesia monitor is not required to be

present during the time the patient is sedated unless the permit holder leaves the patient.
(d) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with ~~818-026-0050(7) and (8)~~ **Board rules.**
(2) Under indirect supervision, a dental assistant may perform those procedures for which the dental assistant holds the appropriate certification for a patient who is under nitrous oxide or minimal sedation under the following conditions:
(a) A licensee holding the Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; and
(c) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with ~~818-026-0050(7) and (8)~~ **Board rules.**
(3) Under indirect supervision, a dental therapist may perform procedures for which they hold the appropriate license for a patient who is under nitrous oxide or minimal sedation under the following conditions:
(a) A licensee holding the Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; and
(c) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with Board rules.

Correspondence from Dr. Leslee Huggins, D.D.S.
Dr. Huggins submitted a letter to the committee in regards to the current requirements for obtaining a Moderate Sedation Permit.

Correspondence from Oregon Society of Anesthesiologists
The committee reviewed testimony submitted by the Oregon Society of Anesthesiologists regarding rule changes to OAR 818-026-0065 – Deep Sedation and 818-026-0070 – General Anesthesia effective 1/1/2020.

Correspondence from American Society of Anesthesiologists
The committee reviewed testimony submitted by the American Society of Anesthesiologists regarding rule changes to OAR 818-026-0065 – Deep Sedation and 818-026-0070 – General Anesthesia effective 1/1/2020.

Correspondence from Oregon Society of Oral & Maxillofacial Surgeons
The committee reviewed testimony submitted by the Oregon Society of Oral & Maxillofacial Surgeons regarding rule changes to OAR 818-026-0065 – Deep Sedation and 818-026-0070 – General Anesthesia effective 1/1/2020.

Federal Anesthesia Monitor Requirements
The committee reviewed and discussed federal anesthesia monitor requirements and the impact on Oregon laws and rules.

OAR 818-026-0080 – Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia
Dr. Schwindt moved and Dr. Mutschler seconded that the Committee recommend that the Board send OAR 818-026-0080 to the Rules Oversight Committee as amended. The motion passed unanimously.

818-026-0080
Standards Applicable When a Dentist Performs Dental Procedures and a Qualified Provider Induces Anesthesia
(1) A dentist who does not hold an anesthesia permit may perform dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist licensed by the Oregon Medical Board, another Oregon licensed dentist holding an appropriate anesthesia permit, or a Certified Registered Nurse Anesthetist (CRNA) licensed by the Oregon Board of Nursing.
(2) A dentist who does not hold a Nitrous Oxide Permit for nitrous oxide sedation may perform dental procedures on a patient who receives nitrous oxide induced by an Oregon licensed dental hygienist holding a Nitrous Oxide Permit.
(3) A dentist who performs dental procedures on a patient who receives anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit, a CRNA, or a dental hygienist who induces nitrous oxide sedation, shall maintain a current BLS for Healthcare Providers certificate, or its equivalent, and have the same personnel, facilities, equipment and drugs available during the procedure and during recovery as required of a dentist who has a permit for the level of anesthesia being provided.
(4) A dentist~~, a dental hygienist or an Expanded Function Dental Assistant (EFDA)~~ who performs procedures on a patient who is receiving anesthesia induced by a physician anesthesiologist, another dentist holding an anesthesia permit or a CRNA shall not schedule or treat patients for non emergent care during the period of time of the sedation procedure.
(5) Once anesthetized, a patient shall remain in the operatory for the duration of treatment until criteria for transportation to recovery have been met.
(6) The qualified anesthesia provider who induces moderate sedation, deep sedation or general anesthesia shall monitor the patient until easily arousable and can independently and continuously maintain their airway with stable vital signs. Once this has occurred the patient may be monitored by a qualified anesthesia monitor until discharge criteria is met. The patient's dental record shall document the patient's condition at discharge as required by the rules applicable to the level of anesthesia being induced. A copy of the anesthesia record shall be maintained in the patient's dental record and is the responsibility of the dentist who is performing the dental procedures.
(7) No qualified provider shall have more than one person under any form of sedation or general anesthesia at the same time exclusive of recovery.
(8) A dentist who intends to use the services of a qualified anesthesia provider as described in section 1 above, shall notify the Board in writing of ~~his/her~~ **their** intent. Such notification need only be submitted once every licensing period.

The meeting adjourned at 5:45 p.m.

DENTAL THERAPY RULES OVERSIGHT COMMITTEE #5
Held as a Zoom Meeting

Minutes
February 23, 2022

MEMBERS PRESENT:	Committee Members: Yadira Martinez, R.D.H., Chair – OBD Rep. Sheena Kansal, D.D.S. – OBD Rep. Jennifer Brixey– OBD Rep. Kaz Rafia, D.D.S. – OHA Rep. Brandon Schwindt, D.M.D. - ODA Rep. (portion of meeting) Amy Coplen, R.D.H. - ODHA Rep. Mary Harrison, CDA, EFDA, EFODA, FADAA for Ginny Jorgensen, CDA - ODAA Rep. Miranda Davis, D.D.S. – Dental Therapy Rep. Kari Kuntzelman – Dental Therapy Rep.
STAFF PRESENT:	Stephen Prisby, Executive Director Angela Smorra, D.M.D., Dental Investigator Haley Robinson, Office Manager Ingrid Nye, Investigator
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT: Jen Lewis-Goff, Oregon Dental Association (ODA); Alicia Riedman, Bonnie Marshall, Barry Taylor, Mark Schoenbaum, Wilber Ramirez, Karen Phillips, Kim Laudenslager – CRDTS Rep., George Okulitch.

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

Call to Order: The virtual meeting was called to order by Chair Martinez at 5:00 p.m.

The agenda was briefly reviewed and discussed.

Dr. Rafia moved and Ms. Coplen seconded that the Dental Therapy Rules Oversight (DTRO) Committee approve the minutes from the January 19, 2022 DTRO Committee Meeting as presented. The motion passed unanimously.

The DTRO committee discussed the CDCA-WREB Dental Therapy Exam and CRDTS Dental Therapy Exam presented in the packet. Kim Laudenslager from CRDTS shared that this is the second year administering their Dental Therapy exam. The exam is tailored to the specific duties permitted within the state-specific dental therapy scope.

There is not a written exam required for dental therapy licensure at this point. Committee members expressed the importance of requiring a written knowledge-based exam similar to the ones required for dental hygiene and dental licensure. Dr. Davis expressed that the CDCA-WREB and CRDTS exams were written and manikin-based and that she did not see the point in requiring a written exam.

Dr. Schwindt moved and Ms. Harrison seconded that when a written knowledge-based examination becomes available that it is required for licensure as a dental therapist in Oregon. The motion passed unanimously.

Ms. Coplen moved and Ms. Kuntzelman seconded to move the proposed rules and amendments to the full Board for review. The motion passed unanimously.

818-001-0002
Definitions
As used in OAR chapter 818:
(1) "Board" means the Oregon Board of Dentistry, the members of the Board, its employees, its agents, and its consultants.
(2) "Dental Practice Act" means ORS Chapter 679 and 680.010 to 680.170 and the rules adopted pursuant thereto.
(3) "Dentist" means a person licensed pursuant to ORS Chapter 679 to practice dentistry.
(4) "Dental Hygienist" means a person licensed pursuant to ORS 680.010 to 680.210 to practice dental hygiene.
(5) "Dental Therapist" means a person licensed pursuant to ORS 679.603 to practice dental therapy.
(6) "Dental Therapy" means the provision of preventative care, restorative dental treatment and other educational, clinical and therapeutic patient services as part of a dental care team.
(7) "Direct Supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.
(8) "General Supervision" means supervision requiring that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.
(9) "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.
(10) "Informed Consent" means the consent obtained following a thorough and easily understood
explanation to the patient, or patient's guardian, of the proposed procedures, any available alternative procedures and any risks associated with the procedures. Following the explanation, the licensee shall ask the patient, or the patient's guardian, if there are any questions. The licensee shall provide thorough and easily understood answers to all questions asked.
(11) "Licensee" means a dentist**,** hygienist **or dental therapist.**
(12) "Volunteer Licensee" is a dentist**,** hygienist **or dental therapist** licensed according to rule to provide dental health care without receiving or expecting to receive compensation.

(13) "Limited Access Patient" means a patient who, due to age, infirmity, or handicap is unable to receive regular dental hygiene treatment in a dental office.
(14) "Specialty." The specialty definitions are added to more clearly define the scope of the practice as it pertains to the specialty areas of dentistry.
(a) “Dental Anesthesiology” is the specialty of dentistry that deals with the management of pain through the use of advanced local and general anesthesia techniques.
(b) "Dental Public Health" is the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice which serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.
(c) "Endodontics" is the specialty of dentistry which is concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.
(d) "Oral and Maxillofacial Pathology" is the specialty of dentistry and discipline of pathology that deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of oral pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations.
(e) “Oral and Maxillofacial Radiology” is the specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.
(f) "Oral and Maxillofacial Surgery" is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.
(g) "Oral Medicine" is the specialty of dentistry responsible for the oral health care of medically complex patients and for the diagnosis and management of medically-related diseases, disorders and conditions affecting the oral and maxillofacial region.
(h) "Orofacial Pain" Orofacial Pain is the specialty of dentistry that encompasses the diagnosis, management and treatment of pain disorders of the jaw, mouth, face, head and neck. The specialty of Orofacial Pain is dedicated to the evidenced-based understanding of the underlying pathophysiology, etiology, prevention, and treatment of these disorders and improving access to interdisciplinary patient care.
(i) "Orthodontics and Dentofacial Orthopedics" is the specialty of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application and control of functional and corrective appliances; and the guidance of the dentition and its

supporting structures to attain and maintain optimum occlusal relations in physiologic and esthetic harmony among facial and cranial structures.
(j) "Pediatric Dentistry" is an age defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.
(k) "Periodontics" is the specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues.
(l) "Prosthodontics" is the specialty of dentistry pertaining to the restoration and maintenance of oral functions, comfort, appearance and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes.
(15) "Full-time" as used in ORS 679.025 and 680.020 is defined by the Board as any student who is enrolled in an institution accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency in a course of study for dentistry**,** dental hygiene **or dental therapy.**
(16) For purposes of ORS 679.020(4)(h) the term "dentist of record" means a dentist that either authorized treatment for, supervised treatment of or provided treatment for the patient in clinical settings of the institution described in 679.020(3).
(17) "Dental Study Group" as used in ORS 679.050, OAR 818-021-0060 and OAR 818-021-0070 is defined as a group of licensees who come together for clinical and non-clinical educational study for the purpose of maintaining or increasing their competence. This is not meant to be a replacement for residency requirements.
(18) "Physical Harm" as used in OAR 818-001-0083(2) is defined as any physical injury that caused, partial or total physical disability, incapacity or disfigurement. In no event shall physical harm include mental pain, anguish, or suffering, or fear of injury.
(19) "Teledentistry" is defined as the use of information technology and telecommunications to facilitate the providing of dental primary care, consultation, education, and public awareness in the same manner as telehealth and telemedicine.
(20) "BLS for Healthcare Providers or its Equivalent" the BLS/CPR certification standard is the American Heart Association's BLS Healthcare Providers Course or its equivalent, as determined by the Board. This initial BLS/CPR course must be a hands-on course; online BLS/CPR courses will not be approved by the Board for initial BLS/CPR certification: After the initial BLS/CPR certification, the Board will accept a Board-approved BLS for Healthcare Providers or its equivalent Online Renewal course for license renewal. A BLS/CPR certification card with an expiration date must be received from the BLS/CPR provider as documentation of BLS/CPR certification. The Board considers the BLS/CPR expiration date to be the last day of the month that the BLS/CPR instructor indicates that the certification expires.

818-001-0082
Access to Public Records
(1) Public records not exempt from disclosure may be inspected during office hours at the Board office upon reasonable notice.
(2) Copies of public records not exempt from disclosure may be purchased upon receipt of a written request. The Board may withhold copies of public records until the requestor pays for the copies.

(3) The Board follows the Department of Administrative Service's statewide policy (107-001-030) for fees in regards to public records request; in addition, the Board establishes the following fees:
(a) $0.10 per name and address for computer-generated lists on paper; $0.20 per name and address for computer-generated lists on paper sorted by specific zip code;
(b) Data files submitted electronically or on a device:
(A) All Licensed Dentists — $50;
(B) All Licensed Dental Hygienists **and Dental Therapists** — $50;
(C) All Licensees — $100.
(c) Written verification of licensure — $2.50 per name; and
(d) Certificate of Standing — $20.

818-001-0087
Fees
(1) The Board adopts the following fees:
(a) Biennial License Fees:
(A) Dental —$390;
(B) Dental — retired — $0;
(C) Dental Faculty — $335;
(D) Volunteer Dentist — $0;
(E) Dental Hygiene —$230;
(F) Dental Hygiene — retired — $0;
(G) Volunteer Dental Hygienist — $0;
(H) Dental Therapy - $230;
(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 — $75;
(D) Deep Sedation Permit — $75;
(E) General Anesthesia Permit — $140;
(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;
(c) Applications for Licensure:
(A) Dental — General and Specialty — $345;
(B) Dental Faculty — $305;
(C) Dental Hygiene — $180;
(D) **Dental Therapy - $180;**
(E) Licensure Without Further Examination — Dental**,** Dental Hygiene **and Dental Therapy** — $790.

(d) Examinations:
(A) Jurisprudence — $0;
(e) 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.

OAR 818-012-0020
Additional Methods of Discipline for Unacceptable Patient Care
In addition to other discipline, the Board may order a licensee who engaged in or permitted unacceptable patient care to:
(1) Make restitution to the patient in an amount to cover actual costs in correcting the unacceptable care.
(2) Refund fees paid by the patient with interest.
(3) Complete a Board-approved course of remedial education.
(4) Discontinue practicing in specific areas of dentistry**, dental therapy,** or hygiene.
(5) Practice under the supervision of another licensee.

OAR 818-012-0030
Unprofessional Conduct
The Board finds that in addition to the conduct set forth in ORS 679.140(2), unprofessional conduct includes, but is not limited to, the following in which a licensee does or knowingly permits any person to:
(1) Attempt to obtain a fee by fraud, or misrepresentation.
(2) Obtain a fee by fraud, or misrepresentation.
(a) A licensee obtains a fee by fraud if the licensee knowingly makes, or permits any person to make, a material, false statement intending that a recipient, who is unaware of the truth, rely upon the statement.
(b) A licensee obtains a fee by misrepresentation if the licensee obtains a fee through making or permitting any person to make a material, false statement.
(c) Giving cash discounts and not disclosing them to third party payers is not fraud or misrepresentation.
(3) Offer rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee, or employer.
(4) Accept rebates, split fees, or commissions for services rendered to a patient from any person other than a partner, employee, or employer.
(5) Initiate, or engage in, with a patient, any behavior with sexual connotations. The behavior can include but is not limited to, inappropriate physical touching; kissing of a sexual nature; gestures or expressions, any of which are sexualized or sexually demeaning to a patient; inappropriate procedures, including, but not limited to, disrobing and draping practices that reflect a lack of respect for the patient's privacy; or initiating inappropriate communication, verbal or written, including, but not limited to, references to a patient's body or clothing that are sexualized or sexually demeaning to a patient; and inappropriate comments or queries about the professional's or patient's sexual orientation, sexual performance, sexual fantasies, sexual problems, or sexual preferences.

(6) Engage in an unlawful trade practice as defined in ORS 646.605 to 646.608.
(7) Fail to present a treatment plan with estimated costs to a patient upon request of the patient or to a patient's guardian upon request of the patient's guardian.
(8) Misrepresent any facts to a patient concerning treatment or fees.
(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, radiographs of the same quality as the originals, and photographs if they have been paid for.
(b) The licensee may require the patient or guardian to pay in advance a fee reasonably calculated to cover the costs of making the copies or duplicates. The licensee may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for pages 11 through 50 and no more than $0.25 for each additional page (including records copied from microfilm), plus any postage costs to mail copies requested and actual costs of preparing an explanation or summary of information, if requested. The actual cost of duplicating radiographs may also be charged to the patient. Patient records or summaries may not be withheld from the patient because of any prior unpaid bills, except as provided in (9)(a)(B) of this rule.
(10) Fail to identify to a patient, patient's guardian, or the Board the name of an employee, employer, contractor, or agent who renders services.
(11) Use prescription forms pre-printed with any Drug Enforcement Administration number, name of controlled substances, or facsimile of a signature.
(12) Use a rubber stamp or like device to reproduce a signature on a prescription form or sign a blank prescription form.
(13) Order drugs listed on Schedule II of the Drug Abuse Prevention and Control Act, 21 U.S.C. Sec. 812, for office use on a prescription form.
(14) Violate any Federal or State law regarding controlled substances.
(15) Becomes addicted to, or dependent upon, or abuses alcohol, illegal or controlled drugs, or mind altering substances, or practice with an untreated substance use disorder diagnosis that renders the licensee unable to safely conduct the practice of dentistry**,** dental hygiene **or dental therapy.**
(16) Practice dentistry**,** dental hygiene **or dental therapy** in a dental office or clinic not owned by an Oregon licensed dentist(s), except for an entity described under ORS 679.020(3) and dental hygienists practicing pursuant to ORS 680.205(1)(2).
(17) Make an agreement with a patient or person, or any person or entity representing patients or persons, or provide any form of consideration that would prohibit, restrict, discourage or otherwise limit a person's ability to file a complaint with the Oregon Board of Dentistry; to truthfully and fully answer any questions posed by an agent or representative of the Board; or to participate as a witness in a Board proceeding.
(18) Fail to maintain at a minimum a current BLS for Healthcare Providers certificate or its equivalent.
(19) Conduct unbecoming a licensee or detrimental to the best interests of the public, including conduct contrary to the recognized standards of ethics of the licensee’s profession or conduct that endangers the health, safety or welfare of a patient or the public.
(20) Knowingly deceiving or attempting to deceive the Board, an employee of the Board, or an agent of the Board in any application or renewal, or in reference to any matter under investigation by the Board. This includes but is not limited to the omission, alteration or

destruction of any record in order to obstruct or delay an investigation by the Board, or to omit, alter or falsify any information in patient or business records.
(21) Knowingly practicing with a physical or mental impairment that renders the Licensee unable to safely conduct the practice of dentistry**,** dental hygiene **or dental therapy.**
(22) Take any action which could reasonably be interpreted to constitute harassment or retaliation towards a person whom the licensee believes to be a complainant or witness.
(23) Fail to register with the Prescription Drug Monitoring Program (PDMP) in order to have access to the Program's electronic system if the Licensee holds a Federal Drug Enforcement Administration (DEA) registration.

818-021-0052
Application for License to Practice Dental Therapy
(1) An applicant to practice dental therapy, in addition to the requirements set forth in ORS 679.603 and 679.609, shall submit to the Board satisfactory evidence of:
(a) Having graduated from a dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Having graduated from a dental therapy program located outside the United States or Canada, completion of not less than one year in a program accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and
(2) An applicant who has not met the educational requirements for licensure may apply if the Director of an accredited program certifies the applicant will graduate.
(3) An applicant must pass a Board examination consisting of a clinical portion administered by the Board, or any clinical Board examination administered by any state, regional testing agency, national testing agency or other Board-recognized testing agency and a jurisprudence portion administered by the Board. Clinical examination results will be recognized by the Board for five years.
(4) A person who fails any Board approved clinical examination three times must successfully complete the remedial training recommended by the testing agency. Such remedial training must be conducted by a dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association.

818-021-0054
Application for License to Practice Dental Therapy Without Further Examination
(1) The Oregon Board of Dentistry may grant a license without further examination to a dental therapist who holds a license to practice dental therapy in another state or states if the dental therapist meets the requirements set forth in 679.603 and 679.609 and submits to the Board satisfactory evidence of:
(a) Having graduated from a dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Having completed or graduated from a dental therapy education program, and
(c) Having passed the clinical dental therapy examination conducted by a regional testing agency or by a state dental or dental therapy licensing authority, by a national testing agency or other Board-recognized testing agency; and
(d) Holding an active license to practice dental therapy, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dental therapy, without restrictions, and

whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and
(e) Having conducted licensed clinical practice in Oregon, in other states or in the Armed Forces of the United States, the United States Public Health Service, the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately preceding application. Licensed clinical practice could include hours devoted to teaching by dental therapists employed by a CODA accredited dental therapy program with verification from the dean or appropriate administration of the institution documenting the length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dental therapy, and any adverse actions or restrictions; and
(f) Having completed 36 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.
(2) Applicants must pass the Board's Jurisprudence Examination.

818-021-0026
State and Nationwide Criminal Background Checks, Fitness Determinations
(1) The Board requires fingerprints of all applicants for a dental**, dental therapy** or dental hygiene license to determine the fitness of an applicant. The purpose of this rule is to provide for the reasonable screening of dental and dental hygiene applicants and licensees in order to determine if they have a history of criminal behavior such that they are not fit to be granted or hold a license that is issued by the Board.
(2) These rules are to be applied when evaluating the criminal history of all licensees and applicants for a dental**, dental therapy** or dental hygiene license and for conducting fitness determinations consistent with the outcomes provided in OAR 125-007-0260.
(3) Criminal records checks and fitness determinations are conducted according to ORS 181A.170 to 181A.215, ORS 670.280 and OAR 125-007-0200 to 127-007-0310.
(a) The Board will request the Oregon Department of State Police to conduct a state and nationwide criminal records check. Any original fingerprint cards will subsequently destroyed.
(b) All background checks must include available state and national data, unless obtaining one or the other is an acceptable alternative.
(c) The applicant or licensee must disclose all arrests, charges, and convictions regardless of the outcome or date of occurrence. Disclosure includes but is not limited to military, dismissed or set aside criminal records.
(4) If the applicant or licensee has potentially disqualifying criminal offender information, the Board will consider the following factors in making a fitness determination:
(a) The nature of the crime;
(b) The facts that support the conviction or pending indictment or that indicates the making of the false statement;
(c) The relevancy, if any, of the crime or the false statement to the specific requirements of the subject individual’s present or proposed position, services, employment, license, or permit; and
(d) Intervening circumstances relevant to the responsibilities and circumstances of the position, services, employment, license, or permit. Intervening circumstances include but are not limited to:
(A) The passage of time since the commission of the crime;
(B) The age of the subject individual at the time of the crime;

(C) The likelihood of a repetition of offenses or of the commission of another crime:
(D) The subsequent commission of another relevant crime;
(E) Whether the conviction was set aside and the legal effect of setting aside the conviction; and
(F) A recommendation of an employer.
(e) Any false statements or omissions made by the applicant or licensee; and
(f) Any other pertinent information obtained as part of an investigation.
(5) The Board will make a fitness determination consistent with the outcomes provided in OAR 125-007-0260.
(a) A fitness determination approval does not guarantee the granting or renewal of a license.
(b) An incomplete fitness determination results if the applicant or licensee refuses to consent to the criminal history check, refuses to be fingerprinted or respond to written correspondence, or discontinues the criminal records process for any reason. Incomplete fitness determinations may not be appealed.
(6) The Board may require fingerprints of any licensed Oregon dentist**, dental therapist** or dental hygienist, who is the subject of a complaint or investigation for the purpose of requesting a state or nationwide criminal records background check.
(7) All background checks shall be requested to include available state and national data, unless obtaining one or the other is an acceptable alternative.
(8) Additional information required. In order to conduct the Oregon and National Criminal History Check and fitness determination, the Board may require additional information from the licensee/applicant as necessary, such but not limited to, proof of identity; residential history; names used while living at each residence; or additional criminal, judicial or other background information.
(9) Criminal offender information is confidential. Dissemination of information received may be disseminated only to people with a demonstrated and legitimate need to know the information. The information is part of the investigation of an applicant or licensee and as such is confidential pursuant to ORS 676.175(1).
(10) The Board will permit the individual for whom a fingerprint-based criminal records check was conducted, to inspect the individual's own state and national criminal offender records and, if requested by the individual, provide the individual with a copy of the individual's own state and national criminal offender records.
(11) The Board shall determine whether an individual is fit to be granted a license or permit, based on fitness determinations, on any false statements made by the individual regarding criminal history of the individual, or any refusal to submit or consent to a criminal records check including fingerprint identification, and any other pertinent information obtained as a part of an investigation. If an individual is determined to be unfit, then the individual may not be granted a license or permit. The Board may make fitness determinations conditional upon applicant's acceptance of probation, conditions, or limitations, or other restrictions upon licensure.
(12) An applicant or licensee may appeal a final fitness determination pursuant to OAR 125-007-0300. Challenges to the accuracy of completeness of criminal history information must be made in accordance with OAR 125-007-0030(7).

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 includes an examination and the dental therapist passes the examination.
(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.

818-021-0080
Renewal of License
Before the expiration date of a license, the Board will, as a courtesy, mail notice for renewal of license to the last mailing address on file in the Board's records to every licensee holding a current license. The licensee must complete the online renewal application and pay the current renewal fees prior to the expiration of said license. Licensees who fail to renew their license prior to the expiration date may not practice dentistry**, dental therapy** or dental hygiene until the license is reinstated and are subject to the provisions of OAR 818-021-0085, "Reinstatement of Expired Licenses."
(1) Each dentist shall submit the renewal fee and completed online renewal application by March 31 every other year. Dentists licensed in odd numbered years shall apply for renewal in odd numbered years and dentists licensed in even numbered years shall apply for renewal in even numbered years.
(2) Each dental hygienist must submit the renewal fee and completed online renewal application ~~form~~ by September 30 every other year. Dental hygienists licensed in odd numbered years shall apply for renewal in odd numbered years and dental hygienists licensed in even numbered years shall apply for renewal in even numbered years.

(3) Each dental therapist must submit the renewal fee and completed and signed renewal application form by September 30 every other year. Dental Therapists licensed in odd numbered years shall apply for renewal in odd numbered years and dental therapists licensed in even numbered years shall apply for renewal in even numbered years.
(4) The renewal application shall contain:
(a) Licensee's full name;
(b) Licensee's mailing address;
(c) Licensees business address including street and number or if the licensee has no business address, licensee's home address including street and number;
(d) Licensee's business telephone number or if the licensee has no business telephone number, licensee's home telephone number;
(e) Licensee's employer or person with whom the licensee is on contract;
(f) Licensee's assumed business name;
(g) Licensee's type of practice or employment;
(h) A statement that the licensee has met the continuing educational requirements for **their specific license** renewal set forth in OAR 818-021-0060 or **OAR** 818-021-0070 **or OAR 818-021-0076:**
(i) Identity of all jurisdictions in which the licensee has practiced during the two past years; and
(j) A statement that the licensee has not been disciplined by the licensing board of any other jurisdiction or convicted of a crime.

818-021-0085
Renewal or Reinstatement of Expired License
Any person whose license to practice as a dentist**,** dental hygienist **or dental therapist** has expired, may apply for reinstatement under the following circumstances:
(1) If the license has been expired 30 days or less, the applicant shall:
(a) Pay a penalty fee of $50;
(b) Pay the biennial renewal fee; and
(c) Submit a completed renewal application and certification of having completed the Board's continuing education requirements.
(2) If the license has been expired more than 30 days but less than 60 days, the applicant shall:
(a) Pay a penalty fee of $100;
(b) Pay the biennial renewal fee; and
(c) Submit a completed renewal application and certification of having completed the continuing education requirements.
(3) If the license has been expired more than 60 days, but less than one year, the applicant shall:
(a) Pay a penalty fee of $150;
(b) Pay a fee equal to the renewal fees that would have been due during the period the license was expired;
(c) Pay a reinstatement fee of $500; and
(d) Submit a completed application for reinstatement provided by the Board, including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.

(4) If the license has been expired for more than one year but less than four years, the applicant shall:
(a) Pay a penalty fee of $250;
(b) Pay a fee of equal to the renewal fees that would have been due during the period the license was expired;
(c) Pay a reinstatement fee of $500;
(d) Pass the Board's Jurisprudence Examination;
(e) Pass any other qualifying examination as may be determined necessary by the Board after assessing the applicant's professional background and credentials;
(f) Submit evidence of good standing from all states in which the applicant is currently licensed; and
(g) Submit a completed application for reinstatement provided by the Board including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.
(5) If a **Licensee** fails to renew or reinstate **their** license within four years from expiration, the **Licensee** must apply for licensure under the current statute and rules of the Board.

818-021-0088
Volunteer License
(1) An Oregon licensed dentist**, dental therapist** or dental hygienist who will be practicing for a supervised volunteer dental clinic, as defined in ORS 679.020(3)(f) and (g), may be granted a volunteer license provided licensee completes the following:
(a) Licensee must register with the Board as a health care professional and provide a statement as required by ORS 676.345.
(b) Licensee will be responsible to meet all the requirements set forth in ORS 676.345.
(c) Licensee must provide the health care service without compensation.
(d) Licensee shall not practice dentistry**, dental therapy** or dental hygiene for remuneration in any capacity
under the volunteer license.
(e) Licensee must comply with all continuing education requirements for active licensed dentist**, dental therapist,**
or dental hygienist.
(f) Licensee must agree to volunteer for a minimum of 80 hours in Oregon per renewal cycle.
(2) Licensee may surrender the volunteer license designation at anytime and request a return to an active license. The Board will grant an active license as long as all active license requirements have been met.

818-021-0090
Retirement of License
(1) A **Licensee** who no longer practices in any jurisdiction may retire **their** license by submitting a request to retire such license on a form provided by the Board.
(2) A license that has been retired may be reinstated if the applicant:
(a) Pays a reinstatement fee of $500;
(b) Passes the Board’s Jurisprudence Examination;
(c) Passes any other qualifying examination as may be determined necessary by the Board after assessing the applicant’s professional background and credentials;

(d) Submits evidence of good standing from all states in which the applicant is currently licensed; and
(e) Submits a completed application for reinstatement provided by the Board including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.
(3) If the **Licensee** fails to reinstate **their** license within four years from retiring the license, the **Licensee** must apply for licensure under the current statute and rules of the Board.

818-021-0095
Resignation of License
(1) The Board may allow a dentist**,** dental hygienist **or dental therapist** who no longer practices in Oregon to resign **their** license, unless the Board determines the license should be revoked.
(2) Licenses that are resigned under this rule may not be reinstated.

818-021-0110
Reinstatement Following Revocation
(1) Any person whose license has been revoked for a reason other than failure to pay the ~~annual~~ **renewal** fee may petition the Board for reinstatement after five years from the date of revocation.
(2) The Board shall hold a hearing on the petition and, if the petitioner demonstrates that reinstatement of the license will not be detrimental to the health or welfare of the public, the Board may allow the petitioner to retake the Board examination.
(3) If the license was revoked for unacceptable patient care, the petitioner shall provide the Board with satisfactory evidence that the petitioner has completed a course of study sufficient to remedy the petitioner's deficiencies in the practice of dentistry**, dental therapy** or dental hygiene.
(4) If the petitioner passes the Board examination, the Board may reinstate the license, place the petitioner on probation for not less than two years, and impose appropriate conditions of probation.

818-026-0055
Dental Hygiene, Dental Therapy and Dental Assistant Procedures Performed Under Nitrous Oxide or Minimal Sedation
(1) Under indirect supervision, dental hygiene procedures may be performed for a patient who is under nitrous oxide or minimal sedation under the following conditions:
(a) A licensee holding a Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; or
(c) If a dental hygienist with a nitrous oxide permit administers nitrous oxide sedation to a patient and then performs authorized procedures on the patient, an anesthesia monitor is not required to be present during the time the patient is sedated unless the permit holder leaves the patient.
(d) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with **Board rules.**
(2) Under indirect supervision, a dental assistant may perform those procedures for which the dental assistant holds the appropriate certification for a patient who is under nitrous oxide or

minimal sedation under the following conditions:
(a) A licensee holding the Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; and
(c) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with **Board rules.**
(3) Under indirect supervision, a dental therapist may perform procedures for which they hold the appropriate license for a patient who is under nitrous oxide or minimal sedation under the following conditions:
(a) A licensee holding the Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; and
(c) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with Board rules.

818-038-0001
Definitions
(1) “Dental Therapist” means a person licensed to practice dental therapy under ORS 679.603.
(2) “Dental Therapy” means the provision of preventive dental care, restorative dental treatment and other educational, clinical and therapeutic patient services as part of a dental care team, including the services described under ORS 679.621.
(3) "Direct Supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.
(4) "General Supervision" means supervision requiring that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.
(5) "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.
(6) "Informed Consent" means the consent obtained following a thorough and easily understood explanation to the patient, or patient's guardian, of the proposed procedures, any available alternative procedures and any risks associated with the procedures. Following the explanation, the licensee shall ask the patient, or the patient's guardian, if there are any questions. The licensee shall provide thorough and easily understood answers to all questions asked.
(7) “Collaborative Agreement” means a written and signed agreement entered into between a dentist and a dental therapist under ORS 679.618.

818-038-0010
Authorization to Practice
(1) A dental therapist may practice dental therapy only under the supervision of a dentist and pursuant to a collaborative agreement with the dentist that outlines the supervision logistics and requirements for the dental therapist’s practice.
(2) A dental therapist shall dedicate at least 51 percent of the dental therapist’s practice to patients who represent underserved populations, as defined by the Oregon Health

Authority by rule, or patients located in dental care health professional shortage areas, as determined by the authority.
(3) A dental therapist may perform the procedures listed in OAR 818-038- 0020 so long as the procedures were included in the dental therapist's education program or the dental therapist has received additional training in the procedure through a Board approved course.

818-038-0020
Scope of Practice
(1) A dental therapist may perform, pursuant to the dental therapist's collaborative agreement, the following procedures under the general supervision of the dentist:
(a) Identification of conditions requiring evaluation, diagnosis or treatment by a dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390 or other licensed health care provider;
(b) Comprehensive charting of the oral cavity;
(c) Oral health instruction and disease prevention education, including nutritional counseling and dietary analysis;
(d) Exposing and evaluation of radiographic images;
(e) Dental prophylaxis, including subgingival scaling and polishing procedures;
(f) Application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;
(g) Administering local anesthetic;
(h) Pulp vitality testing;
(i) Application of desensitizing medication or resin;
(j) Fabrication of athletic mouth guards;
(k) Changing of periodontal dressings;
(L) Simple extractions of erupted primary anterior teeth and coronal remnants of any primary teeth;
(m) Emergency palliative treatment of dental pain;
(n) Preparation and placement of direct restoration in primary and permanent teeth;
(o) Fabrication and placement of single-tooth temporary crowns;
(p) Preparation and placement of preformed crowns on primary teeth;
(q) Indirect pulp capping on permanent teeth;
(r) Indirect pulp capping on primary teeth;
(s) Suture removal;
(t) Minor adjustments and repairs of removable prosthetic devices;
(u) Atraumatic restorative therapy and interim restorative therapy;
(v) Oral examination, evaluation and diagnosis of conditions within the scope of practice of the dental therapist and with the supervising dentist's authorization;
(w) Removal of space maintainers;
(x) The dispensation and oral or topical administration of:
(A) Nonnarcotic analgesics;
(B) Anti-inflammatories; and
(C) Antibiotics; and
(y) Other services as specified by the Oregon Board of Dentistry by rule;
(2) A dental therapist may perform, pursuant to the dental therapist's collaborative agreement, the following procedures under the indirect supervision of the dentist:

(a) Placement of temporary restorations;
(b) Fabrication of soft occlusal guards;
(c) Tissue reconditioning and soft reline;
(d) Tooth reimplantation and stabilization;
(e) Recementing of permanent crowns;
(f) Pulpotomies on primary teeth;
(g) Simple extractions of:
(A) Erupted posterior primary teeth; and
(B) Permanent teeth that have horizontal movement of greater than two millimeters or vertical movement and that have at least 50 percent periodontal bone loss;
(h) Brush biopsies; and
(i) Direct pulp capping on permanent teeth.
(3) The supervising dentist described in subsection (2) of this rule shall review a procedure described in subsection (2) of this rule that is performed by the dental therapist and the patient chart that contains information regarding the procedure.
(4)(a) A dental therapist may supervise a dental assistant and an expanded function dental assistant, as defined by the board by rule, if the dental therapist is authorized to perform the services provided by the dental assistant or expanded function dental assistant.
(b) A dental therapist may supervise up to two individuals under this subsection.

818-038-0025
Prohibited Acts
A dental therapist may not:
(2) Place or Restore Dental Implants or any other soft tissue surgery except as described in 818-038-0020
(3) Prescribe any drugs, unless permitted by ORS 679.010
(4) Use the behavior management techniques of Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.
(5) Perform any dental therapy procedure unless it is documented in the collaborative agreement and rendered under appropriate Oregon Licensed Dentist supervision.
(6) Operate a hard or soft tissue Laser.
(7) Treat a patient under moderate, deep or general anesthesia.
(8) Order a computerized tomography scan

818-038-0030
Collaborative Agreements
(1) A dentist may supervise and enter into collaborative agreements with up to three dental therapists at any one time.
(2) A dental therapist may enter into a collaborative agreement with more than one dentist if each collaborative agreement includes the same supervision and requirements of scope of practice.
(3) The collaborative agreement must include at least the following information:
(a) The level of supervision required for each procedure performed by the dental therapist;
(b) Circumstances under which the prior knowledge and consent of the dentist is required to allow the dental therapist to provide a certain service or perform a certain procedure;
(c) The practice settings in which the dental therapist may provide care;
(d) Any limitation on the care the dental therapist may provide;
(e) Patient age-specific and procedure-specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency;
(f) Procedures for creating and maintaining dental records for patients treated by the dental therapist;
(g) Guidelines for the management of medical emergencies in each of the practice settings in which the dental therapist provides care;
(h) A quality assurance plan for monitoring care provided by the dental therapist, including chart review, patient care review and referral follow-up;
(i) Protocols for the dispensation and administration of drugs by the dental therapist, (as described in ORS 679.621) including circumstances under which the dental therapist may dispense and administer drugs;
(j) Criteria for the provision of care to patients with specific medical conditions or complex medical histories, including any requirements for consultation with the dentist prior to the provision of care; and
(k) Protocols for when a patient requires treatment outside the dental therapist's scope of practice (in accordance with ORS 679.618), including for referral of the patient for evaluation and treatment by the dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390 or other licensed health care provider.
(2) (a) In addition to the information described in subsection (3) of this section, a collaborative agreement must include a provision that requires the dental therapist to consult with a dentist if the dental therapist intends to perform an irreversible surgical

procedure under general supervision on a patient who has a severe systemic disease. Severe systemic disease is defined as ASA III.

818-038-0035
Record Keeping
(1) A dental therapist shall annually submit a signed copy of their collaborative agreement (s) to the Oregon Board of Dentistry. If the collaborative agreement(s) are revised in between annual submissions, a signed and dated copy of the revised collaborative agreement(s) must be submitted to the board as soon as practicable after the revision is made.
(2) The annual submission of the collaborative agreement shall coincide with the license renewal period between August 1 and September 30 each year.
(3) A dental therapist shall purchase and maintain liability insurance.

818-042-0010
Definitions
(1) "Dental Assistant" means a person who, under the supervision of a dentist, renders assistance to a dentist, dental hygienist, **dental therapist**, dental technician or another dental assistant**.** ~~or renders assistance under the supervision of a dental hygienist providing dental hygiene services.~~
(2) "Expanded Function Dental Assistant" means a dental assistant certified by the Board to perform expanded function duties.
(3) "Expanded Function Orthodontic Assistant" means a dental assistant certified by the Board to perform expanded orthodontic function duties.
(4) "Direct Supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.
(5) "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.
(6) "General Supervision" means supervision requiring that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.

818-042-0020
Dentist, Dental Therapist and Dental Hygienist Responsibility
(1) A dentist is responsible for assuring that a dental assistant has been properly trained, has demonstrated proficiency, and is supervised in all the duties the assistant performs in the dental office. Unless otherwise specified, dental assistants shall work under indirect supervision in the dental office.
(2) A dental hygienist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental hygienist in providing dental hygiene services and the dentist is not in the office to provide indirect supervision. A dental hygienist with an Expanded Practice Permit may hire and supervise dental assistants who will render assistance to the dental hygienist in providing dental hygiene services.
(3) A dental therapist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental therapist in providing dental therapy services. ~~and a dentist has authorized it.~~
(4) The supervising dentist**, dental therapist** or dental hygienist is responsible for assuring that all required licenses, permits or certificates are current and posted in a conspicuous place.

~~(4)~~ **(5)** Dental assistants who are in compliance with written training and screening protocols adopted by the Board may perform oral health screenings under general supervision.

818-042-0050
Taking of X-Rays — Exposing Radiographic Images
(1) A ~~dentist~~ **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 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.
(2) A dentist**, dental therapist** or dental hygienist 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.
(3) A dental therapist may not order a computerized tomography scan

818-042-0060
Certification — Radiologic Proficiency
(1) The Board may certify a dental assistant in radiologic proficiency by credential in accordance with OAR 818-042-0120, or if the assistant:
(2) Submits an application on a form approved by the Board, pays the application fee and:
(a) Completes a course of instruction approved by the Oregon Board of Dentistry, in accordance with OAR 333-106-0055 or submits evidence that the Oregon Health Authority, Center for Health Protection, Radiation Protection Services recognizes that the equivalent training has been successfully completed;
(b) Passes the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, Inc. (DANB), or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry; and
(c) Certification by an Oregon licensed dentist**, dental therapist** or dental hygienist that the assistant is proficient to take radiographs.

818-042-0090
Additional Functions of EFDAs
Upon successful completion of a course of instruction in a program accredited by the Commissi on on Dental Accreditation of the American Dental Association, or other
course of instruction approved by the Board, a certified Expanded Function Dental Assistant ma y perform the following functions under the indirect supervision of a dentist**, dental therapist** or dental hygienist providing that the procedure is checked by the dentist**, dental therapist** or dental hygienist prior to the patient being dismissed:
(1) Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a

dentist**, dental therapist** or dental hygienist.
(2) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.
(3) Place retraction material subgingivally.

818-042-0114
Additional Functions of EFPDAs
(1) Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Preventive Dental Assistant may perform the following functions under the indirect supervision of a dentist**, dental therapist** or dental hygienist providing that the procedure is checked by the dentist**, dental therapist** or dental hygienist prior to the patient being dismissed:
(2) Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a dentist**, dental therapist** or dental hygienist.

Dr. Davis moved and Ms. Harrison seconded to approve the Verification of Collaborative Agreement as amended. The motion passed unanimously.

DRAFT
Oregon Board of Dentistry
Dental Therapist
Verification of Collaborative Agreement

I, (print your name)_____, a licensed Dentist pursuant to ORS 679.020 and 679.025, license number _____, have entered into a Collaborative Agreement with (print your name)_____, an Oregon licensed Dental Therapist, license number DT_____. The Collaborative Agreement sets forth the agreed-upon practice limitations of the Dental Therapist's practice and adheres to all the requirements set forth by the Legislature and the Oregon Board of Dentistry.

Please describe the circumstances under which the prior knowledge and consent of the dentist is required to allow the dental therapist to provide a certain service or perform a certain procedure within the scope of dental therapy:
_____
_____
_____
_____

Please define the practice settings in which the dental therapist may provide care:
_____
_____
_____

Please describe any limitation on the care the dental therapist may provide:
_____
_____
_____

Please define patient age-specific and procedure-specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency, (attach a copy of the guidelines):

Please describe procedures for creating and maintaining dental records for patients treated by the dental therapist:

Please describe guidelines for the management of medical emergencies in each of the practice settings in which the dental therapist provides care, (attach copy of guidelines):

Please provide a quality assurance plan for monitoring care provided by the dental therapist, including chart review, patient care review and referral follow-up, (attach copy of plan):

Please describe protocols for the dispensation and administration of local anesthetic, non-narcotic analgesic's, and anti-inflammatories or antibiotics; including the dispensation of oral or topical administration of non-narcotic analgesics, anti-inflammatories and antibiotics:

Please describe the criteria for the provision of care to patients with specific medical conditions or complex medical histories, including any requirements for consultation with the dentist prior to the provision of care:

Please describe protocols for when a patient requires treatment outside the dental therapist's scope of practice, including for referral of the patient for evaluation and treatment by the dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390 or other licensed health care provider, (attach protocols):

Please briefly summarize the following treatment parameters for when the dental therapist consults with a dentist, if the dental therapist intends to administer local anesthesia and perform an irreversible surgical procedure under general supervision on a patient who has a severe systemic disease. Severe systemic disease is defined as ASA III:

General Supervision: requires that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.

Indirect Supervision: requires that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.

Direct Supervision: requires that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.

The below listed duties may be performed under **general supervision**, unless otherwise indicated.

If **all** duties listed below are allowed under **general supervision**, please initial here: _____

***If a duty listed below is **not** allowed, or allowed under a different level of supervision, please indicate that by checking the appropriate box.

Specific Supervision Levels	**GS**	**IS**	**DS**	**Not Allowed**

Identification of conditions requiring evaluation, diagnosis or treatment by a dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390				
Comprehensive charting of the oral cavity				
Oral health instruction and disease prevention education, including nutritional counseling and dietary analysis				
Exposing and evaluation of radiographic images				
Dental prophylaxis, including subgingival scaling and polishing procedures				
Application of topical preventative or prophylactic agents, including fluoride varnishes and pit and fissure sealants				
Administering local anesthetic				
Pulp vitality testing				
Application of desensitizing medication or resin				
Fabrication of athletic mouth guards				
Changing of periodontal dressings				
Simple extractions of erupted primary anterior teeth and coronal remnants of any primary teeth				
Emergency palliative treatment of dental pain				
Preparation and placement of direct restoration in primary and permanent teeth				
Fabrication and placement of single-tooth temporary crowns				
Preparation and placement of preformed crowns on primary teeth				
Indirect pulp capping in permanent teeth				
Indirect pulp capping on primary teeth				
Suture removal				
Minor adjustments and repairs of removable prosthetic devices				
Atraumatic restorative therapy and interim restorative therapy				

Oral examination, evaluation and diagnosis of conditions within the supervising dentist' s authorization				
Removal of space maintainers				
The dispensation and oral or topical administration of: o Non-narcotic analgesics o Anti-inflammatories o Antibiotics				

The below listed duties may be performed under **indirect supervision**, unless otherwise indicated.

If **all** duties listed below are allowed under **indirect supervision**, please initial here: _____

In accordance with OAR 818-038-0020 (3) Please indicate whether review with the supervising dentist is to be completed before the procedure, after the procedure, or both.

***If a duty listed below is **not** allowed, or allowed under a different level of supervision, please indicate that by checking the appropriate box.

Specific Supervision Levels	**Review Before**	**Review After**	**IS**	**DS**	**Not Allowed**
Placement of temporary restorations **Additional comments:**					
Fabrication of soft occlusal guards **Additional comments:**					
Tissue reconditioning and soft relines **Additional comments:**					

Tooth reimplantation and stabilization **Additional comments:**					
Recementing of permanent crowns **Additional comments:**					
Pulpotomies on primary teeth **Additional comments:**					
Simple extractions of: o Erupted posterior primary teeth; and **Additional comments:**					

Simple extractions of: o Permanent teeth that have horizontal movement of greater than two millimeters or vertical movement and that have at least 50 percent periodontal bone loss **Additional comments:**					
Brush biopsies **Additional comments:**					
Direct pulp capping on permanent teeth **Additional comments:**					

Dentist:

I understand that this agreement will remain in effect with the Oregon Board of Dentistry (OBD) until I submit a written change. If any changes are made to this agreement, a new verification and copy of the agreement must be submitted to the OBD as soon as reasonably possible (this means in less than 14 days of the change). Failure to do so may result in Board action.

I understand that I may supervise and enter into collaborative agreements with up to three dental therapists at one time.

I attest that a copy of the Collaborative Agreement, signed by both parties, is attached to this verification. I understand that failure to provide a copy of the agreement with the verification will result in the verification form being rejected and returned.

Dentist's Signature: _____ Date: _____

Address: _____

_____

Cell phone #_____ Email _____

Dental Therapist:

I understand that this agreement will remain in effect with the Oregon Board of Dentistry (OBD) until I submit a written change. I understand that I shall submit annually a signed copy of the collaborative agreement to the Oregon Board of Dentistry. If any changes are made to this agreement, a new verification and copy of the agreement must be submitted to the OBD as soon as reasonably possible (this means in less than 14 days of the change). Failure to do so may result in Board action.

I understand that I may enter into collaborative agreements with more than one dentist if each collaborative agreement includes the same supervision requirements and scope of practice.

I attest that a copy of my liability insurance is attached to this verification.

I attest that at least 51 percent of my dental therapy practice will be to patients who represent underserved populations, as defined by the Oregon Health Authority by rule, or patients located in dental care health professional shortage areas, as determined by the authority.

I attest that a copy of the Collaborative Agreement, signed by both parties, is attached to this verification. I understand that failure to provide a copy of the agreement with the verification will result in the verification form being rejected and returned.

Dental Therapist's Signature:_____ Date: _____

Address: _____

_____

Cell phone #_____ Email _____

STOP – Did you remember to attach your….

1. Patient age-specific and procedure-specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency?
2. Medical emergency guidelines?
3. Quality assurance plan?
4. Protocols for when a patient requires treatment outside the dental therapist's scope of practice?

From HB 2528 (2021) Sections 8 - 10

SECTION 8. (1) A dental therapist may practice dental therapy only under the supervision of a dentist and pursuant to a practice agreement with the dentist. The practice agreement must include at least the following information:

(a) The level of supervision required;
(b) Circumstances under which the prior knowledge and consent of the dentist is required
to allow the dental therapist to provide a certain service or perform a certain procedure;
(c) The practice settings in which the dental therapist may provide care;
(d) Any limitation on the care the dental therapist may provide;
(e) Patient age- and procedure-specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency;
(f) Procedures for creating and maintaining dental records for patients treated by the dental therapist;
(g) Guidelines for the management of medical emergencies in each of the practice settings in which the dental therapist provides care;
(h) A quality assurance plan for monitoring care provided by the dental therapist, including chart review, patient care review and referral follow-up;
(i) Protocols for the dispensation and administration of drugs, as described in section 10 of this 2021 Act, by the dental therapist, including circumstances under which the dental therapist may dispense and administer drugs;
(j) Criteria for the provision of care to patients with specific medical conditions or complex medical histories, including any requirements for consultation with the dentist prior to the provision of care; and
(k) Protocols for when a patient requires treatment outside the dental therapist's scope of practice, including for referral of the patient for evaluation and treatment by the dentist,
a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375
to 678.390 or other licensed health care provider.
(2) A dentist who enters into a practice agreement with a dental therapist shall:
(a) Directly provide care to a patient that is outside the scope of practice of the dental therapist or arrange for the provision of care by another dentist; and
(b) Ensure that the dentist, or another dentist, is available to the dental therapist for timely communication during the dental therapist's provision of care to a patient.
(3) A dental therapist may perform and provide only those procedures and services authorized by the dentist and set out in the practice agreement, and shall maintain with the dentist an appropriate level of contact, as determined by the dentist.
(4) A dental therapist and a dentist who enter into a practice agreement together shall each maintain a physical copy of the practice agreement.
(5)(a) A dental therapist may enter into a practice agreement that allows for supervision by more than one dentist.
(b) A dentist may supervise and enter into practice agreements with up to five dental therapists at any one time.
(6)(a) A practice agreement must be signed by the dentist and dental therapist.
(b) A dental therapist shall submit the signed practice agreement to the Oregon Board of Dentistry. A practice agreement is not valid until approved by the board. The board may require changes to the practice agreement submitted under this paragraph prior to approval.
(c) A dental therapist shall submit a copy of the signed practice agreement with each application for license renewal. Any changes to the practice agreement require renewed approval by the board.
SECTION 9. (1) A dental therapist may provide, pursuant to the dental therapist's practice agreement, the following services:

(a) Oral health instruction and disease prevention education, including nutritional counseling and dietary analysis;
(b) Comprehensive charting of the oral cavity;
(c) Exposure and evaluation of radiographic images;
(d) Mechanical polishing;
(e) Prophylaxis;
(f) Periodontal scaling;
(g) Application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;
(h) Pulp vitality testing;
(i) Application of desensitizing medication or resin;
(j) Fabrication of athletic mouth guards;
(k) Placement of temporary restorations;
(L) Fabrication of soft occlusal guards;
(m) Tissue conditioning and soft reline;
(n) Atraumatic restorative therapy and interim restorative therapy;
(o) Dressing changes;
(p) Tooth reimplantation and stabilization;
(q) Administration of local anesthetic;
(r) Administration of nitrous oxide with a valid permit issued by the Oregon Board of Dentistry;
(s) Emergency palliative treatment of dental pain;
(t) Placement and removal of space maintainers;
(u) Cavity preparation;
(v) Restoration of primary and permanent teeth;
(w) Fabrication and placement of temporary crowns;
(x) Preparation and placement of preformed crowns;
(y) Pulpotomies on primary teeth;
(z) Indirect and direct pulp capping on primary and permanent teeth;
(aa) Recementing of permanent crowns;
(bb) Extractions of primary teeth;
(cc) Simple extractions of periodontally diseased permanent teeth with advanced mobility;
(dd) Suture placement and removal;
(ee) Brush biopsies;
(ff) Minor adjustments and repair of defective prosthetic devices;
(gg) Identification of conditions requiring evaluation, diagnosis or treatment by a dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375
to 678.390 or other licensed health care provider;
(hh) Oral examination, evaluation and diagnosis of conditions within the supervising dentist's authorization; and
(ii) Other services as specified by the board by rule.
(2) A dental therapist may provide a service listed in subsection (1) of this section that is outside the dental therapist's scope of practice if the dental therapist has received:
(a) Instruction in the service through the dental therapist's dental therapy education program; or
(b) Additional training approved by the board.
(3)(a) A dental therapist may supervise a dental assistant and an expanded function dental assistant, as defined by the board by rule, if the dental therapist is authorized to

perform the services provided by the dental assistant or expanded function dental assistant.
(b) A dental therapist may supervise up to four individuals under this subsection.
SECTION 10. (1) A dental therapist may, pursuant to the practice agreement, dispense and orally administer the following drugs:
(a) Nonnarcotic analgesics;
(b) Anti-inflammatories;
(c) Preventive agents; and
(d) Antibiotics.
(2) A dental therapist may, pursuant to the practice agreement, dispense samples of the drugs described in subsection (1) of this section.
(3) A practice agreement may impose greater restrictions on the dispensation and administration of drugs by a dental therapist than specified under this section

Dr. Schwindt moved and Ms. Coplen seconded that the Board direct staff to draft rules for Dental Therapist reexamination similarly to dentistry and dental hygiene. The motion passed unanimously.

President Riedman expressed concern that dually licensed hygienists/dental therapists will have to be wary of what license they are utilizing and that it could decrease the access to care.

Chair Martinez asked if anyone representing the Tribes or Dental Pilot Projects wanted to offer any public comment. None was provided. She also asked if anyone else wanted to address the Committee.

Chair Martinez announced that the next DTRO Committee Meeting had not been set and would be announced in the future via proper channels.

Chair Martinez thanked everyone for their attendance and contributions.

The meeting adjourned at 6:43 p.m.

At the August 20, 2021 Board Meeting the Oregon Board of Dentistry (OBD) established a new standing Committee named the “Dental Therapy Rules Oversight Committee” per ORS 679.280, to create, amend, review and discuss the implementation of dental therapy rules with the passage of HB 2528 (2021). This historic piece of legislation was signed by Governor Kate Brown on July 19, 2021.

This new Committee is being created because the OBD seeks a dedicated and focused group of committee members to draft new dental therapy rules in a deliberate, fair and equitable manner for the OBD to consider. This Committee will also consider cost of compliance and racial justice issues as well with the development of these rules.

The Dental Therapy Rules Oversight Committee shall be comprised of three current OBD Board Members, one who will serve as the Chair of the Committee.

The Committee shall include three representatives from the Oregon dental therapy community or organizations that represent dental therapists in Oregon. The Committee members must reside or work in Oregon and the OBD President will select the three members if more than three people volunteer to serve on this Committee. Ideally, Oregon licensed dental therapists will serve on this Committee in the future once licenses are issued.

The Committee shall include one representative from the Oregon Health Authority, ideally the Dental Director or their designee. This is to leverage their experience with dental pilot projects.

The Committee will also include one representative from each of the professional associations: The Oregon Dental Association, The Oregon Dental Hygienists’ Association and the Oregon Dental Assistants Association.

All Committee meetings will be held virtually unless conditions allow for safe in person meetings. All OBD Committee and Board meetings are public meetings.

The Legislature requires that the OBD adopt rules necessary to administer certain provisions of the new legislation. In adopting rules, the board shall consult with dental therapists and organizations that represent dental therapists in Oregon.

The public, dental therapy communities and all interested parties can take part in the implementation of the new dental therapy rules as they will be subject to the OBD’s public rulemaking process.

Chair, Yadira Martinez, RDH - OBD Representative
Sheena Kansal, DDS - OBD Representative
Jennifer Brixey - OBD Representative
Kaz Rafia, DDS OHA - Representative
Brandon Schwindt, DMD - ODA Representative
Amy Coplen, RDH - ODHA Representative
Ginny Jorgensen, CDA - ODAA Representative
Miranda Davis, DDS - DT Representative
Kari Douglass - DT Representative
Jason Mecum - DT Representative

Inaugural meeting held October 7, 2021 from 5 pm – 7 pm
Second meeting held November 10, 2021 from 5 pm - 7 pm
Third meeting held December 8, 2021 from 5 pm - 7 pm
Fourth meeting held January 19, 2022 from 5 pm - 7 pm
Fifth meeting held February 23, 2022 from 5 pm - 7 pm

EXECUTIVE DIRECTOR'S REPORT

Oregon
Kate Brown, Governor

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

TO: OBD Board Members

FROM: Stephen Prisby, Executive Director

DATE: March 14, 2022

SUBJECT: Proposed Dental Therapy Rule Making Timeline

I attached a calendar and comments laying out a proposed timeline to conduct public rulemaking hearings, gather public comment and next steps for the Board to consider as it promulgates new rules to license Dental Therapists.

I have been the OBD Rules Coordinator since 2013 and added Haley Robinson to be a Coordinator in 2020.

The attached calendar attempts to illustrate the proposed timeline of events to have the new and amended rules effective July 1, 2022.

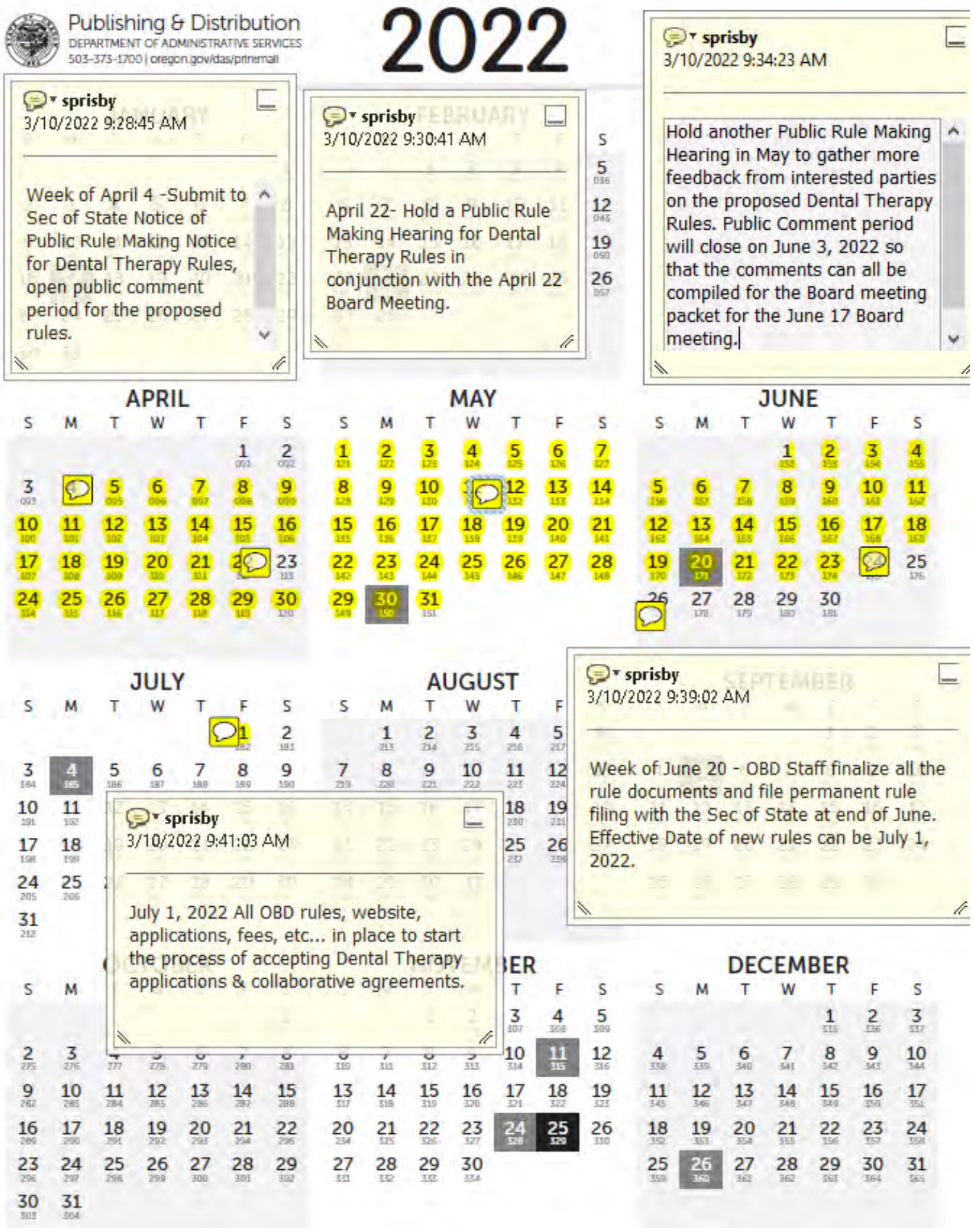
The April 22, 2022 Board Meeting could carve out 30 minutes (or more) for a public rulemaking hearing. Another public rulemaking hearing could be conducted via Zoom in May. The public comment period on the proposed rules would be open from the first week of April and close on June 3, 2022.

The comments would then be compiled and presented to the Board and public at the June 17, 2022 Board Meeting. The Board could vote on the proposed rules, make slight edits, or send back to a Committee for additional work. The Board could choose to make all or some of the rules effective July 1, 2022.

I would be happy to answer any questions at the March 30, 2022 Board Meeting.

Attachment

DRAFT – The Board will review and consider this timeline at the March 30, 2022 Special Board Meeting



2021 Legislative Session
AGENCY FISCAL IMPACT STATEMENT FORM
(See instructions for completing form)

Please complete this form and return completed form and any supporting documents via email to the requesting Legislative Fiscal Office (LFO) Analyst and to LFO.FISREQ@oregonlegislature.gov.

Agency Name: **Board of Dentistry**
Preparer Name/Title: **Stephen Prisby Executive Director**
Preparer Phone #: **971-673-3200**
Date Submitted: **May 26, 2021**

Measure #: **HB 2528** Version: **-A15, 16 & 17**

___ **No fiscal impact** The absence of an expenditure or revenue (non-tax) impact.
___ **Minimal Impact** A fiscal impact that can be absorbed with existing agency resources.
X **Fiscal Impact** A fiscal impact determined to be greater than a minimal fiscal impact.

The budgetary impact of this bill was reviewed and approved by the Interim Joint Committee on Ways and Means to be recommended to be included in the omnibus budget bill.
Yes ___ No **X**

Is the bill anticipated by the Governor's Recommended Budget as a Policy Option Package? If yes, please identify the Policy Option Package name and number in your written analysis.
Yes ___ No **X**

BILL DESCRIPTION
State your agency's understanding of what the bill proposes. For FIS prepared on subsequent bill versions (amendments), please provide an explanation of the changes made in each version of the measure.

Directs Oregon Board of Dentistry to issue dental therapist license to qualified applicant. Prohibits unlicensed use of title "dental therapist" and practice of dental therapy. Provides exceptions to prohibition. Adds dental therapist member to board.

AGENCY WRITTEN ANALYSIS:
How would the proposal be implemented? Provide a high-level summary of the general requirements of the bill and what your agency will need to do to comply with the requirements. Identify any ambiguity or other issues related to the measure's language. Identify measure's effective date, and if applicable, operative dates. Summarize the methodology used to make fiscal calculations/determination. See instructions for other considerations.

We anticipate a Fiscal Impact on the Oregon Board of Dentistry (OBD)

General estimates for fiscal impact include:
$2100 per OBD Committee Meeting- it appears there could be several committee meetings to promulgate new rules.
We are charged at a rate of $218 per hour for OBD assigned DOJ Attorney to review proposed rules and give advice to the Board. The attorney will be utilized extensively to implement this legislation.

Unknown staff hours needed to review other state and jurisdictions dental therapy education and licensure requirements.
Unknown staff hours needed to review CODA accreditation standards for dental therapy programs.
Unknown staff hours needed to create new forms and documents for dental therapy regulations and licensure.
Unknown staff hours needed to update OBD Website with Dental Therapy information.
Unknown staff hours needed to develop templates and review dental therapist practice plan agreements.
Unknown staff hours needed to assist new dental therapist applicants for licensure.
Unknown staff hours needed for informational outreach on this new type of Licensee.
Unknown staff hours needed for OBD Investigators to investigate complaints arising from dental therapists.
Unknown staff hours to review liability insurance criteria and develop recommendations to the Board to approve.

This is a new Licensee for the OBD to regulate. We last added dental hygienists as a Licensee type in 1946. This could be substantial work, with all our other work and priorities

The number of new dental therapists should be quite small over the next 2 - 4 years.
This should allow the OBD some time to ramp up with all the new rules, policies, forms and communications related to the implementation of this legislation.

Attorney charges $218 per hour for advice and guidance
Staff (average $50/hour) will need to focus resources on all the requirements of the legislation:

- Create forms and instructions for applications
- Create Applications and systems to track collaborative agreements
- Update Website
- Update Database
- Communicate new statute and rule changes to interested parties
- My estimate is 400 Staff hours of work on this
- My estimate is we would utilize our attorney for 100 hours of work and attendance at meetings involving this legislation
- Total estimated cost to implement in the 2021-2023 Biennium is about $50,000 - $54,000

AGENCY QUANTITATIVE ANALYSIS *Provide a detail description of the proposed legislation's effect on expenditures, revenues, and full time equivalent (FTE) positions. The table below is an embedded Excel worksheet. To fill out the form, place your mouse on the table; right click; select Worksheet Object and Open. If your analysis is number intensive, you may want to use just the Excel version of this template.*

Effect on Expenditure (by Fund and Category):

	General Fund	Lottery Funds	Other Funds	Federal Funds	NL Other Funds	NL Federal Funds	TOTAL FUNDS
2021-23 Biennium				-		-	
Personal Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Services and Supplies	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Special Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Outlay	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Construction	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Debt Service	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -

	General Fund	Lottery Funds	Other Funds	Federal Funds	NL Other Funds	NL Federal Funds	TOTAL FUNDS
2023-25 Biennium							
Personal Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Services and Supplies	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Special Payments	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Outlay	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Construction	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Debt Service	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Effect on Revenues (by Fund):

	General Fund	Lottery Funds	Other Funds	Federal Funds	NL Other Funds	NL Federal Funds	TOTAL FUNDS
2021-23 Biennium	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2023-25 Biennium	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Effect on Position(s) / FTE(s):

Months of Impact 2021-23	Months of Impact 2023-25	2021-23 Position Count	2021-23 FTE	2023-25 Position Count	2023-25 FTE

Oregon
Kate Brown, Governor

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

TO: DAS-CFO Budget & Management

FROM: Stephen Prisby, Executive Director of the Oregon Board of Dentistry

DATE: March 22, 2022

SUBJECT: Oregon Board of Dentistry (AGY 834) Request to Initiate New Fees

The OBD is submitting this request to get approval to initiate new fees for a new Licensee the OBD is required to regulate and license.

HB 2528 (2021) was signed by Governor Kate Brown in July 2021.The Bill is attached to this memo for reference. The bill was incorporated into ORS 679.603 authorizing our agency to initiate fees.

679.603. (1) The Oregon Board of Dentistry shall issue a license to practice dental therapy to an applicant who: (a) Is at least 18 years of age; (b) Submits to the board a completed application form; (c) Demonstrates: (A) The completion of a dental therapy education program that is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization, and approved by the board by rule; or (B) That the applicant is or was a participant in a dental pilot project; (d) Passes an examination described in ORS 679.606; and (e) Pays the application and licensure fees established by the board. (2)(a) An individual who completed a dental therapy education program in another state or jurisdiction may apply for licensure under this section if the dental therapy education program is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization. (b) The board shall determine whether the training and education of an applicant described in this subsection is sufficient to meet the requirements of subsection (1) of this section. (3) If an applicant holds a current or expired authorization to practice dental therapy issued by another state, the federal government or a tribal authority, the applicant shall include with the application a copy of the authorization and an affidavit from the dental regulatory body of the other jurisdiction that demonstrates the applicant was authorized to practice dental therapy in that jurisdiction.

The OBD created a new standing Committee named the “Dental Therapy Rules Oversight Committee.” This new Committee was created because the OBD sought a dedicated and focused group of committee members to draft new dental therapy rules in a deliberate, fair and equitable manner for the OBD to consider. This Committee has also considered cost of compliance and racial justice issues with the development of these rules. The Committee met five times throughout the end of 2021 into 2022.

The Committee involved important stakeholders and interested parties from the Tribes, the Dental Therapy Community, professional associations, the OHA and the process has been

widely publicized. We are confident that the communities impacted by this new type of Licensees have been a part of the discussion throughout committee work, board meetings and the upcoming rulemaking process. We have not encountered any negative feedback or criticism over the fees proposed.

The Committee made recommendations to the Board including new fees that will go through the Board's regular and transparent rulemaking process.

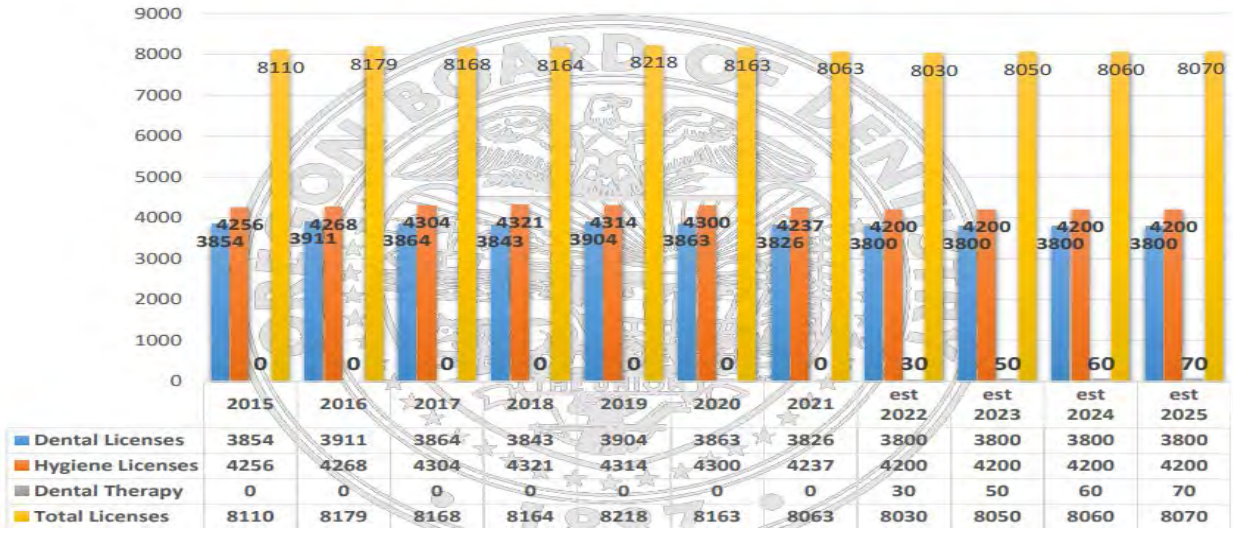
Dental Therapists will renew licenses between mid-July and Sept 30th every year. If someone is licensed in an even numbered year (2022), then two years later they renew their license (2024). If someone is licensed in an odd numbered year (2021), then two years later they renew their license (2023). It is understood that some clinics, community health centers, large healthcare systems, fully funded nonprofits, government agencies, etc…pay their license and renewal fees for their employees. Some licensee's licensure fees can be written off on their taxes. The healthcare field and most industries are experiencing a shortage of workers. The OBD believes that these initial dental therapy licensure fees are fair and appropriate.

The OBD is an Other Funds agency and has to cover the costs of the administration of licensing along with all the other functions delegated to our staff. The OBD's funding is derived approximately 96% from licensure, renewal and permit fees. The OBD fully supports and encourages the development of Dental Therapy in Oregon with the goal of expanding access to oral healthcare to underserved populations and Oregon as a whole.

The OBD expects to issue approximately 30 - 40 Dental Therapist licenses through June 30, 2023. This figure is derived from the number of individuals coming out of the OHA's Dental Pilot Projects who are the only individuals able to meet licensure criteria. The fees collected from this new Licensee will never provide substantial funding for the OBD in the foreseeable future.

The OBD staff has put in extra work in preparation of issuing these new licenses for Dental Therapists in supporting the Committee work. Along with the additional hours put in on administrative tasks with the OBD Website, designing new Dental Therapy licensure instructions, applications and licensure materials.

The chart below shows licensee statistics and estimates going forward.



	2015	2016	2017	2018	2019	2020	2021	est 2022	est 2023	est 2024	est 2025
Dental Licenses	3854	3911	3864	3843	3904	3863	3826	3800	3800	3800	3800
Hygiene Licenses	4256	4268	4304	4321	4314	4300	4237	4200	4200	4200	4200
Dental Therapy	0	0	0	0	0	0	0	30	50	60	70
Total Licenses	8110	8179	8168	8164	8218	8163	8063	8030	8050	8060	8070

There are new fees to initiate for Dental Therapists:

- Dental Therapy Application Fee - $180
- Dental Therapy Biennial Licensure Fee - $230

There are fees that apply to all the Board's Licensees (that will include Dental therapists)

- Access to Public Records - Lists of Licensees $50
- Delinquent Fees and License Reinstatement $50, $100, $250 & $500
- Merchant Card – Credit Card Service fee $3.50

818-001-0087 Fees
(1) The Board adopts the following fees:
(a) Biennial License Fees:
(A) Dental —$390;
(B) Dental — retired — $0;
(C) Dental Faculty — $335;
(D) Volunteer Dentist — $0;
(E) Dental Hygiene —$230;
(F) Dental Hygiene — retired — $0;
(G) Volunteer Dental Hygienist — $0;
(H) Dental Therapy - $230;
(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 — $75;
(D) Deep Sedation Permit — $75;
(E) General Anesthesia Permit — $140;
(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;
(c) Applications for Licensure:
(A) Dental — General and Specialty — $345;
(B) Dental Faculty — $305;
(C) Dental Hygiene — $180;
(D) **Dental Therapy - $180;**
(D) **(E)** Licensure Without Further Examination — Dental**, and** Dental Hygiene **and Dental Therapy** — $790.
(d) Examinations:
(A) Jurisprudence — $0;
(e) 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

Other fees are referenced already in the Dental Practice Act, but these rules and fees cover all the OBD's Licensees. We do not expect to receive any substantial revenue from incorporating dental therapists into these existing rules through June 30, 2023.

818-001-0082
Access to Public Records

(1) Public records not exempt from disclosure may be inspected during office hours at the Board office upon reasonable notice.
(2) Copies of public records not exempt from disclosure may be purchased upon receipt of a written request. The Board may withhold copies of public records until the requestor pays for the copies.
(3) The Board follows the Department of Administrative Service's statewide policy (107-001-030) for fees in regards to public records request; in addition, the Board establishes the following fees:
(a) $0.10 per name and address for computer-generated lists on paper; $0.20 per name and address for computer-generated lists on paper sorted by specific zip code;
(b) Data files submitted electronically or on a device:
(A) All Licensed Dentists — $50;
(B) All Licensed Dental Hygienists **and Dental Therapists** — $50;
(C) All Licensees — $100.
(c) Written verification of licensure — $2.50 per name; and
(d) Certificate of Standing — $20.

818-021-0080
Renewal of License
Before the expiration date of a license, the Board will, as a courtesy, mail notice for renewal of license to the last mailing address on file in the Board's records to every licensee holding a current license. The licensee must complete the online renewal application and pay the current renewal fees prior to the expiration of said license. Licensees who fail to renew their license prior to the expiration date may not practice dentistry**, dental therapy** or dental hygiene until the license is reinstated and are subject to the provisions of OAR 818-021-0085, "Reinstatement of Expired Licenses."
(1) Each dentist shall submit the renewal fee and completed online renewal application by March 31 every other year. Dentists licensed in odd numbered years shall apply for renewal in odd numbered years and dentists licensed in even numbered years shall apply for renewal in even numbered years.
(2) Each dental hygienist must submit the renewal fee and completed online renewal application ~~form~~ by September 30 every other year. Dental hygienists licensed in odd numbered years shall apply for renewal in odd numbered years and dental hygienists licensed in even numbered years shall apply for renewal in even numbered years.
(3) Each dental therapist must submit the renewal fee and completed and signed renewal application form by September 30 every other year. Dental Therapists licensed in odd numbered years shall apply for renewal in odd numbered years and dental therapists licensed in even numbered years shall apply for renewal in even numbered years.
(4) The renewal application shall contain:
(a) Licensee's full name;
(b) Licensee's mailing address;
(c) Licensees business address including street and number or if the licensee has no business address, licensee's home address including street and number;
(d) Licensee's business telephone number or if the licensee has no business telephone number, licensee's home telephone number;
(e) Licensee's employer or person with whom the licensee is on contract;
(f) Licensee's assumed business name;
(g) Licensee's type of practice or employment;
(h) A statement that the licensee has met the continuing educational requirements for **their specific license** renewal set forth in OAR 818-021-0060 or **OAR** 818-021-0070 **or OAR 818-021-0080**;
(i) Identity of all jurisdictions in which the licensee has practiced during the two past years; and
(j) A statement that the licensee has not been disciplined by the licensing board of any other jurisdiction or convicted of a crime.

818-021-0085
Renewal or Reinstatement of Expired License
Any person whose license to practice as a dentist**,** dental hygienist **or dental therapist** has expired, may apply for reinstatement under the following circumstances:
(1) If the license has been expired 30 days or less, the applicant shall:
(a) Pay a penalty fee of $50;
(b) Pay the biennial renewal fee; and
(c) Submit a completed renewal application and certification of having completed the Board's continuing education requirements.
(2) If the license has been expired more than 30 days but less than 60 days, the applicant shall:
(a) Pay a penalty fee of $100;
(b) Pay the biennial renewal fee; and
(c) Submit a completed renewal application and certification of having completed the continuing education requirements.
(3) If the license has been expired more than 60 days, but less than one year, the applicant shall:
(a) Pay a penalty fee of $150;
(b) Pay a fee equal to the renewal fees that would have been due during the period the license was expired;
(c) Pay a reinstatement fee of $500; and
(d) Submit a completed application for reinstatement provided by the Board, including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.
(4) If the license has been expired for more than one year but less than four years, the applicant shall:
(a) Pay a penalty fee of $250;
(b) Pay a fee of equal to the renewal fees that would have been due during the period the license was expired;
(c) Pay a reinstatement fee of $500;
(d) Pass the Board's Jurisprudence Examination;
(e) Pass any other qualifying examination as may be determined necessary by the Board after assessing the applicant's professional background and credentials;
(f) Submit evidence of good standing from all states in which the applicant is currently licensed; and
(g) Submit a completed application for reinstatement provided by the Board including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.
(5) If a **Licensee** fails to renew or reinstate **their** license within four years from expiration, the **Licensee** must apply for licensure under the current statute and rules of the Board.

818-021-0090
Retirement of License
(1) A **Licensee** who no longer practices in any jurisdiction may retire **their** license by submitting a request to retire such license on a form provided by the Board.
(2) A license that has been retired may be reinstated if the applicant:
(a) Pays a reinstatement fee of $500;
(b) Passes the Board’s Jurisprudence Examination;
(c) Passes any other qualifying examination as may be determined necessary by the Board after assessing the applicant’s professional background and credentials;
(d) Submits evidence of good standing from all states in which the applicant is currently licensed; and

(e) Submits a completed application for reinstatement provided by the Board including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.
(3) If the **Licensee** fails to reinstate **their** license within four years from retiring the license, the **Licensee** must apply for licensure under the current statute and rules of the Boa

Two Attachments

- Fee Detail Form
- HB 2528 (2021)

FEE CHANGE DETAIL REPORT

Fee Title/Description	ORS/OAR	Who Pays Fee	Increase, Establish, or Decrease	Date of Last Change	Amount of Last Change	Effective Date of Requested Change	Current Fee	Proposed Fee	Amount of Proposed Fee Change	Number of 2019-21 Transactions with New Fee	Estimated Impact on 2019-21 Revenue	Total 2019-21 Revenue	Projected 2021-23 Transactions with New Fee	Impact on 2021-23 Revenue	Total 2021-23 Revenue	Legislative Concept Number	Policy Package Number
Dental Therapy- Application	ORS 679.060, 679.603, 679.615, 680.050/OAR 818-001-0087	Dental Therapist (DT)	Establish			7.1.2022		180	180	40	7,200		40	7,200	7,200		
Dental Therapy - Application LWOFE	ORS 679.060, 679.603, 679.615, 680.050/OAR 818-001-0087	Dental Therapist (DT)	Establish			7.1.2022		790	790	-	-			-			
Renewal of License	ORS 679.120, 679.603, 679.615, 680.075/OAR 818-001-0087	Dental Therapist (DT)	Establish			7.1.2022		230	230	40	9,200		40	9,200	9,200		
Renewal or Reinstatement of Exp License	ORS 679.120, 679.603, 679.615, 680.075/OAR 818-021-0085	All Licensees	current- adding DT		unknown	7.1.2022	50										
Renewal or Reinstatement of Exp License	ORS 679.120, 679.603, 679.615, 680.075/OAR 818-021-0085	All Licensees	current- adding DT		unknown	7.1.2022	100										
Renewal or Reinstatement of Exp License	ORS 679.120, 679.603, 679.615, 680.075/OAR 818-021-0085	All Licensees	current- adding DT		unknown	7.1.2022	150										
Renewal or Reinstatement of Exp License	ORS 679.120, 679.603, 679.615, 680.075/OAR 818-021-0085	All Licensees	current- adding DT		unknown	7.1.2022	250										
Renewal or Reinstatement of Exp License	ORS 679.120, 679.603, 679.615, 680.075/OAR 818-021-0085	All Licensees	current- adding DT		unknown	7.1.2022	500				-			-			
Retirement of License	ORS 679.120, 679.603, 679.615, 680.075/OAR 818-021-0090	All Licensees	current- adding DT		unknown	7.1.2022	500				-			-			
Access to Public records	ORS 192.324/OAR 818-001-0082	Anyone	current- adding DT		unknown	7.1.2022	variable				-			-			
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This form and accompanying cover letter must be completed and submitted for three separate purposes:

1) Submitted to DAS with the Fee Approval Form (107bf21) when requesting DAS approval to change a fee administratively (Legislative Concept/Policy Package columns not relevant).

2) Submitted to DAS with a Legislative Concept, if that concept would increase a fee or assessment (2019-21 columns not relevant).

3) Submitted electronically to CFO analyst, at same time as Agency Request Budget, if budget includes a fee establishment, increase, or decrease (2019-21 columns not relevant).

A cover letter is required to provide an overview of and context for the impact of the fee change or establishment.

See instructions on following page for more information.

Note: Shaded fields are reported on the Detail of Fee, License, or Assessment Revenue Increase form in the budget binder (107bf08).

A cover letter on agency letterhead that provides an overview of and provides context for the impact of the fee change or establishment. The cover letter should include the following information, when relevant, in order for DAS to review the proposal:

a. An explanation of why the fee change or new fee is required. For example, was the fee change necessary due to:

- An increase or decrease in Federal Funds or Other Funds revenues?
- Increased program costs? If so, please explain what factors have contributed to rising costs.
- Changes in transaction volumes like number of fee payers or renewals? Please provide trend information and related FTE workload statistics.
- A new fee created by statute?
- Policy changes? Regulatory streamlining? Please explain.
- Other?

b. A summary of program funding. For example, how much of the program is covered by fee revenues? How much by General Fund or Federal Funds? Will the new fee level allow replacement of General Fund? Do statutes/rules require General Fund to constitute a minimum proportion of overall program funding?

c. An estimate of the timeframe the proposed fee will sustain the program. Please explain the underlying assumptions.

d. A table showing calculations if the fee is based on a sliding scale.

e. A summary of who pays the fee and the stakeholders and recipients of the program.

f. An overview of stakeholder/fee payer participation in the fee-setting process, including: a summary of stakeholder impacts; any outreach done to garner stakeholder input prior to setting the new fee level; and whether there is stakeholder approval or opposition to the new rate. If opposition, summarize those comments. If the only outreach done was via public comment during rulemaking please state so. Also, please identify if the fees relate to policy discussions/concerns raised during the legislative session, and provide a summary of those discussions/concerns.

Enrolled
House Bill 2528

Sponsored by Representatives SANCHEZ, BYNUM; Representatives ALONSO LEON, CAMPOS, DEXTER, MEEK, PRUSAK, SOLLMAN, WILLIAMS, WITT, Senator DEMBROW (Presession filed.)

CHAPTER .....

AN ACT

Relating to dental therapy; creating new provisions; amending ORS 679.010, 679.140, 679.170 and 679.250 and section 1, chapter 716, Oregon Laws 2011; and prescribing an effective date.

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

SECTION 1. Sections 2 to 12 of this 2021 Act are added to and made a part of ORS chapter 679.

SECTION 2. As used in sections 2 to 12 of this 2021 Act:

(1) "Collaborative agreement" means a written and signed agreement entered into between a dentist and a dental therapist under section 8 of this 2021 Act.

(2) "Dental pilot project" means an Oregon Health Authority dental pilot project developed and operated by the authority.

(3) "Dentist" means a person licensed to practice dentistry under this chapter.

SECTION 3. (1) The Oregon Board of Dentistry shall issue a license to practice dental therapy to an applicant who:

(a) Is at least 18 years of age;

(b) Submits to the board a completed application form;

(c) Demonstrates the completion of a dental therapy education program;

(d) Passes an examination described in section 4 of this 2021 Act; and

(e) Pays the application and licensure fees established by the board.

(2)(a) An individual who completed a dental therapy education program in another state or jurisdiction may apply for licensure under this section if the dental therapy education program is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization.

(b) The board shall determine whether the training and education of an applicant described in this subsection is sufficient to meet the requirements of subsection (1) of this section.

(3) If an applicant holds a current or expired authorization to practice dental therapy issued by another state, the federal government or a tribal authority, the applicant shall include with the application a copy of the authorization and an affidavit from the dental regulatory body of the other jurisdiction that demonstrates the applicant was authorized to practice dental therapy in that jurisdiction.

SECTION 3a. Section 3 of this 2021 Act is amended to read:

Sec. 3. (1) The Oregon Board of Dentistry shall issue a license to practice dental therapy to an applicant who:

(a) Is at least 18 years of age;

(b) Submits to the board a completed application form;

(c) Demonstrates**:**

(A) The completion of a dental therapy education program **that is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization, and approved by the board by rule; or**

(B) That the applicant is or was a participant in a dental pilot project;

(d) Passes an examination described in section 4 of this 2021 Act; and

(e) Pays the application and licensure fees established by the board.

(2)(a) An individual who completed a dental therapy education program in another state or jurisdiction may apply for licensure under this section if the dental therapy education program is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization.

(b) The board shall determine whether the training and education of an applicant described in this subsection is sufficient to meet the requirements of subsection (1) of this section.

(3) If an applicant holds a current or expired authorization to practice dental therapy issued by another state, the federal government or a tribal authority, the applicant shall include with the application a copy of the authorization and an affidavit from the dental regulatory body of the other jurisdiction that demonstrates the applicant was authorized to practice dental therapy in that jurisdiction.

SECTION 4. (1)(a) The Oregon Board of Dentistry may require an applicant for a license to practice dental therapy to pass written, laboratory or clinical examinations to test the professional knowledge and skills of the applicant.

(b) The examinations may not be affiliated with or administered by a dental pilot project or a dental therapy education program described in section 3 of this 2021 Act.

(c) The examinations must:

(A) Be elementary and practical in character, and sufficiently thorough to test the fitness of the applicant to practice dental therapy;

(B) Be written in English; and

(C) Include questions on subjects pertaining to dental therapy.

(2) If a test or examination was taken within five years of the date of application and the applicant received a passing score on the test or examination, as established by the board by rule, the board:

(a) To satisfy the written examination authorized under this section, may accept the results of national standardized examinations.

(b) To satisfy the laboratory or clinical examination authorized under this section:

(A) Shall accept the results of regional and national testing agencies or clinical board examinations administered by other states; and

(B) May accept the results of board-recognized testing agencies.

(3) The board shall accept the results of regional and national testing agencies or of clinical board examinations administered by other states, and may accept results of board-recognized testing agencies, in satisfaction of the examinations authorized under this section for applicants who have engaged in the active practice of dental therapy in Oregon, another state, the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a period of at least 3,500 hours in the five years immediately preceding application and who meet all other requirements for licensure.

(4) The board shall establish rules related to reexamination for an applicant who fails an examination.

SECTION 5. The Oregon Board of Dentistry may refuse to issue or renew a license to practice dental therapy if the applicant or licensee:

(1) Subject to ORS 670.280, has been convicted of a violation of the law. A certified copy of the record of conviction is conclusive evidence of conviction.

(2) Has been disciplined by a state licensing or regulatory agency of this state or another state regarding a health care profession if, in the judgment of the board, the acts or conduct resulting in the disciplinary action bears a demonstrable relationship to the ability of the applicant or licensee to practice dental therapy in accordance with sections 2 to 12 of this 2021 Act. A certified copy of the disciplinary action is conclusive evidence of the disciplinary action.

(3) Has falsified an application for issuance or renewal of licensure.

(4) Has violated any provision of sections 2 to 12 of this 2021 Act or a rule adopted under sections 2 to 12 of this 2021 Act.

SECTION 6. (1) A person may not practice dental therapy or assume or use any title, words or abbreviations, including the title or designation "dental therapist," that indicate that the person is authorized to practice dental therapy unless the person is licensed under section 3 of this 2021 Act.

(2) Subsection (1) of this section does not prohibit:

(a) The practice of dental therapy by a health care provider performing services within the health care provider's authorized scope of practice.

(b) The practice of dental therapy in the discharge of official duties on behalf of the United States government, including but not limited to the Armed Forces of the United States, the United States Coast Guard, the United States Public Health Service, the United States Bureau of Indian Affairs or the United States Department of Veterans Affairs.

(c) The practice of dental therapy pursuant to an educational program described in section 3 of this 2021 Act.

(d) A dental therapist authorized to practice in another state or jurisdiction from making a clinical presentation sponsored by a bona fide dental or dental therapy association or society or an accredited dental or dental therapy education program approved by the Oregon Board of Dentistry.

(e) Bona fide students of dental therapy from engaging in clinical studies during the period of their enrollment and as a part of the course of study in a dental therapy education program described in section 3 (1) of this 2021 Act. The clinical studies may be conducted on the premises of the program or in a clinical setting located off the premises. The facility, instructional staff and course of study at an off-premises location must meet minimum requirements established by the board by rule. The clinical studies at the off-premises location must be performed under the indirect supervision of a member of the program faculty.

(f) Bona fide full-time students of dental therapy, during the period of their enrollment and as a part of the course of study in a dental therapy education program located outside of Oregon that is accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency, from engaging 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 established by the board by rule and are performed under the indirect supervision of a member of the faculty of the Oregon Health and Science University School of Dentistry.

(g) The performance of duties by a federally certified dental health aide therapist or tribally authorized dental therapist in a clinic operated by the Indian Health Service, including, as described in 25 U.S.C. 1603, an Indian Health Service Direct Service Tribe clinic, a clinic operated under an Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638) contract or a clinic operated under an urban Indian organization.

SECTION 7. (1) The Oregon Board of Dentistry may impose nonrefundable fees for the following:

(a) Application for licensure;

(b) Examinations;

(c) Biennial dental therapy licenses, both active and inactive;

(d) Licensure renewal fees;

(e) Permits; and

(f) Delinquency.

(2) Subject to prior approval of the Oregon Department of Administrative Services and a report to the Emergency Board prior to adopting fees and charges, the fees and charges established under sections 2 to 12 of this 2021 Act may not exceed the cost of administering sections 2 to 12 of this 2021 Act as authorized by the Legislative Assembly within the Oregon Board of Dentistry budget and as modified by the Emergency Board.

(3)(a) The Oregon Board of Dentistry may waive a license fee for a licensee who provides to the board satisfactory evidence that the licensee has discontinued the practice of dental therapy because of retirement.

(b) A licensee described in this subsection may apply to the board for reinstatement of the license pursuant to rules adopted by the board. An application under this paragraph must include a fee. If the licensee has been retired or inactive for more than one year from the date of application, the licensee shall include with the application satisfactory evidence of clinical competence, as determined by the board.

(4)(a) A license to practice dental therapy is valid for two years and may be renewed. A licensee shall submit to the board an application for renewal and payment of the fee.

(b) A dental therapist issued a license in an even-numbered year must apply for renewal by September 30 of each even-numbered year thereafter. A dental therapist issued a license in an odd-numbered year must apply for renewal by September 30 of each odd-numbered year thereafter.

(c) The board may charge a reasonable fee if the application for renewal or the fee is submitted more than 10 days delinquent.

(5) A dental therapist shall inform the board of a change of the dental therapist's address within 30 days of the change.

SECTION 8. (1) A dental therapist may practice dental therapy only under the supervision of a dentist and pursuant to a collaborative agreement with the dentist that outlines the supervision logistics and requirements for the dental therapist's practice. The collaborative agreement must include at least the following information:

(a) The level of supervision required for each procedure performed by the dental therapist;

(b) Circumstances under which the prior knowledge and consent of the dentist is required to allow the dental therapist to provide a certain service or perform a certain procedure;

(c) The practice settings in which the dental therapist may provide care;

(d) Any limitation on the care the dental therapist may provide;

(e) Patient age-specific and procedure-specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency;

(f) Procedures for creating and maintaining dental records for patients treated by the dental therapist;

(g) Guidelines for the management of medical emergencies in each of the practice settings in which the dental therapist provides care;

(h) A quality assurance plan for monitoring care provided by the dental therapist, including chart review, patient care review and referral follow-up;

(i) Protocols for the dispensation and administration of drugs, as described in section 9 of this 2021 Act, by the dental therapist, including circumstances under which the dental therapist may dispense and administer drugs;

(j) Criteria for the provision of care to patients with specific medical conditions or complex medical histories, including any requirements for consultation with the dentist prior to the provision of care; and

(k) Protocols for when a patient requires treatment outside the dental therapist's scope of practice, including for referral of the patient for evaluation and treatment by the dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390 or other licensed health care provider.

(2) In addition to the information described in subsection (1) of this section, a collaborative agreement must include a provision that requires the dental therapist to consult with a dentist if the dental therapist intends to perform an irreversible surgical procedure under general supervision on a patient who has a severe systemic disease.

(3) A dentist who enters into a collaborative agreement with a dental therapist shall:

(a) Directly provide care to a patient that is outside the scope of practice of the dental therapist or arrange for the provision of care by another dentist; and

(b) Ensure that the dentist, or another dentist, is available to the dental therapist for timely communication during the dental therapist's provision of care to a patient.

(4) A dental therapist may perform and provide only those procedures and services authorized by the dentist and set out in the collaborative agreement, and shall maintain with the dentist an appropriate level of contact, as determined by the dentist.

(5) A dental therapist and a dentist who enter into a collaborative agreement together shall each maintain a physical copy of the collaborative agreement.

(6)(a) A dental therapist may enter into collaborative agreements with more than one dentist if each collaborative agreement includes the same supervision requirements and scope of practice.

(b) A dentist may supervise and enter into collaborative agreements with up to three dental therapists at any one time.

(7)(a) A collaborative agreement must be signed by the dentist and dental therapist.

(b) A dental therapist shall annually submit a signed copy of the collaborative agreement to the Oregon Board of Dentistry. If the collaborative agreement is revised in between annual submissions, a signed copy of the revised collaborative agreement must be submitted to the board as soon as practicable after the revision is made.

SECTION 9. (1) A dental therapist may perform, pursuant to the dental therapist's collaborative agreement, the following procedures under the general supervision of the dentist:

(a) Identification of conditions requiring evaluation, diagnosis or treatment by a dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390 or other licensed health care provider;

(b) Comprehensive charting of the oral cavity;

(c) Oral health instruction and disease prevention education, including nutritional counseling and dietary analysis;

(d) Exposing and evaluation of radiographic images;

(e) Dental prophylaxis, including subgingival scaling and polishing procedures;

(f) Application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;

(g) Administering local anesthetic;

(h) Pulp vitality testing;

(i) Application of desensitizing medication or resin;

(j) Fabrication of athletic mouth guards;

(k) Changing of periodontal dressings;

(L) Simple extractions of erupted primary anterior teeth and coronal remnants of any primary teeth;

(m) Emergency palliative treatment of dental pain;

(n) Preparation and placement of direct restoration in primary and permanent teeth;

(o) Fabrication and placement of single-tooth temporary crowns;

(p) Preparation and placement of preformed crowns on primary teeth;

(q) Indirect pulp capping on permanent teeth;

(r) Indirect pulp capping on primary teeth;

(s) Suture removal;

(t) Minor adjustments and repairs of removable prosthetic devices;

(u) Atraumatic restorative therapy and interim restorative therapy;

(v) Oral examination, evaluation and diagnosis of conditions within the supervising dentist's authorization;

(w) Removal of space maintainers;

(x) The dispensation and oral or topical administration of:

(A) Nonnarcotic analgesics;

(B) Anti-inflammatories; and

(C) Antibiotics; and

(y) Other services as specified by the Oregon Board of Dentistry by rule.

(2) A dental therapist may perform, pursuant to the dental therapist's collaborative agreement, the following procedures under the indirect supervision of the dentist:

(a) Placement of temporary restorations;

(b) Fabrication of soft occlusal guards;

(c) Tissue reconditioning and soft reline;

(d) Tooth reimplantation and stabilization;

(e) Recementing of permanent crowns;

(f) Pulpotomies on primary teeth;

(g) Simple extractions of:

(A) Erupted posterior primary teeth; and

(B) Permanent teeth that have horizontal movement of greater than two millimeters or vertical movement and that have at least 50 percent periodontal bone loss;

(h) Brush biopsies; and

(i) Direct pulp capping on permanent teeth.

(3) The dentist described in subsection (2) of this section shall review a procedure described in subsection (2) of this section that is performed by the dental therapist and the patient chart that contains information regarding the procedure.

(4)(a) A dental therapist may supervise a dental assistant and an expanded function dental assistant, as defined by the board by rule, if the dental therapist is authorized to perform the services provided by the dental assistant or expanded function dental assistant.

(b) A dental therapist may supervise up to two individuals under this subsection.

SECTION 10. (1) A dental therapist may perform the procedures listed in section 9 of this 2021 Act so long as the procedures are included in an education program described in section 3 (1) of this 2021 Act or the dental therapist has received additional training in the procedure approved by the Oregon Board of Dentistry.

(2) A dental therapist shall purchase and maintain liability insurance as determined sufficient by the board.

(3) A dental therapist shall dedicate at least 51 percent of the dental therapist's practice to patients who represent underserved populations, as defined by the Oregon Health Authority by rule, or patients located in dental care health professional shortage areas, as determined by the authority.

SECTION 11. A person licensed under section 3 of this 2021 Act is subject to the provisions of ORS 679.140.

SECTION 12. The Oregon Board of Dentistry shall adopt rules necessary to administer sections 2 to 12 of this 2021 Act. In adopting rules under this section, the board shall consult with dental therapists and organizations that represent dental therapists in this state.

SECTION 13. ORS 679.010 is amended to read:

679.010. As used in this chapter and ORS 680.010 to 680.205, unless the context requires otherwise:

(1) "Dental assistant" means a person who, under the supervision of a dentist **or dental therapist**, renders assistance to a dentist, **dental therapist,** dental hygienist, dental technician or another dental assistant or who, under the supervision of a dental hygienist, renders assistance to a dental hygienist providing dental hygiene.

(2) "Dental hygiene" is that portion of dentistry that includes, but is not limited to:

(a) The rendering of educational, preventive and therapeutic dental services and diagnosis and treatment planning for such services;

(b) Prediagnostic risk assessment, scaling, root planing, curettage, the application of sealants and fluoride and any related intraoral or extraoral procedure required in the performance of such services; and

(c) Prescribing, dispensing and administering prescription drugs for the services described in paragraphs (a) and (b) of this subsection.

(3) "Dental hygienist" means a person who, under the supervision of a dentist, practices dental hygiene.

(4) "Dental technician" means a person who, at the authorization of a dentist, makes, provides, repairs or alters oral prosthetic appliances and other artificial materials and devices that are returned to a dentist and inserted into the human oral cavity or that come in contact with its adjacent structures and tissues.

(5) "Dental therapist" means a person licensed to practice dental therapy under section 3 of this 2021 Act.

(6) "Dental therapy" means the provision of preventive dental care, restorative dental treatment and other educational, clinical and therapeutic patient services as part of a dental care team, including the services described under section 9 of this 2021 Act.

[*(5)*] **(7)** "Dentist" means a person who may perform any intraoral or extraoral procedure required in the practice of dentistry.

[*(6)*] **(8)** "Dentist of record" means a dentist that either authorizes treatment for, supervises treatment of or provides treatment for a patient in a dental office or clinic owned or operated by an institution as described in ORS 679.020 (3).

[*(7)(a)*] **(9)(a)** "Dentistry" means the healing art concerned with:

(A) The examination, diagnosis, treatment planning, treatment, care and prevention of conditions within the human oral cavity and maxillofacial region, and of conditions of adjacent or related tissues and structures; and

(B) The prescribing, dispensing and administering of prescription drugs for purposes related to the activities described in subparagraph (A) of this paragraph.

(b) "Dentistry" includes, but is not limited to:

(A) The cutting, altering, repairing, removing, replacing or repositioning of hard or soft tissues and other acts or procedures as determined by the Oregon Board of Dentistry and included in the curricula of:

(i) Dental schools accredited by the Commission on Dental Accreditation of the American Dental Association;

(ii) Post-graduate training programs; or

(iii) Continuing education courses.

(B) The prescription and administration of vaccines.

[*(8)*] **(10)** "Direct supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.

[*(9)*] **(11)** "Expanded practice dental hygienist" means a dental hygienist who performs dental hygiene services in accordance with ORS 680.205 as authorized by an expanded practice dental hygienist permit issued by the board under ORS 680.200.

[*(10)*] **(12)** "General supervision" means supervision requiring that a dentist authorize the procedures by standing orders, practice agreements or collaboration agreements, but not requiring that

a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.

[*(11)*] **(13)** "Indirect supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.

SECTION 14. ORS 679.140 is amended to read:

679.140. (1) The Oregon Board of Dentistry may discipline as provided in this section any person licensed to practice dentistry in this state for any of the following causes:

(a) Conviction of any violation of the law for which the court could impose a punishment if the board makes the finding required by ORS 670.280. The record of conviction or a certified copy thereof, certified by the clerk of the court or by the judge in whose court the conviction is entered, is conclusive evidence of the conviction.

(b) Renting or lending a license or diploma of the dentist to be used as the license or diploma of another person.

(c) Unprofessional conduct.

(d) Any violation of this chapter or ORS 680.010 to 680.205, of rules adopted pursuant to this chapter or ORS 680.010 to 680.205 or of an order issued by the board.

(e) Engaging in or permitting the performance of unacceptable patient care by the dentist or by any person working under the supervision of the dentist due to a deliberate or negligent act or failure to act by the dentist, regardless of whether actual injury to the patient is established.

(f) Incapacity to practice safely.

(2) "Unprofessional conduct" as used in this chapter includes but is not limited to the following:

(a) Obtaining any fee by fraud or misrepresentation.

(b) Willfully betraying confidences involved in the patient-dentist relationship.

(c) Employing, aiding, abetting or permitting any unlicensed personnel to practice dentistry [*or*]**,** dental hygiene **or dental therapy**.

(d) Making use of any advertising statements of a character tending to deceive or mislead the public or that are untruthful.

(e) Impairment as defined in ORS 676.303.

(f) Obtaining or attempting to obtain a controlled substance in any manner proscribed by the rules of the board.

(g) Prescribing or dispensing drugs outside the scope of the practice of dentistry or in a manner that impairs the health and safety of an individual.

(h) Disciplinary action by a state licensing or regulatory agency of this or another state regarding a license to practice dentistry, dental hygiene**, dental therapy** or any other health care profession when, in the judgment of the board, the act or conduct resulting in the disciplinary action bears a demonstrable relationship to the ability of the licensee or applicant to practice dentistry [*or*]**,** dental hygiene **or dental therapy** in accordance with the provisions of this chapter. A certified copy of the record of the disciplinary action is conclusive evidence of the disciplinary action.

(3) The proceedings under this section may be taken by the board from the matters within its knowledge or may be taken upon the information of another, but if the informant is a member of the board, the other members of the board shall constitute the board for the purpose of finding judgment of the accused.

(4) In determining what constitutes unacceptable patient care, the board may take into account all relevant factors and practices, including but not limited to the practices generally and currently followed and accepted by persons licensed to practice dentistry in this state, the current teachings at accredited dental schools, relevant technical reports published in recognized dental journals and the desirability of reasonable experimentation in the furtherance of the dental arts.

(5) In disciplining a person as authorized by subsection (1) of this section, the board may use any or all of the following methods:

(a) Suspend judgment.

(b) Place a licensee on probation.

(c) Suspend a license to practice dentistry in this state.

(d) Revoke a license to practice dentistry in this state.

(e) Place limitations on a license to practice dentistry in this state.

(f) Refuse to renew a license to practice dentistry in this state.

(g) Accept the resignation of a licensee to practice dentistry in this state.

(h) Assess a civil penalty.

(i) Reprimand a licensee.

(j) Impose any other disciplinary action the board in its discretion finds proper, including assessment of the costs of the disciplinary proceedings as a civil penalty.

(6) If the board places any person upon probation as set forth in subsection (5)(b) of this section, the board may determine and may at any time modify the conditions of the probation and may include among them any reasonable condition for the purpose of protection of the public and for the purpose of the rehabilitation of the probationer or both. Upon expiration of the term of probation, further proceedings shall be abated by the board if the person holding the license furnishes the board with evidence that the person is competent to practice dentistry and has complied with the terms of probation. If the evidence fails to establish competence to the satisfaction of the board or if the evidence shows failure to comply with the terms of the probation, the board may revoke or suspend the license.

(7) If a license to practice dentistry in this state is suspended, the person holding the license may not practice during the term of suspension. Upon the expiration of the term of suspension, the license shall be reinstated by the board if the board finds, based upon evidence furnished by the person, that the person is competent to practice dentistry and has not practiced dentistry in this state during the term of suspension. If the evidence fails to establish to the satisfaction of the board that the person is competent or if any evidence shows the person has practiced dentistry in this state during the term of suspension, the board may revoke the license after notice and hearing.

(8) Upon receipt of a complaint under this chapter or ORS 680.010 to 680.205, the board shall conduct an investigation as described under ORS 676.165.

(9) Information that the board obtains as part of an investigation into licensee or applicant conduct or as part of a contested case proceeding, consent order or stipulated agreement involving licensee or applicant conduct is confidential as provided under ORS 676.175. Notwithstanding ORS 676.165 to 676.180, the board may disclose confidential information regarding a licensee or an applicant to persons who may evaluate or treat the licensee or applicant for drug abuse, alcohol abuse or any other health related conditions.

(10) The board may impose against any person who violates the provisions of this chapter or ORS 680.010 to 680.205 or rules of the board a civil penalty of up to $5,000 for each violation. Any civil penalty imposed under this section shall be imposed in the manner provided in ORS 183.745.

(11) Notwithstanding the expiration, suspension, revocation or surrender of the license, or the resignation or retirement of the licensee, the board may:

(a) Proceed with any investigation of, or any action or disciplinary proceedings against, the dentist [*or*]**,** dental hygienist **or dental therapist**; or

(b) Revise or render void an order suspending or revoking the license.

(12)(a) The board may continue with any proceeding or investigation for a period not to exceed four years from the date of the expiration, suspension, revocation or surrender of the license, or the resignation or retirement of the licensee; or

(b) If the board receives a complaint or initiates an investigation within that four-year period, the board's jurisdiction continues until the matter is concluded by a final order of the board following any appeal.

(13) Withdrawing the application for license does not close any investigation, action or proceeding against an applicant.

SECTION 15. ORS 679.170 is amended to read:

679.170. [*No person shall*] **A person may not**:

(1) Sell or barter, or offer to sell or barter, any diploma or document conferring or purporting to confer any dental degree, or any certificate or transcript made or purporting to be made, pursuant to the laws regulating the license and registration of dentists.

(2) Purchase or procure by barter, any [*such*] diploma, certificate or transcript **described in subsection (1) of this section**, with intent that it be used as evidence of the holder's qualification to practice dentistry, or in fraud of the laws regulating [*such*] **the** practice **of dentistry**.

(3) With fraudulent intent, alter in a material regard any [*such*] diploma, certificate or transcript **described in subsection (1) of this section**.

(4) Use or attempt to use any [*such*] diploma, certificate or transcript **described in subsection (1) of this section**, which has been purchased, fraudulently issued, counterfeited or materially altered, either as a license or color of license to practice dentistry, or in order to procure registration as a dentist.

(5) Willfully make a false written or recorded oral statement to the Oregon Board of Dentistry in a material regard.

(6) Within 10 days after demand made by the board, fail to respond to the board's written request for information or fail to furnish to the board the name and address of all persons practicing or assisting in the practice of dentistry in the office of such person at any time within 60 days prior to the notice, together with a sworn statement showing under and by what license or authority such person and employee are and have been practicing dentistry.

(7) Employ or use the services of any unlicensed person, to practice dentistry [*or*]**,** dental hygiene **or dental therapy**, except as permitted by ORS 679.025, 679.176 and 680.010 to 680.205.

SECTION 16. ORS 679.250 is amended to read:

679.250. The powers and duties of the Oregon Board of Dentistry are as follows:

(1) To, during the month of April of each year, organize and elect from its membership a president who shall hold office for one year, or until the election and qualification of a successor.

(2) To authorize all necessary disbursements to carry out the provisions of this chapter, including but not limited to, payment for necessary supplies, office equipment, books and expenses for the conduct of examinations, payment for legal and investigative services rendered to the board, and such other expenditures as are provided for in this chapter.

(3) To employ such inspectors, examiners, special agents, investigators, clerical assistants, assistants and accountants as are necessary for the investigation and prosecution of alleged violations and the enforcement of this chapter and for such other purposes as the board may require. Nothing in this chapter shall be construed to prevent assistance being rendered by an employee of the board in any hearing called by it. However, all obligations for salaries and expenses incurred under this chapter shall be paid from the fees accruing to the board under this chapter and not otherwise.

(4)(a) To conduct examinations of applicants for license to practice dentistry [*and*]**,** dental hygiene **and dental therapy** at least twice in each year.

(b) In conducting examinations for licensure, the board may enter into a compact with other states for conducting regional examinations with other board of dental examiners concerned, or by a testing service recognized by such boards.

(5) To meet for the transaction of other business at the call of the president. A majority of board members shall constitute a quorum. A majority vote of those present shall be a decision of the entire board. The board's proceedings shall be open to public inspection in all matters affecting public interest.

(6) To keep an accurate record of all proceedings of the board and of all its meetings, of all receipts and disbursements, of all prosecutions for violation of this chapter, of all examinations for license to practice dentistry, with the names and qualifications for examination of any person examined, together with the addresses of those licensed and the results of such examinations, a record of the names of all persons licensed to practice dentistry in Oregon together with the addresses of all such persons having paid the license fee prescribed in ORS 679.120 and the names of all persons whose license to practice has been revoked or suspended.

(7) To make and enforce rules necessary for the procedure of the board, for the conduct of examinations, for regulating the practice of dentistry, and for regulating the services of dental hygienists and dental auxiliary personnel not inconsistent with the provisions of this chapter. As part of such rules, the board may require the procurement of a permit or other certificate. Any permit issued may be subject to periodic renewal. In adopting rules, the board shall take into account all relevant factors germane to an orderly and fair administration of this chapter and of ORS 680.010 to 680.205, the practices and materials generally and currently used and accepted by persons licensed to practice dentistry in this state, dental techniques commonly in use, relevant technical reports published in recognized dental journals, the curriculum at accredited dental schools, the desirability of reasonable experimentation in the furtherance of the dental arts, and the desirability of providing the highest standard of dental care to the public consistent with the lowest economic cost.

(8) Upon its own motion or upon any complaint, to initiate and conduct investigations of and hearings on all matters relating to the practice of dentistry, the discipline of licensees, or pertaining to the enforcement of any provision of this chapter. In the conduct of investigations or upon the hearing of any matter of which the board may have jurisdiction, the board may take evidence, administer oaths, take the depositions of witnesses, including the person charged, in the manner provided by law in civil cases, and compel their appearance before it in person the same as in civil cases, by subpoena issued over the signature of an employee of the board and in the name of the people of the State of Oregon, require answers to interrogatories, and compel the production of books, papers, accounts, documents and testimony pertaining to the matter under investigation or to the hearing. In all investigations and hearings, the board and any person affected thereby may have the benefit of counsel, and all hearings shall be held in compliance with ORS chapter 183. Notwithstanding ORS 676.165, 676.175 and 679.320, if a licensee who is the subject of an investigation or complaint is to appear before members of the board investigating the complaint, the board shall provide the licensee with a current summary of the complaint or the matter being investigated not less than five days prior to the date that the licensee is to appear. At the time the summary of the complaint or the matter being investigated is provided, the board shall provide to the licensee a current summary of documents or alleged facts that the board has acquired as a result of the investigation. The name of the complainant or other information that reasonably may be used to identify the complainant may be withheld from the licensee.

(9) To require evidence as determined by rule of continuing education or to require satisfactory evidence of operative competency before reissuing or renewing licenses for the practice of dentistry [*or*]**,** dental hygiene **or dental therapy**.

(10) To adopt and enforce rules regulating administration of general anesthesia and conscious sedation by a dentist or under the supervision of a dentist in the office of the dentist. As part of such rules, the board may require the procurement of a permit which must be periodically renewed.

(11) To order an applicant or licensee to submit to a physical examination, mental examination or a competency examination when the board has evidence indicating the incapacity of the applicant or licensee to practice safely.

SECTION 17. Section 1, chapter 716, Oregon Laws 2011, is amended to read:

Sec. 1. (1) The Oregon Health Authority may approve pilot projects to encourage the development of innovative practices in oral health care delivery systems with a focus on providing care to populations that evidence-based studies have shown have the highest disease rates and the least access to dental care. The authority may approve a pilot project that is designed to:

(a) Operate for three to five years or a sufficient amount of time to evaluate the validity of the pilot project;

(b) Evaluate quality of care, access, cost, workforce and efficacy; and

(c) Achieve at least one of the following:

(A) Teach new skills to existing categories of dental personnel;

(B) Develop new categories of dental personnel;

(C) Accelerate the training of existing categories of dental personnel; or

(D) Teach new oral health care roles to previously untrained persons.

(2) The authority shall adopt rules:

(a) Establishing an application process for pilot projects;

(b) Establishing minimum standards, guidelines and instructions for pilot projects; and

(c) Requiring an approved pilot project to report to the authority on the progress and outcomes of the pilot project, including:

(A) The process used to evaluate the progress and outcomes of the pilot project;

(B) The baseline data and information to be collected;

(C) The nature of program data that will be collected and the methods for collecting and analyzing the data;

(D) The provisions for protecting the safety of patients seen or treated in the project; and

(E) A statement of previous experience in providing related health care services.

(3) The authority shall seek the advice of appropriate professional societies and licensing boards before adopting rules under subsection (2) of this section.

(4)(a) Notwithstanding ORS 679.020 and 680.020, a person may practice dentistry [*or*]**,** dental hygiene **or dental therapy** without a license as part of a pilot project approved under this section under the general supervision of a dentist licensed under ORS chapter 679 and in accordance with rules adopted by the authority.

(b) A person practicing dentistry [*or*]**,** dental hygiene **or dental therapy** without a license under this section is subject to the same standard of care and is entitled to the same immunities as a person performing the services with a license.

(5) The authority may accept gifts, grants or contributions from any public or private source for the purpose of carrying out this section. Funds received under this subsection shall be deposited in the Dental Pilot Projects Fund established under section 17 [*of this 2011 Act*]**, chapter 716, Oregon Laws 2011**.

SECTION 18. (1) Sections 2, 3 and 4 to 12 of this 2021 Act and the amendments to ORS 679.010, 679.140, 679.170 and 679.250 and section 1, chapter 716, Oregon Laws 2011, by sections 13 to 17 of this 2021 Act become operative on January 1, 2022.

(2) The amendments to section 3 of this 2021 Act by section 3a of this 2021 Act become operative on January 1, 2025.

(3) The Oregon Board of Dentistry may take any action before the operative dates specified in subsections (1) and (2) of this section that is necessary to enable the board to exercise, on and after the operative dates specified in subsections (1) and (2) of this section, all of the duties, functions and powers conferred on the board by sections 2, 3 and 4 to 12 of this 2021 Act and the amendments to ORS 679.010, 679.140, 679.170 and 679.250 and section 1, chapter 716, Oregon Laws 2011, and section 3 of this 2021 Act by sections 3a and 13 to 17 of this 2021 Act.

SECTION 19. This 2021 Act takes effect on the 91st day after the date on which the 2021 regular session of the Eighty-first Legislative Assembly adjourns sine die.

Passed by House April 27, 2021

Repassed by House June 23, 2021

.....
Timothy G. Sekerak, Chief Clerk of House

.....
Tina Kotek, Speaker of House

Passed by Senate June 22, 2021

.....
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2021

Approved:

.....M.,....., 2021

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2021

.....
Shemia Fagan, Secretary of State

Title: OBD Tribal Relationship & Cooperation Policy

Effective Date: February 25, 2022

Purpose:

The State of Oregon and the Oregon Board of Dentistry (OBD) share the goal to establish clear policies establishing the tribal consultation and requirements to further the government-to-government relationship between the OBD and the nine federally recognized Tribes of Oregon (Oregon Tribes) with the passage of HB 2528 (2021) and on any other matters that are important to the Tribes. This policy shall fulfill the requirements of ORS 182.164 & ORS 182.166.

Nine Federally Recognized Tribes of Oregon ("Oregon Tribes"):

- Burns Paiute Tribe
- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
- Confederated Tribes of Grande Ronde
- Confederated Tribes of Siletz Indians
- Confederated Tribes of the Umatilla Indian Reservation
- Confederated Tribes of Warms Springs
- Coquille Indian Tribe
- Cow Creek Band of Umpqua Tribe of Indians
- Klamath Tribes

Other Organizations
Urban Indian Health Programs (UIHP)
Northwest Portland Area Indian Health Board (NPAIHB)

This Policy:

- Identifies individuals within the OBD who are responsible for developing and implementing programs, rules, policies and draft legislation that affect Tribes.
- Establishes a process to identify the OBD programs, rules, policies and draft legislation that impact Tribes.
- Promotes communication between the OBD and the Tribes.
- Promotes positive government-to-government relations between the OBD and Tribes.
- Promotes positive relationships with any entity that serves tribal members including the Northwest Portland Area Indian Health Board and Urban Indian Health Programs
- Establishes a method for ensuring that OBD employees comply with ORS 182.162 to 182.168 and this policy.
- Streamlined for ease to understand and apply: the OBD is a small agency with 8 employees.
- This Policy is to meet compliance with ORS 182.164, but also should be utilized in working with any tribal group, entity or organization that supports tribal members and is impacted by the OBD's work.

Meaningful consultation between tribal leadership and agency leadership shall result in information exchange, transparency, mutual understanding, and informed decision-making on

behalf of the Oregon Tribes and the State. One key goal of this policy is to prevent avoidable surprises between the OBD and Oregon Tribes.

Other key goals of this policy include, but are not limited to: helping to eliminate health and human service disparities of Indians; ensuring that access to critical health and human services is maximized; advancing and enhancing the social, physical, behavioral and oral health of Indians; making accommodations in State programs when possible to account for the unique nature of Indian health programs; collaborating on the development and improvement of programs, rules, policies and draft legislation; and ensuring that the Oregon Tribes are consulted to ensure meaningful and timely tribal input as required under Federal and State law when health and human service policies have an impact on Indians and the Oregon Tribes. To achieve this goal, and to the extent practicable and permitted by law, it is essential that the Oregon Tribes and the OBD engage in open, continuous and meaningful consultation and collaboration.

This policy applies to the OBD (Board Members and staff) and shall serve as a guide for the Oregon Tribes to participate in OBD legislative, rule and policy development to the greatest extent allowable under law. The relationship between the OBD and the Oregon Tribes is important and should be on a foundation of trust and mutual respect. It is important for the OBD to work closely with Oregon Tribes on issues related to Dental Therapy and any other matter that is important to the Oregon Tribes.

Policy #834-413-019 OBD Tribal Relationship & Cooperation
Policy Effective Date: February 25, 2022

Applicability: All Board Members, full and part time employees, temporary employees and volunteers

References:
(1) Purpose
This tribal relations policy is adopted pursuant to ORS 182.162 – 182.168, which requires state agencies to develop and implement tribal relations policies.
(2) General Policies and Principles
It is OBD's policy to promote the principle stated in Executive Order No.96-30 that "[a]s sovereigns the tribes and the State of Oregon must work together to develop mutual respect for the sovereign interests of both parties." OBD interacts with tribes in differing roles: in its role as legal advisor to and representative of other state agencies; and in its role as independent administrator of certain OBD programs. In all of its roles, it is OBD's policy to promote positive government to government relations with the federally recognized tribes in Oregon ("tribes") by
(a) Facilitating communication and understanding and appropriate dispute resolution among OBD, other state agencies and those tribes;
(b) Striving to prevent unnecessary conflict with tribes;
(c) Interacting with tribes in a spirit of mutual respect;
(d) Involving tribal representatives in the development and implementation of programs, rules, policies and draft legislation that affect them; and
(e) Seeking to understand the varying tribal perspectives.
(3) The OBD's Native American Affairs Coordinator is the OBD's Executive Director
(a) The state is best served through a coordinated approach to tribal issues. The OBD's Executive Director has been designated as the OBD's Native American Affairs Coordinator, who serves as the OBD's key contact with tribal representatives.
(b) Individuals at the OBD who are working on a significant matter involving or affecting a tribe

shall notify the Native American Affairs Coordinator.
(4) Dissemination of Tribal Relations Policy
(a) Upon adoption, this policy shall be disseminated to members of the OBD, and shall be incorporated into the OBD Policy Manual. In addition, this policy and information regarding ORS 182.162 – 168 shall be included in new Board Member and employee orientation.
(b) The Executive Director will be responsible for submitting the OBD's annual report in December to the Governor and the Commission on Indian Service per ORS 182.166 detailing its work with the Tribes for the prior year and this Policy.
(5) Training
(a) Appropriate OBD representatives will attend annual training provided by the Department of Administrative Services pursuant to ORS 182.166(1).
(b) The OBD's assigned attorney who may come into contact with tribes will be encouraged to consider taking advantage of outside CLE opportunities on Indian law and culture.
(7) Identification of OBD Programs Affecting Tribes
The Executive Director will compile a list of OBD programs, rules, policies and draft legislation that affect tribes, as well as the OBD individuals responsible for implementing them with feedback from the affected Tribes or tribal members.
(8) Guidelines for OBD Programs
The OBD will invite tribal participation on Dental Therapy issues and other areas of interest that the Tribes bring forth to the OBD.

OBD Commitment to Tribal Consultation

The OBD was established by the Oregon State Legislature in 1887 and is accountable to the people of Oregon, acknowledges this unique relationship, the statutory and regulatory framework for states to consult with Tribes, and recognizes the right of Indian tribes to self-determination and self-governance. The special government-to-government relationship between the Tribes and federal and state governments will be respected in all dealings with the Tribes and OBD. Relationship of State Agencies with Indian Tribes, ORS 182.162 to 182.168.

In order to fully effectuate this policy, OBD will:

- Ensure inclusion of the Tribes prior to the development of policies and program activities that impact Tribes, utilizing the OBD's formal notice that provides descriptive content and a timeline of all public meetings;
- Create opportunities for Tribes to raise issues with the OBD and for the OBD to seek consultation with Tribes;
- Establish communication channels with Tribes to increase knowledge and understanding of OBD programs;
- Support tribal self-determination;
- Include on every regular Board Meeting Agenda an opportunity for the Tribes to directly communicate with the OBD.

Tribal Consultation Principles:

Consultation is an enhanced form of communication that emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation includes collaboration and often results in an iterative process between parties. Meaningful consultation is integral to a

deliberative process that results in effective collaboration and informed decision-making, with the ultimate goal of reaching consensus on issues and better outcomes.

To establish and maintain a positive government-to-government relationship, meaningful communication and consultation must occur on a regular and as needed basis so that Tribes have an opportunity to provide meaningful, and timely input on issues that may have an impact on Tribes. This government-to-government relationship applies between the Tribes and the State.

Consultation with the Tribes is important in the context of health programs because the Tribes serve many roles in their communities:

- Tribes and tribal governments are sovereign nations with inherent authority over their internal affairs; have a government-to-government relationship with the federal government, state governments, and other sovereigns; and have the responsibility to ensure the health and well-being of their tribal citizens, among various other governmental responsibilities.
- Tribal governments operate businesses, are employers, and are health care providers, through administration of clinics and other health programs, which includes public health

Policy Action

It is the intent of OBD to meaningfully consult with Tribes on any rule changes, policy, programs, rules and draft legislation that will impact the Tribes before any action is taken.

Such rule changes or policies include those that:

- Have Indian or Tribal implications; or
- Have implications on the Indian Health Service, tribal health programs or urban Indian health program, or
- Have a direct effect on one or more Tribes, or
- Have a direct effect on the relationship between the state and Tribes, or
- Have a direct effect on the distribution of power and responsibilities between the state and Tribes; or
- Are a federally or statutorily mandated proposal or change in which OBD has flexibility in implementation.

Tribal Consultation Process:

An effective consultation between the OBD and the Tribes requires trust between all parties which is an indispensable element in establishing a good consultative relationship.
Any Issue includes, but is not limited to:

- Policy, programs, rules and draft legislation development impacting the Tribes;
- Program activities that impacting Tribes;
- Data collection and reporting activities impacting Tribes;
- Rulemaking impacting Tribes; or
- Any other OBD action impacting Tribes or that has implications on the NPAIHB, tribal health programs or IHS.

Upon identification of any Issue meeting any of the above criteria the OBD will initiate consultation regarding the issue.

To initiate and conduct consultation, the following serves as a guideline to be utilized by the OBD and the Tribes:

- Identify the Issue: complexity, implications, time constraints, deadlines and issue(s).
- Identify how the Issue impacts the Tribes.
- Identify affected/potentially affected Tribes.

Determining Consultation Mechanism: The most useful and appropriate consultation mechanisms can be determined by OBD and Tribes after considering the Issue and Tribes affected/potentially affected. Consultation mechanisms include but are not limited to one or more of the following:

- Email
- Teleconferences
- Virtual Meetings
- Face-to-Face Meetings at regular Board or Committee Meetings
- Other regular or special consultation sessions needed.

Communication Methods: The determination of the Issue and the level of consultation mechanism to be used by OBD shall be communicated to affected/potentially affected Tribes using all appropriate methods and with as much advance notice as practicable or as required under this policy.

These methods include but are not limited to the following:

- Official Notification: Upon the determination of the consultation mechanism, proper notice of the Issue and the consultation mechanism utilized shall be communicated to affected/potentially affected Tribes using all appropriate methods including mailing and broadcast e-mail. Such notice shall be provided to:
    - Tribal Chair or Chief and their designated representative(s)
    - Any other entity that the Tribes identify that should be included

- The OBD will regularly update its mailing/email list to ensure notice is being provided to designated leadership. Each Tribe is responsible for providing this information to OBD's Executive Director to regularly update the list.

Rulemaking: The OBD will include the Tribes in all legislative, rulemaking and policy making processes that have tribal implications. The Tribes will have a regular and open invitation to attend any OBD Committee meeting or public rulemaking hearing to provide additional input on rule concepts and language.

Creation of Committees/Work Group(s): Round tables and work groups may be used for discussions, problem resolution, and preparation for communication and consultation related to an Issue but do not replace formal tribal consultation. Round tables and work groups will provide the opportunity for technical assistance from the OBD to Indian health programs and the Tribes to address challenges or barriers and work collaboratively on development of solutions to bring to the meetings.

Implementation Process and Responsibilities: The process should be reviewed and evaluated for effectiveness as requested.

Tribal Consultation Evaluation: The OBD is responsible for evaluating its performance under this Tribal Consultation Policy. To effectively evaluate the results of the consultation process and the ability of the OBD to incorporate tribal recommendations, the OBD may assess its performance on an annual basis in the Executive Director's performance review or as needed.

Meeting Records and Additional Reporting: The OBD is responsible for making and keeping records of all public meetings and its tribal consultation activity. All such records shall be made readily available to the Tribes.

Definitions:

Indian or American Indian/Alaska Native (Al/AN1Indian and/or American Indian/Alaska Native (Al/AN) means any individual defined at 25 USC 1603(13),1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual:

Is a member of a Federally recognized Indian Tribe;
Resides in an urban center and meets one or more of the four criteria:
Is a member of a Tribe, band, or other organized group of Indians, including those Tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
Is an Eskimo or Aleut or other Alaska Native;
Is considered by the Secretary of the Interior to be an Indian for any purpose; or
Is determined to be an Indian under regulations issued by the Secretary;
Is considered by the Secretary of the Interior to be an Indian for any purpose; or
Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.
Tribe. Tribe means any Federally recognized Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. Oregon's nine Federally Recognized Tribes include:

- Burns Paiute Tribe
- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
- Confederated Tribes of Grande Ronde
- Confederated Tribes of Siletz Indians
- Confederated Tribes of the Umatilla Indian Reservation
- Confederated Tribes of Warms Springs
- Coquille Indian Tribe
- Cow Creek Band of Umpqua Tribe of Indians
- Klamath Tribes

Disclaimer:

OBD respects the sovereignty of each of Oregon's Tribes. In executing this policy, no party waives any rights, including treaty rights; immunities, including sovereign immunities; or jurisdictions. This policy does not diminish any rights or protections afforded other Indian persons or entities under state or federal law. Through this policy, the parties strengthen their collective ability to successfully resolve issues of mutual concern. While the relationship described by this policy provides increased ability to solve problems, it likely will not result in a resolution of all issues. Therefore, inherent in their relationship is the right of each of the parties to elevate an issue of importance to any decision-making authority of another party, including, where appropriate, the Governor’s Office.

RULES - DENTAL THERAPY

Staff Suggestions for Application Rules

818-021-0052
Application for License to Practice Dental Therapy
(1) An applicant to practice dental therapy, in addition to the requirements set forth in ORS 679.603 and 679.609, shall submit to the Board satisfactory evidence of:
(a) Having graduated from a dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Having successfully completed or graduated from a Board-approved dental therapy education program that includes all procedures outlined in OAR 818-038-0020, and includes at least 500 hours of hands-on clinical dental therapy practice.
(2) An applicant who has not met the educational requirements for licensure may apply if the Director of an accredited program certifies the applicant will graduate.
(3) An applicant must pass a Board examination consisting of a clinical portion administered by the Board, or any clinical Board examination administered by any state, regional testing agency, national testing agency or other Board-recognized testing agency and a jurisprudence portion administered by the Board. Clinical examination results will be recognized by the Board for five years.
(4) A person who fails any Board approved clinical examination three times must successfully complete the remedial training recommended by the testing agency. Such remedial training must be conducted by a dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association.

DTRO Committee Suggestions for Application Rules

818-021-0052
Application for License to Practice Dental Therapy
(1) An applicant to practice dental therapy, in addition to the requirements set forth in ORS 679.603 and 679.609, shall submit to the Board satisfactory evidence of:
(a) Having graduated from a dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Having graduated from a dental therapy program located outside the United States or Canada, completion of not less than one year in a program accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and
(2) An applicant who has not met the educational requirements for licensure may apply if the Director of an accredited program certifies the applicant will graduate.
(3) An applicant must pass a Board examination consisting of a clinical portion administered by the Board, or any clinical Board examination administered by any state, regional testing agency, national testing agency or other Board-recognized testing agency and a jurisprudence portion administered by the Board. Clinical examination results will be recognized by the Board for five years.
(4) A person who fails any Board approved clinical examination three times must successfully complete the remedial training recommended by the testing agency. Such remedial training must be conducted by a dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association.

Staff Suggestions for Application Rules

818-021-0054
Application for License to Practice Dental Therapy Without Further Examination
(1) The Oregon Board of Dentistry may grant a license without further examination to a dental therapist who holds a license to practice dental therapy in another state or states if the dental therapist meets the requirements set forth in ORS 679.603 and 679.609 and submits to the Board satisfactory evidence of:
(a) Having graduated from a dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Having successfully completed or graduated from a Board-approved dental therapy education program that includes all procedures outlined in OAR 818-038-0020, and includes at least 500 hours of hands-on clinical dental therapy practice; and
(c) Having passed the clinical dental therapy examination conducted by a regional testing agency, by a state dental or dental therapy licensing authority, by a national testing agency or other Board-recognized testing agency; and
(d) Holding an active license to practice dental therapy, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dental therapy, without restrictions, and whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and
(e) Having conducted licensed clinical practice in Oregon, in other states or in the Armed Forces of the United States, the United States Public Health Service, the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately preceding application. Licensed clinical practice could include hours devoted to teaching by dental therapists employed by a CODA accredited dental therapy program with verification from the dean or appropriate administration of the institution documenting the length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dental therapy, and any adverse actions or restrictions; and
(f) Having completed 36 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.
(2) Applicants must pass the Board's Jurisprudence Examination.

DTRO Committee Suggestions for Application Rules

818-021-0054
Application for License to Practice Dental Therapy Without Further Examination
(1) The Oregon Board of Dentistry may grant a license without further examination to a dental therapist who holds a license to practice dental therapy in another state or states if the dental therapist meets the requirements set forth in 679.603 and 679.609 and submits to the Board satisfactory evidence of:
(a) Having graduated from a dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Having completed or graduated from a dental therapy education program, and
(c) Having passed the clinical dental therapy examination conducted by a regional testing agency or by a state dental or dental therapy licensing authority, by a national testing agency or other Board-recognized testing agency; and
(d) Holding an active license to practice dental therapy, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dental therapy, without restrictions, and whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and
(e) Having conducted licensed clinical practice in Oregon, in other states or in the Armed Forces of the United States, the United States Public Health Service, the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately preceding application. Licensed clinical practice could include hours devoted to teaching by dental therapists employed by a CODA accredited dental therapy program with verification from the dean or appropriate administration of the institution documenting the length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dental therapy, and any adverse actions or restrictions; and
(f) Having completed 36 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.
(2) Applicants must pass the Board's Jurisprudence Examination.

679.603 Dental therapy license. (1) The Oregon Board of Dentistry shall issue a license to practice dental therapy to an applicant who:

(a) Is at least 18 years of age;

(b) Submits to the board a completed application form;

(c) Demonstrates the completion of a dental therapy education program;

(d) Passes an examination described in ORS 679.606; and

(e) Pays the application and licensure fees established by the board.

(2)(a) An individual who completed a dental therapy education program in another state or jurisdiction may apply for licensure under this section if the dental therapy education program is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization.

(b) The board shall determine whether the training and education of an applicant described in this subsection is sufficient to meet the requirements of subsection (1) of this section.

(3) If an applicant holds a current or expired authorization to practice dental therapy issued by another state, the federal government or a tribal authority, the applicant shall include with the application a copy of the authorization and an affidavit from the dental regulatory body of the other jurisdiction that demonstrates the applicant was authorized to practice dental therapy in that jurisdiction. [2021 c.530 §3]

Note: The amendments to 679.603 by section 3a, chapter 530, Oregon Laws 2021, become operative January 1, 2025. See section 18, chapter 530, Oregon Laws 2021. The text that is operative on and after January 1, 2025, is set forth for the user's convenience.

679.603. (1) The Oregon Board of Dentistry shall issue a license to practice dental therapy to an applicant who:

(a) Is at least 18 years of age;

(b) Submits to the board a completed application form;

(c) Demonstrates:

(A) The completion of a dental therapy education program that is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization, and approved by the board by rule; or

(B) That the applicant is or was a participant in a dental pilot project;

(d) Passes an examination described in ORS 679.606; and

(e) Pays the application and licensure fees established by the board.

(2)(a) An individual who completed a dental therapy education program in another state or jurisdiction may apply for licensure under this section if the dental therapy education program is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization.

(b) The board shall determine whether the training and education of an applicant described in this subsection is sufficient to meet the requirements of subsection (1) of this section.

(3) If an applicant holds a current or expired authorization to practice dental therapy issued by another state, the federal government or a tribal authority, the applicant shall include with the application a copy of the authorization and an affidavit from the dental regulatory body of the other jurisdiction that demonstrates the applicant was authorized to practice dental therapy in that jurisdiction.

679.606 Examinations, reexamination; acceptable results; rules. (1)(a) The Oregon Board of Dentistry may require an applicant for a license to practice dental therapy to pass written, laboratory or clinical examinations to test the professional knowledge and skills of the applicant.

(b) The examinations may not be affiliated with or administered by a dental pilot project or a dental therapy education program described in ORS 679.603.

(c) The examinations must:

(A) Be elementary and practical in character, and sufficiently thorough to test the fitness of the applicant to practice dental therapy;

(B) Be written in English; and

(C) Include questions on subjects pertaining to dental therapy.

(2) If a test or examination was taken within five years of the date of application and the applicant received a passing score on the test or examination, as established by the board by rule, the board:

(a) To satisfy the written examination authorized under this section, may accept the results of national standardized examinations.

(b) To satisfy the laboratory or clinical examination authorized under this section:

(A) Shall accept the results of regional and national testing agencies or clinical board examinations administered by other states; and

(B) May accept the results of board-recognized testing agencies.

(3) The board shall accept the results of regional and national testing agencies or of clinical board examinations administered by other states, and may accept results of board-recognized testing agencies, in satisfaction of the examinations authorized under this section for applicants who have engaged in the active practice of dental therapy in Oregon, another state, the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a period of at least 3,500 hours in the five years immediately preceding application and who meet all other requirements for licensure.

(4) The board shall establish rules related to reexamination for an applicant who fails an examination. [2021 c.530 §4]

818-038-0005

The Board defines "Dental Therapy Education Program" as:

(1) **A program accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization, and approved by the Board by rule;**
(2) **A dental pilot project as defined in ORS 679.600 and includes at least 500 hours of combined didactic and hands-on clinical dental therapy practice.**
(3) **A program determined by the Board to be substantially equivalent to subsection (1) or (2) of this paragraph with the same hour requirements as section 2.**

Final Recommendations from DTRO Committee to go to the Board

818-001-0002
Definitions
As used in OAR chapter 818:
(1) "Board" means the Oregon Board of Dentistry, the members of the Board, its employees, its agents, and its consultants.
(2) "Dental Practice Act" means ORS Chapter 679 and 680.010 to 680.170 and the rules adopted pursuant thereto.
(3) "Dentist" means a person licensed pursuant to ORS Chapter 679 to practice dentistry.
(4) "Dental Hygienist" means a person licensed pursuant to ORS 680.010 to 680.210 to practice dental hygiene.
(5) "Dental Therapist" means a person licensed to practice dental therapy under ORS 679.603.
(6) "Dental Therapy" means the provision of preventative dental care, restorative dental treatment and other educational, clinical and therapeutic patient services as part of a dental care team, including the services described under ORS 679.621.
(7) "Direct Supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.
(8) "General Supervision" means supervision requiring that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.
(9) "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.
(10) "Informed Consent" means the consent obtained following a thorough and easily understood
explanation to the patient, or patient's guardian, of the proposed procedures, any available alternative procedures and any risks associated with the procedures. Following the explanation, the licensee shall ask the patient, or the patient's guardian, if there are any questions. The licensee shall provide thorough and easily understood answers to all questions asked.
(11) "Licensee" means a dentist**,** hygienist **or dental therapist.**
(12) "Volunteer Licensee" is a dentist**,** hygienist **or dental therapist** licensed according to rule to provide dental health care without receiving or expecting to receive compensation.
(13) "Limited Access Patient" means a patient who, due to age, infirmity, or handicap is unable to receive regular dental hygiene treatment in a dental office.
(14) "Specialty." The specialty definitions are added to more clearly define the scope of the practice as it pertains to the specialty areas of dentistry.
(a) "Dental Anesthesiology" is the specialty of dentistry that deals with the management of pain through the use of advanced local and general anesthesia techniques.
(b) "Dental Public Health" is the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice which serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.
(c) "Endodontics" is the specialty of dentistry which is concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and

practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.
(d) "Oral and Maxillofacial Pathology" is the specialty of dentistry and discipline of pathology that deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of oral pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations.
(e) “Oral and Maxillofacial Radiology” is the specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.
(f) "Oral and Maxillofacial Surgery" is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.
(g) "Oral Medicine" is the specialty of dentistry responsible for the oral health care of medically complex patients and for the diagnosis and management of medically-related diseases, disorders and conditions affecting the oral and maxillofacial region.
(h) "Orofacial Pain" Orofacial Pain is the specialty of dentistry that encompasses the diagnosis, management and treatment of pain disorders of the jaw, mouth, face, head and neck. The specialty of Orofacial Pain is dedicated to the evidenced-based understanding of the underlying pathophysiology, etiology, prevention, and treatment of these disorders and improving access to interdisciplinary patient care.
(i) "Orthodontics and Dentofacial Orthopedics" is the specialty of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application and control of functional and corrective appliances; and the guidance of the dentition and its supporting structures to attain and maintain optimum occlusal relations in physiologic and esthetic harmony among facial and cranial structures.
(j) "Pediatric Dentistry" is an age defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.
(k) "Periodontics" is the specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues.
(l) "Prosthodontics" is the specialty of dentistry pertaining to the restoration and maintenance of oral functions, comfort, appearance and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes.
(15) “Full-time” as used in ORS 679.025 and 680.020 is defined by the Board as any student who is enrolled in an institution accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency in a course of study for dentistry**,** dental hygiene **or dental therapy.**
(16) For purposes of ORS 679.020(4)(h) the term “dentist of record” means a dentist that either authorized treatment for, supervised treatment of or provided treatment for the patient in clinical settings of the institution described in 679.020(3).

(17) "Dental Study Group" as used in ORS 679.050, OAR 818-021-0060 and OAR 818-021-0070 is defined as a group of licensees who come together for clinical and non-clinical educational study for the purpose of maintaining or increasing their competence. This is not meant to be a replacement for residency requirements.
(18) "Physical Harm" as used in OAR 818-001-0083(2) is defined as any physical injury that caused, partial or total physical disability, incapacity or disfigurement. In no event shall physical harm include mental pain, anguish, or suffering, or fear of injury.
(19) "Teledentistry" is defined as the use of information technology and telecommunications to facilitate the providing of dental primary care, consultation, education, and public awareness in the same manner as telehealth and telemedicine.
(20) "BLS for Healthcare Providers or its Equivalent" the BLS/CPR certification standard is the American Heart Association's BLS Healthcare Providers Course or its equivalent, as determined by the Board. This initial BLS/CPR course must be a hands-on course; online BLS/CPR courses will not be approved by the Board for initial BLS/CPR certification: After the initial BLS/CPR certification, the Board will accept a Board-approved BLS for Healthcare Providers or its equivalent Online Renewal course for license renewal. A BLS/CPR certification card with an expiration date must be received from the BLS/CPR provider as documentation of BLS/CPR certification. The Board considers the BLS/CPR expiration date to be the last day of the month that the BLS/CPR instructor indicates that the certification expires.

818-001-0082
Access to Public Records
(1) Public records not exempt from disclosure may be inspected during office hours at the Board office upon reasonable notice.
(2) Copies of public records not exempt from disclosure may be purchased upon receipt of a written request. The Board may withhold copies of public records until the requestor pays for the copies.
(3) The Board follows the Department of Administrative Service's statewide policy (107-001-030) for fees in regards to public records request; in addition, the Board establishes the following fees:
(a) $0.10 per name and address for computer-generated lists on paper; $0.20 per name and address for computer-generated lists on paper sorted by specific zip code;
(b) Data files submitted electronically or on a device:
(A) All Licensed Dentists — $50;
(B) All Licensed Dental Hygienists **and Dental Therapists** — $50;
(C) All Licensees — $100.
(c) Written verification of licensure — $2.50 per name; and
(d) Certificate of Standing — $20.

818-001-0087
Fees
(1) The Board adopts the following fees:
(a) Biennial License Fees:
(A) Dental —$390;
(B) Dental — retired — $0;
(C) Dental Faculty — $335;
(D) Volunteer Dentist — $0;
(E) Dental Hygiene —$230;
(F) Dental Hygiene — retired — $0;
(G) Volunteer Dental Hygienist — $0;
(H) Dental Therapy - $230;

(l) Dental Therapy - retired - $0;
(b) Biennial Permits, Endorsements or Certificates:
(A) Nitrous Oxide Permit — $40;
(B) Minimal Sedation Permit — $75;
(C) Moderate Sedation Permit — $75;
(D) Deep Sedation Permit — $75;
(E) General Anesthesia Permit — $140;
(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;
(c) Applications for Licensure:
(A) Dental — General and Specialty — $345;
(B) Dental Faculty — $305;
(C) Dental Hygiene — $180;
(D) **Dental Therapy - $180;**
(E) Licensure Without Further Examination — Dental**,** Dental Hygiene **and Dental Therapy** — $790.
(d) Examinations:
(A) Jurisprudence — $0;
(e) 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.

OAR 818-012-0020
Additional Methods of Discipline for Unacceptable Patient Care
In addition to other discipline, the Board may order a licensee who engaged in or permitted unacceptable patient care to:
(1) Make restitution to the patient in an amount to cover actual costs in correcting the unacceptable care.
(2) Refund fees paid by the patient with interest.
(3) Complete a Board-approved course of remedial education.
(4) Discontinue practicing in specific areas of dentistry**, dental therapy,** or hygiene.
(5) Practice under the supervision of another licensee.

OAR 818-012-0030
Unprofessional Conduct
The Board finds that in addition to the conduct set forth in ORS 679.140(2), unprofessional conduct includes, but is not limited to, the following in which a licensee does or knowingly permits any person to:
(1) Attempt to obtain a fee by fraud, or misrepresentation.
(2) Obtain a fee by fraud, or misrepresentation.

(a) A licensee obtains a fee by fraud if the licensee knowingly makes, or permits any person to make, a material, false statement intending that a recipient, who is unaware of the truth, rely upon the statement.
(b) A licensee obtains a fee by misrepresentation if the licensee obtains a fee through making or permitting any person to make a material, false statement.
(c) Giving cash discounts and not disclosing them to third party payers is not fraud or misrepresentation.
(3) Offer rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee, or employer.
(4) Accept rebates, split fees, or commissions for services rendered to a patient from any person other than a partner, employee, or employer.
(5) Initiate, or engage in, with a patient, any behavior with sexual connotations. The behavior can include but is not limited to, inappropriate physical touching; kissing of a sexual nature; gestures or expressions, any of which are sexualized or sexually demeaning to a patient; inappropriate procedures, including, but not limited to, disrobing and draping practices that reflect a lack of respect for the patient's privacy; or initiating inappropriate communication, verbal or written, including, but not limited to, references to a patient's body or clothing that are sexualized or sexually demeaning to a patient; and inappropriate comments or queries about the professional's or patient's sexual orientation, sexual performance, sexual fantasies, sexual problems, or sexual preferences.
(6) Engage in an unlawful trade practice as defined in ORS 646.605 to 646.608.
(7) Fail to present a treatment plan with estimated costs to a patient upon request of the patient or to a patient's guardian upon request of the patient's guardian.
(8) Misrepresent any facts to a patient concerning treatment or fees.
(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, radiographs of the same quality as the originals, and photographs if they have been paid for.
(b) The licensee may require the patient or guardian to pay in advance a fee reasonably calculated to cover the costs of making the copies or duplicates. The licensee may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for pages 11 through 50 and no more than $0.25 for each additional page (including records copied from microfilm), plus any postage costs to mail copies requested and actual costs of preparing an explanation or summary of information, if requested. The actual cost of duplicating radiographs may also be charged to the patient. Patient records or summaries may not be withheld from the patient because of any prior unpaid bills, except as provided in (9)(a)(B) of this rule.
(10) Fail to identify to a patient, patient's guardian, or the Board the name of an employee, employer, contractor, or agent who renders services.
(11) Use prescription forms pre-printed with any Drug Enforcement Administration number, name of controlled substances, or facsimile of a signature.
(12) Use a rubber stamp or like device to reproduce a signature on a prescription form or sign a blank prescription form.
(13) Order drugs listed on Schedule II of the Drug Abuse Prevention and Control Act, 21 U.S.C. Sec. 812, for office use on a prescription form.
(14) Violate any Federal or State law regarding controlled substances.
(15) Becomes addicted to, or dependent upon, or abuses alcohol, illegal or controlled drugs, or mind altering substances, or practice with an untreated substance use disorder diagnosis that renders the licensee unable to safely conduct the practice of dentistry**,** dental hygiene **or dental therapy.**

(16) Practice dentistry**,** dental hygiene **or dental therapy** in a dental office or clinic not owned by an Oregon licensed dentist(s), except for an entity described under ORS 679.020(3) and dental hygienists practicing pursuant to ORS 680.205(1)(2).
(17) Make an agreement with a patient or person, or any person or entity representing patients or persons, or provide any form of consideration that would prohibit, restrict, discourage or otherwise limit a person's ability to file a complaint with the Oregon Board of Dentistry; to truthfully and fully answer any questions posed by an agent or representative of the Board; or to participate as a witness in a Board proceeding.
(18) Fail to maintain at a minimum a current BLS for Healthcare Providers certificate or its equivalent.
(19) Conduct unbecoming a licensee or detrimental to the best interests of the public, including conduct contrary to the recognized standards of ethics of the licensee's profession or conduct that endangers the health, safety or welfare of a patient or the public.
(20) Knowingly deceiving or attempting to deceive the Board, an employee of the Board, or an agent of the Board in any application or renewal, or in reference to any matter under investigation by the Board. This includes but is not limited to the omission, alteration or destruction of any record in order to obstruct or delay an investigation by the Board, or to omit, alter or falsify any information in patient or business records.
(21) Knowingly practicing with a physical or mental impairment that renders the Licensee unable to safely conduct the practice of dentistry**,** dental hygiene **or dental therapy.**
(22) Take any action which could reasonably be interpreted to constitute harassment or retaliation towards a person whom the licensee believes to be a complainant or witness.
(23) Fail to register with the Prescription Drug Monitoring Program (PDMP) in order to have access to the Program's electronic system if the Licensee holds a Federal Drug Enforcement Administration (DEA) registration.

818-021-0052
Application for License to Practice Dental Therapy
(1) An applicant to practice dental therapy, in addition to the requirements set forth in ORS 679.603 and 679.609, shall submit to the Board satisfactory evidence of:
(a) Having graduated from a dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Having graduated from a dental therapy program located outside the United States or Canada, completion of not less than one year in a program accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and
(2) An applicant who has not met the educational requirements for licensure may apply if the Director of an accredited program certifies the applicant will graduate.
(3) An applicant must pass a Board examination consisting of a clinical portion administered by the Board, or any clinical Board examination administered by any state, regional testing agency, national testing agency or other Board-recognized testing agency and a jurisprudence portion administered by the Board. Clinical examination results will be recognized by the Board for five years.
(4) A person who fails any Board approved clinical examination three times must successfully complete the remedial training recommended by the testing agency. Such remedial training must be conducted by a dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association.

818-021-0054
Application for License to Practice Dental Therapy Without Further Examination
(1) The Oregon Board of Dentistry may grant a license without further examination to a

dental therapist who holds a license to practice dental therapy in another state or states if the dental therapist meets the requirements set forth in 679.603 and 679.609 and submits to the Board satisfactory evidence of:
(a) Having graduated from a dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Having completed or graduated from a dental therapy education program, and
(c) Having passed the clinical dental therapy examination conducted by a regional testing agency or by a state dental or dental therapy licensing authority, by a national testing agency or other Board-recognized testing agency; and
(d) Holding an active license to practice dental therapy, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dental therapy, without restrictions, and whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and
(e) Having conducted licensed clinical practice in Oregon, in other states or in the Armed Forces of the United States, the United States Public Health Service, the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately preceding application. Licensed clinical practice could include hours devoted to teaching by dental therapists employed by a CODA accredited dental therapy program with verification from the dean or appropriate administration of the institution documenting the length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dental therapy, and any adverse actions or restrictions; and
(f) Having completed 36 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.
(2) Applicants must pass the Board's Jurisprudence Examination.

818-021-0026
State and Nationwide Criminal Background Checks, Fitness Determinations
(1) The Board requires fingerprints of all applicants for a dental**, dental therapy** or dental hygiene license to determine the fitness of an applicant. The purpose of this rule is to provide for the reasonable screening of dental and dental hygiene applicants and licensees in order to determine if they have a history of criminal behavior such that they are not fit to be granted or hold a license that is issued by the Board.
(2) These rules are to be applied when evaluating the criminal history of all licensees and applicants for a dental**, dental therapy** or dental hygiene license and for conducting fitness determinations consistent with the outcomes provided in OAR 125-007-0260.
(3) Criminal records checks and fitness determinations are conducted according to ORS 181A.170 to 181A.215, ORS 670.280 and OAR 125-007-0200 to 127-007-0310.
(a) The Board will request the Oregon Department of State Police to conduct a state and nationwide criminal records check. Any original fingerprint cards will subsequently destroyed.
(b) All background checks must include available state and national data, unless obtaining one or the other is an acceptable alternative.
(c) The applicant or licensee must disclose all arrests, charges, and convictions regardless of the outcome or date of occurrence. Disclosure includes but is not limited to military, dismissed or set aside criminal records.
(4) If the applicant or licensee has potentially disqualifying criminal offender information, the Board will consider the following factors in making a fitness determination:
(a) The nature of the crime;

(b) The facts that support the conviction or pending indictment or that indicates the making of the false statement;
(c) The relevancy, if any, of the crime or the false statement to the specific requirements of the subject individual's present or proposed position, services, employment, license, or permit; and
(d) Intervening circumstances relevant to the responsibilities and circumstances of the position, services, employment, license, or permit. Intervening circumstances include but are not limited to:
(A) The passage of time since the commission of the crime;
(B) The age of the subject individual at the time of the crime;
(C) The likelihood of a repetition of offenses or of the commission of another crime:
(D) The subsequent commission of another relevant crime;
(E) Whether the conviction was set aside and the legal effect of setting aside the conviction; and
(F) A recommendation of an employer.
(e) Any false statements or omissions made by the applicant or licensee; and
(f) Any other pertinent information obtained as part of an investigation.
(5) The Board will make a fitness determination consistent with the outcomes provided in OAR 125-007-0260.
(a) A fitness determination approval does not guarantee the granting or renewal of a license.
(b) An incomplete fitness determination results if the applicant or licensee refuses to consent to the criminal history check, refuses to be fingerprinted or respond to written correspondence, or discontinues the criminal records process for any reason. Incomplete fitness determinations may not be appealed.
(6) The Board may require fingerprints of any licensed Oregon dentist**, dental therapist** or dental hygienist, who is the subject of a complaint or investigation for the purpose of requesting a state or nationwide criminal records background check.
(7) All background checks shall be requested to include available state and national data, unless obtaining one or the other is an acceptable alternative.
(8) Additional information required. In order to conduct the Oregon and National Criminal History Check and fitness determination, the Board may require additional information from the licensee/applicant as necessary, such but not limited to, proof of identity; residential history; names used while living at each residence; or additional criminal, judicial or other background information.
(9) Criminal offender information is confidential. Dissemination of information received may be disseminated only to people with a demonstrated and legitimate need to know the information. The information is part of the investigation of an applicant or licensee and as such is confidential pursuant to ORS 676.175(1).
(10) The Board will permit the individual for whom a fingerprint-based criminal records check was conducted, to inspect the individual's own state and national criminal offender records and, if requested by the individual, provide the individual with a copy of the individual's own state and national criminal offender records.
(11) The Board shall determine whether an individual is fit to be granted a license or permit, based on fitness determinations, on any false statements made by the individual regarding criminal history of the individual, or any refusal to submit or consent to a criminal records check including fingerprint identification, and any other pertinent information obtained as a part of an investigation. If an individual is determined to be unfit, then the individual may not be granted a license or permit. The Board may make fitness determinations conditional upon applicant's acceptance of probation, conditions, or limitations, or other restrictions upon licensure.
(12) An applicant or licensee may appeal a final fitness determination pursuant to OAR 125-007-0300. Challenges to the accuracy of completeness of criminal history information must be made in accordance with OAR 125-007-0030(7).

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 includes an examination and the dental therapist passes the examination.
(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.

818-021-0080
Renewal of License
Before the expiration date of a license, the Board will, as a courtesy, mail notice for renewal of license to the last mailing address on file in the Board's records to every licensee holding a current license. The licensee must complete the online renewal application and pay the current renewal fees prior to the expiration of said license. Licensees who fail to renew their license prior to the expiration date may not practice dentistry**, dental therapy** or dental hygiene until the license is reinstated and are subject to the provisions of OAR 818-021-0085, "Reinstatement of Expired Licenses."
(1) Each dentist shall submit the renewal fee and completed online renewal application by March 31 every other year. Dentists licensed in odd numbered years shall apply for renewal in odd numbered years and dentists licensed in even numbered years shall apply for renewal in even numbered years.
(2) Each dental hygienist must submit the renewal fee and completed online renewal application ~~form~~ by September 30 every other year. Dental hygienists licensed in odd numbered years shall

apply for renewal in odd numbered years and dental hygienists licensed in even numbered years shall apply for renewal in even numbered years.

(3) Each dental therapist must submit the renewal fee and completed and signed renewal application form by September 30 every other year. Dental Therapists licensed in odd numbered years shall apply for renewal in odd numbered years and dental therapists licensed in even numbered years shall apply for renewal in even numbered years.

(4) The renewal application shall contain:

(a) Licensee's full name;

(b) Licensee's mailing address;

(c) Licensees business address including street and number or if the licensee has no business address, licensee's home address including street and number;

(d) Licensee's business telephone number or if the licensee has no business telephone number, licensee's home telephone number;

(e) Licensee's employer or person with whom the licensee is on contract;

(f) Licensee's assumed business name;

(g) Licensee's type of practice or employment;

(h) A statement that the licensee has met the continuing educational requirements for **their specific license** renewal set forth in OAR 818-021-0060 or **OAR** 818-021-0070 **or OAR 818-021-0076:**

(i) Identity of all jurisdictions in which the licensee has practiced during the two past years; and

(j) A statement that the licensee has not been disciplined by the licensing board of any other jurisdiction or convicted of a crime.

818-021-0085

Renewal or Reinstatement of Expired License

Any person whose license to practice as a dentist**,** dental hygienist **or dental therapist** has expired, may apply for reinstatement under the following circumstances:

(1) If the license has been expired 30 days or less, the applicant shall:

(a) Pay a penalty fee of $50;

(b) Pay the biennial renewal fee; and

(c) Submit a completed renewal application and certification of having completed the Board's continuing education requirements.

(2) If the license has been expired more than 30 days but less than 60 days, the applicant shall:

(a) Pay a penalty fee of $100;

(b) Pay the biennial renewal fee; and

(c) Submit a completed renewal application and certification of having completed the continuing education requirements.

(3) If the license has been expired more than 60 days, but less than one year, the applicant shall:

(a) Pay a penalty fee of $150;

(b) Pay a fee equal to the renewal fees that would have been due during the period the license was expired;

(c) Pay a reinstatement fee of $500; and

(d) Submit a completed application for reinstatement provided by the Board, including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.

(4) If the license has been expired for more than one year but less than four years, the applicant shall:
(a) Pay a penalty fee of $250;
(b) Pay a fee of equal to the renewal fees that would have been due during the period the license was expired;
(c) Pay a reinstatement fee of $500;
(d) Pass the Board's Jurisprudence Examination;
(e) Pass any other qualifying examination as may be determined necessary by the Board after assessing the applicant's professional background and credentials;
(f) Submit evidence of good standing from all states in which the applicant is currently licensed; and
(g) Submit a completed application for reinstatement provided by the Board including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.
(5) If a **Licensee** fails to renew or reinstate **their** license within four years from expiration, the **Licensee** must apply for licensure under the current statute and rules of the Board.

818-021-0088
Volunteer License
(1) An Oregon licensed dentist**, dental therapist** or dental hygienist who will be practicing for a supervised volunteer dental clinic, as defined in ORS 679.020(3)(f) and (g), may be granted a volunteer license provided licensee completes the following:
(a) Licensee must register with the Board as a health care professional and provide a statement as required by ORS 676.345.
(b) Licensee will be responsible to meet all the requirements set forth in ORS 676.345.
(c) Licensee must provide the health care service without compensation.
(d) Licensee shall not practice dentistry**, dental therapy** or dental hygiene for remuneration in any capacity
under the volunteer license.
(e) Licensee must comply with all continuing education requirements for active licensed dentist**, dental therapist,**
or dental hygienist.
(f) Licensee must agree to volunteer for a minimum of 80 hours in Oregon per renewal cycle.
(2) Licensee may surrender the volunteer license designation at anytime and request a return to an active license. The Board will grant an active license as long as all active license requirements have been met.

818-021-0090
Retirement of License
(1) A **Licensee** who no longer practices in any jurisdiction may retire **their** license by submitting a request to retire such license on a form provided by the Board.
(2) A license that has been retired may be reinstated if the applicant:
(a) Pays a reinstatement fee of $500;
(b) Passes the Board's Jurisprudence Examination;
(c) Passes any other qualifying examination as may be determined necessary by the Board after assessing the applicant's professional background and credentials;
(d) Submits evidence of good standing from all states in which the applicant is currently licensed; and
(e) Submits a completed application for reinstatement provided by the Board including certification of having completed continuing education credits as required by the Board during

the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.
(3) If the **Licensee** fails to reinstate **their** license within four years from retiring the license, the **Licensee** must apply for licensure under the current statute and rules of the Board.

818-021-0095
Resignation of License
(1) The Board may allow a dentist**,** dental hygienist **or dental therapist** who no longer practices in Oregon to resign **their** license, unless the Board determines the license should be revoked.
(2) Licenses that are resigned under this rule may not be reinstated.

818-021-0110
Reinstatement Following Revocation
(1) Any person whose license has been revoked for a reason other than failure to pay the ~~annual~~ **renewal** fee may petition the Board for reinstatement after five years from the date of revocation.
(2) The Board shall hold a hearing on the petition and, if the petitioner demonstrates that reinstatement of the license will not be detrimental to the health or welfare of the public, the Board may allow the petitioner to retake the Board examination.
(3) If the license was revoked for unacceptable patient care, the petitioner shall provide the Board with satisfactory evidence that the petitioner has completed a course of study sufficient to remedy the petitioner's deficiencies in the practice of dentistry**, dental therapy** or dental hygiene.
(4) If the petitioner passes the Board examination, the Board may reinstate the license, place the petitioner on probation for not less than two years, and impose appropriate conditions of probation.

818-026-0055
Dental Hygiene, Dental Therapy and Dental Assistant Procedures Performed Under Nitrous Oxide or Minimal Sedation
(1) Under indirect supervision, dental hygiene procedures may be performed for a patient who is under nitrous oxide or minimal sedation under the following conditions:
(a) A licensee holding a Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; or
(c) If a dental hygienist with a nitrous oxide permit administers nitrous oxide sedation to a patient and then performs authorized procedures on the patient, an anesthesia monitor is not required to be present during the time the patient is sedated unless the permit holder leaves the patient.
(d) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with **Board rules.**
(2) Under indirect supervision, a dental assistant may perform those procedures for which the dental assistant holds the appropriate certification for a patient who is under nitrous oxide or minimal sedation under the following conditions:
(a) A licensee holding the Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; and
(c) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with **Board rules.**
(3) Under indirect supervision, a dental therapist may perform procedures for which they hold the appropriate license for a patient who is under nitrous oxide or minimal sedation

under the following conditions:
(a) A licensee holding the Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;
(b) The permit holder, or an anesthesia monitor, monitors the patient; and
(c) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with Board rules.

818-038-0001
Definitions
(1) “Dental Therapist” means a person licensed to practice dental therapy under ORS 679.603.
(2) “Dental Therapy” means the provision of preventive dental care, restorative dental treatment and other educational, clinical and therapeutic patient services as part of a dental care team, including the services described under ORS 679.621.
(3) "Direct Supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.
(4) "General Supervision" means supervision requiring that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.
(5) "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.
(6) "Informed Consent" means the consent obtained following a thorough and easily understood explanation to the patient, or patient's guardian, of the proposed procedures, any available alternative procedures and any risks associated with the procedures. Following the explanation, the licensee shall ask the patient, or the patient's guardian, if there are any questions. The licensee shall provide thorough and easily understood answers to all questions asked.
(7) “Collaborative Agreement” means a written and signed agreement entered into between a dentist and a dental therapist under ORS 679.618.

818-038-0010
Authorization to Practice
(1) A dental therapist may practice dental therapy only under the supervision of a dentist and pursuant to a collaborative agreement with the dentist that outlines the supervision logistics and requirements for the dental therapist’s practice.
(2) A dental therapist shall dedicate at least 51 percent of the dental therapist’s practice to patients who represent underserved populations, as defined by the Oregon Health Authority by rule, or patients located in dental care health professional shortage areas, as determined by the authority.
(3) A dental therapist may perform the procedures listed in OAR 818-038- 0020 so long as the procedures were included in the dental therapist’s education program or the dental therapist has received additional training in the procedure through a Board approved course.

818-038-0020
Scope of Practice
(1) A dental therapist may perform, pursuant to the dental therapist’s collaborative agreement, the following procedures under the general supervision of the dentist:

(a) Identification of conditions requiring evaluation, diagnosis or treatment by a dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390 or other licensed health care provider;
(b) Comprehensive charting of the oral cavity;
(c) Oral health instruction and disease prevention education, including nutritional counseling and dietary analysis;
(d) Exposing and evaluation of radiographic images;
(e) Dental prophylaxis, including subgingival scaling and polishing procedures;
(f) Application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;
(g) Administering local anesthetic;
(h) Pulp vitality testing;
(i) Application of desensitizing medication or resin;
(j) Fabrication of athletic mouth guards;
(k) Changing of periodontal dressings;
(L) Simple extractions of erupted primary anterior teeth and coronal remnants of any primary teeth;
(m) Emergency palliative treatment of dental pain;
(n) Preparation and placement of direct restoration in primary and permanent teeth;
(o) Fabrication and placement of single-tooth temporary crowns;
(p) Preparation and placement of preformed crowns on primary teeth;
(q) Indirect pulp capping on permanent teeth;
(r) Indirect pulp capping on primary teeth;
(s) Suture removal;
(t) Minor adjustments and repairs of removable prosthetic devices;
(u) Atraumatic restorative therapy and interim restorative therapy;
(v) Oral examination, evaluation and diagnosis of conditions within the scope of practice of the dental therapist and with the supervising dentist's authorization;
(w) Removal of space maintainers;
(x) The dispensation and oral or topical administration of:
(A) Nonnarcotic analgesics;
(B) Anti-inflammatories; and
(C) Antibiotics; and
(y) Other services as specified by the Oregon Board of Dentistry by rule.
(2) A dental therapist may perform, pursuant to the dental therapist's collaborative agreement, the following procedures under the indirect supervision of the dentist:
(a) Placement of temporary restorations;
(b) Fabrication of soft occlusal guards;
(c) Tissue reconditioning and soft reline;
(d) Tooth reimplantation and stabilization;
(e) Recementing of permanent crowns;
(f) Pulpotomies on primary teeth;
(g) Simple extractions of:
(A) Erupted posterior primary teeth; and
(B) Permanent teeth that have horizontal movement of greater than two millimeters or vertical movement and that have at least 50 percent periodontal bone loss;
(h) Brush biopsies; and
(i) Direct pulp capping on permanent teeth.
(3) The dentist described in subsection (2) of this section shall review a procedure described in subsection (2) of this section that is performed by the dental therapist and the patient chart that contains information regarding the procedure.

(4)(a) A dental therapist may supervise a dental assistant and an expanded function dental assistant, as defined by the board by rule, if the dental therapist is authorized to perform the services provided by the dental assistant or expanded function dental assistant.
(b) A dental therapist may supervise up to two individuals under this subsection.

818-038-0025
Prohibited Acts
A dental therapist may not:
(2) Place or Restore Dental Implants or any other soft tissue surgery except as described in 818-038-0020
(3) Prescribe any drugs, unless permitted by ORS 679.010
(4) Use the behavior management techniques of Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.
(5) Perform any dental therapy procedure unless it is documented in the collaborative agreement and rendered under appropriate Oregon Licensed Dentist supervision.
(6) Operate a hard or soft tissue Laser.
(7) Treat a patient under moderate, deep or general anesthesia.
(8) Order a computerized tomography scan

818-038-0030
Collaborative Agreements
(1) A dentist may supervise and enter into collaborative agreements with up to three dental therapists at any one time.
(2) A dental therapist may enter into a collaborative agreement with more than one dentist if each collaborative agreement includes the same supervision and requirements of scope of practice.
(3) The collaborative agreement must include at least the following information:
(a) The level of supervision required for each procedure performed by the dental therapist;
(b) Circumstances under which the prior knowledge and consent of the dentist is required to allow the dental therapist to provide a certain service or perform a certain procedure;
(c) The practice settings in which the dental therapist may provide care;
(d) Any limitation on the care the dental therapist may provide;
(e) Patient age-specific and procedure-specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency;
(f) Procedures for creating and maintaining dental records for patients treated by the dental therapist;
(g) Guidelines for the management of medical emergencies in each of the practice settings in which the dental therapist provides care;
(h) A quality assurance plan for monitoring care provided by the dental therapist, including chart review, patient care review and referral follow-up;
(i) Protocols for the dispensation and administration of drugs by the dental therapist, (as described in ORS 679.621) including circumstances under which the dental therapist may dispense and administer drugs;
(j) Criteria for the provision of care to patients with specific medical conditions or complex medical histories, including any requirements for consultation with the dentist prior to the provision of care; and

(k) Protocols for when a patient requires treatment outside the dental therapist's scope of practice (in accordance with ORS 679.618), including for referral of the patient for evaluation and treatment by the dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390 or other licensed health care provider.

(2) (a) In addition to the information described in subsection (3) of this section, a collaborative agreement must include a provision that requires the dental therapist to consult with a dentist if the dental therapist intends to perform an irreversible surgical procedure under general supervision on a patient who has a severe systemic disease. Severe systemic disease is defined as ASA III.

818-038-0035
Record Keeping

(1) A dental therapist shall annually submit a signed copy of their collaborative agreement (s) to the Oregon Board of Dentistry. If the collaborative agreement(s) are revised in between annual submissions, a signed and dated copy of the revised collaborative agreement(s) must be submitted to the board as soon as practicable after the revision is made.

(2) The annual submission of the collaborative agreement shall coincide with the license renewal period between August 1 and September 30 each year.

(3) A dental therapist shall purchase and maintain liability insurance.

818-042-0010
Definitions

(1) "Dental Assistant" means a person who, under the supervision of a dentist, renders assistance to a dentist, dental hygienist, **dental therapist**, dental technician or another dental assistant**.** ~~or renders assistance under the supervision of a dental hygienist providing dental hygiene services.~~

(2) "Expanded Function Dental Assistant" means a dental assistant certified by the Board to perform expanded function duties.

(3) "Expanded Function Orthodontic Assistant" means a dental assistant certified by the Board to perform expanded orthodontic function duties.

(4) "Direct Supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.

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

(6) "General Supervision" means supervision requiring that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.

818-042-0020
Dentist, Dental Therapist and Dental Hygienist Responsibility

(1) A dentist is responsible for assuring that a dental assistant has been properly trained, has demonstrated proficiency, and is supervised in all the duties the assistant performs in the dental office. Unless otherwise specified, dental assistants shall work under indirect supervision in the dental office.

(2) A dental hygienist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental hygienist in providing dental hygiene services and the dentist is not in the office to provide indirect

supervision. A dental hygienist with an Expanded Practice Permit may hire and supervise dental assistants who will render assistance to the dental hygienist in providing dental hygiene services.
(3) A dental therapist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental therapist in providing dental therapy services. ~~and a dentist has authorized it.~~
(4) The supervising dentist**, dental therapist** or dental hygienist is responsible for assuring that all required licenses, permits or certificates are current and posted in a conspicuous place.
~~(4)~~ (5) Dental assistants who are in compliance with written training and screening protocols adopted by the Board may perform oral health screenings under general supervision.

818-042-0050
Taking of X-Rays — Exposing Radiographic Images
(1) A **~~dentist~~ 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 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.
(2) A dentist**, dental therapist** or dental hygienist 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.
(3) A dental therapist may not order a computerized tomography scan

818-042-0060
Certification — Radiologic Proficiency
(1) The Board may certify a dental assistant in radiologic proficiency by credential in accordance with OAR 818-042-0120, or if the assistant:
(2) Submits an application on a form approved by the Board, pays the application fee and:
(a) Completes a course of instruction approved by the Oregon Board of Dentistry, in accordance with OAR 333-106-0055 or submits evidence that the Oregon Health Authority, Center for Health Protection, Radiation Protection Services recognizes that the equivalent training has been successfully completed;
(b) Passes the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, Inc. (DANB), or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry; and
(c) Certification by an Oregon licensed dentist**, dental therapist** or dental hygienist that the assistant is proficient to take radiographs.

818-042-0090
Additional Functions of EFDAs
Upon successful completion of a course of instruction in a program accredited by the Commissi on on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Dental Assistant ma y perform the following functions under the indirect supervision of a dentist**, dental therapist** or dental hygienist providing that the procedure is checked by the dentist**, dental therapist** or dental hygienist prior to the patient being dismissed:
(1) Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a dentist**, dental therapist** or dental hygienist.
(2) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.
(3) Place retraction material subgingivally.

818-042-0114
Additional Functions of EFPDAs
(1) Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Preventive Dental Assistant may perform the following functions under the indirect supervision of a dentist**, dental therapist** or dental hygienist providing that the procedure is checked by the dentist**, dental therapist** or dental hygienist prior to the patient being dismissed:
(2) Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a dentist**, dental therapist** or dental hygienist.

DRAFT

Oregon Board of Dentistry
Dental Therapist
Verification of Collaborative Agreement

I, (print your name)_____, a licensed Dentist pursuant to ORS 679.020 and 679.025, license number _____, have entered into a Collaborative Agreement with (print your name)_____, an Oregon licensed Dental Therapist, license number DT_____. The Collaborative Agreement sets forth the agreed-upon practice limitations of the Dental Therapist's practice and adheres to all the requirements set forth by the Legislature and the Oregon Board of Dentistry.

Please describe the circumstances under which the prior knowledge and consent of the dentist is required to allow the dental therapist to provide a certain service or perform a certain procedure within the scope of dental therapy:

_____
_____
_____
_____

Please define the practice settings in which the dental therapist may provide care:

_____
_____
_____

Please describe any limitation on the care the dental therapist may provide:

_____
_____
_____

Please define patient age-specific and procedure-specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency, (attach a copy of the guidelines):

_____
_____
_____
_____
_____

Please describe procedures for creating and maintaining dental records for patients treated by the dental therapist:

_____
_____
_____
_____
_____

Please describe guidelines for the management of medical emergencies in each of the practice settings in which the dental therapist provides care, (attach copy of guidelines):

_____
_____
_____
_____
_____

Please provide a quality assurance plan for monitoring care provided by the dental therapist, including chart review, patient care review and referral follow-up, (attach copy of plan):

Please describe protocols for the dispensation and administration of local anesthetic, non-narcotic analgesic's, and anti-inflammatories or antibiotics; including the dispensation of oral or topical administration of non-narcotic analgesics, anti-inflammatories and antibiotics:

Please describe the criteria for the provision of care to patients with specific medical conditions or complex medical histories, including any requirements for consultation with the dentist prior to the provision of care:

Please describe protocols for when a patient requires treatment outside the dental therapist's scope of practice, including for referral of the patient for evaluation and treatment by the dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390 or other licensed health care provider, (attach protocols):

Please briefly summarize the following treatment parameters for when the dental therapist consults with a dentist, if the dental therapist intends to administer local anesthesia and perform an irreversible surgical procedure under general supervision on a patient who has a severe systemic disease. Severe systemic disease is defined as ASA III:

General Supervision: requires that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.

Indirect Supervision: requires that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.

Direct Supervision: requires that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.

The below listed duties may be performed under **general supervision**, unless otherwise indicated.

If **all** duties listed below are allowed under **general supervision**, please initial here:_____

***If a duty listed below is **not** allowed, or allowed under a different level of supervision, please indicate that by checking the appropriate box.

Specific Supervision Levels	**GS**	**IS**	**DS**	**Not Allowed**
Identification of conditions requiring evaluation, diagnosis or treatment by a dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390				
Comprehensive charting of the oral cavity				
Oral health instruction and disease prevention education, including nutritional counseling and dietary analysis				
Exposing and evaluation of radiographic images				
Dental prophylaxis, including subgingival scaling and polishing procedures				
Application of topical preventative or prophylactic agents, including fluoride varnishes and pit and fissure sealants				
Administering local anesthetic				
Pulp vitality testing				
Application of desensitizing medication or resin				
Fabrication of athletic mouth guards				
Changing of periodontal dressings				
Simple extractions of erupted primary anterior teeth and coronal remnants of any primary teeth				
Emergency palliative treatment of dental pain				
Preparation and placement of direct restoration in primary and permanent teeth				

Fabrication and placement of single-tooth temporary crowns				
Preparation and placement of preformed crowns on primary teeth				
Indirect pulp capping in permanent teeth				
Indirect pulp capping on primary teeth				
Suture removal				
Minor adjustments and repairs of removable prosthetic devices				
Atraumatic restorative therapy and interim restorative therapy				
Oral examination, evaluation and diagnosis of conditions within the supervising dentist' s authorization				
Removal of space maintainers				
The dispensation and oral or topical administration of: o Non-narcotic analgesics o Anti-inflammatories o Antibiotics				

The below listed duties may be performed under **indirect supervision**, unless otherwise indicated.

If **all** duties listed below are allowed under **indirect supervision**, please initial here: _____

In accordance with OAR 818-038-0020 (3) Please indicate whether review with the supervising dentist is to be completed before the procedure, after the procedure, or both.

***If a duty listed below is **not** allowed, or allowed under a different level of supervision, please indicate that by checking the appropriate box.

Specific Supervision Levels	**Review Before**	**Review After**	**IS**	**DS**	**Not Allowed**
Placement of temporary restorations **Additional comments:**					
Fabrication of soft occlusal guards **Additional comments:**					
Tissue reconditioning and soft relines **Additional comments:**					

Tooth reimplantation and stabilization **Additional comments:**					
Recementing of permanent crowns **Additional comments:**					
Pulpotomies on primary teeth **Additional comments:**					
Simple extractions of: o Erupted posterior primary teeth; and **Additional comments:**					
Simple extractions of: o Permanent teeth that have horizontal movement of greater than two millimeters or vertical movement and that have at least 50 percent periodontal bone loss **Additional comments:**					
Brush biopsies **Additional comments:**					
Direct pulp capping on permanent teeth **Additional comments:**					

Dentist:

I understand that this agreement will remain in effect with the Oregon Board of Dentistry (OBD) until I submit a written change. If any changes are made to this agreement, a new verification and copy of the agreement must be submitted to the OBD as soon as reasonably possible (this means in less than 14 days of the change). Failure to do so may result in Board action.

I understand that I may supervise and enter into collaborative agreements with up to three dental therapists at one time.

I attest that a copy of the Collaborative Agreement, signed by both parties, is attached to this verification. I understand that failure to provide a copy of the agreement with the verification will result in the verification form being rejected and returned.

Dentist's Signature: _____ Date: _____

Address: _____

_____

Cell phone #_____ Email _____

Dental Therapist:

I understand that this agreement will remain in effect with the Oregon Board of Dentistry (OBD) until I submit a written change. I understand that I shall submit annually a signed copy of the collaborative agreement to the Oregon Board of Dentistry. If any changes are made to this agreement, a new verification and copy of the agreement must be submitted to the OBD as soon as reasonably possible (this means in less than 14 days of the change). Failure to do so may result in Board action.

I understand that I may enter into collaborative agreements with more than one dentist if each collaborative agreement includes the same supervision requirements and scope of practice.

I attest that a copy of my liability insurance is attached to this verification.

I attest that at least 51 percent of my dental therapy practice will be to patients who represent underserved populations, as defined by the Oregon Health Authority by rule, or patients located in dental care health professional shortage areas, as determined by the authority.

I attest that a copy of the Collaborative Agreement, signed by both parties, is attached to this verification. I understand that failure to provide a copy of the agreement with the verification will result in the verification form being rejected and returned.

Dental Therapist's Signature:_____ Date: _____

Address: _____

_____

Cell phone #_____ Email _____

STOP – Did you remember to attach your….

1. Patient age-specific and procedure-specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency?
2. Medical emergency guidelines?
3. Quality assurance plan?
4. Protocols for when a patient requires treatment outside the dental therapist's scope of practice?

ORS 679.618 Collaborative agreement required to practice dental therapy; required provisions; duties of dentist.

(1) A dental therapist may practice dental therapy only under the supervision of a dentist and pursuant to a collaborative agreement with the dentist that outlines the supervision logistics and requirements for the dental therapist's practice. The collaborative agreement must include at least the following information:

(a) The level of supervision required for each procedure performed by the dental therapist;

(b) Circumstances under which the prior knowledge and consent of the dentist is required to allow the dental therapist to provide a certain service or perform a certain procedure;

(c) The practice settings in which the dental therapist may provide care;

(d) Any limitation on the care the dental therapist may provide;

(e) Patient age-specific and procedure-specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency;

(f) Procedures for creating and maintaining dental records for patients treated by the dental therapist;

(g) Guidelines for the management of medical emergencies in each of the practice settings in which the dental therapist provides care;

(h) A quality assurance plan for monitoring care provided by the dental therapist, including chart review, patient care review and referral follow-up;

(i) Protocols for the dispensation and administration of drugs, as described in ORS 679.621, by the dental therapist, including circumstances under which the dental therapist may dispense and administer drugs;

(j) Criteria for the provision of care to patients with specific medical conditions or complex medical histories, including any requirements for consultation with the dentist prior to the provision of care; and

(k) Protocols for when a patient requires treatment outside the dental therapist's scope of practice, including for referral of the patient for evaluation and treatment by the dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390 or other licensed health care provider.

(2) In addition to the information described in subsection (1) of this section, a collaborative agreement must include a provision that requires the dental therapist to consult with a dentist if the dental therapist intends to perform an irreversible surgical procedure under general supervision on a patient who has a severe systemic disease.

(3) A dentist who enters into a collaborative agreement with a dental therapist shall:

(a) Directly provide care to a patient that is outside the scope of practice of the dental therapist or arrange for the provision of care by another dentist; and

(b) Ensure that the dentist, or another dentist, is available to the dental therapist for timely communication during the dental therapist's provision of care to a patient.

(4) A dental therapist may perform and provide only those procedures and services authorized by the dentist and set out in the collaborative agreement, and shall maintain with the dentist an appropriate level of contact, as determined by the dentist.

(5) A dental therapist and a dentist who enter into a collaborative agreement together shall each maintain a physical copy of the collaborative agreement.

(6)(a) A dental therapist may enter into collaborative agreements with more than one dentist if each collaborative agreement includes the same supervision requirements and scope of practice.

(b) A dentist may supervise and enter into collaborative agreements with up to three dental therapists at any one time.

(7)(a) A collaborative agreement must be signed by the dentist and dental therapist.

(b) A dental therapist shall annually submit a signed copy of the collaborative agreement to the Oregon Board of Dentistry. If the collaborative agreement is revised in between annual submissions, a signed copy of the revised collaborative agreement must be submitted to the board as soon as practicable after the revision is made.

OREGON BOARD OF DENTISTRY
GENERAL INFORMATION AND INSTRUCTION SHEET

DENTAL THERAPY
LICENSURE BY EXAMINATION

Introduction:

These instructions are designed to assist you in the application process for dental therapy licensure in Oregon. Licensure by Examination is intended for those applicants who have passed their clinical examination within the immediate five years preceding their application. Please read and follow them carefully. Failure to meet any of the requirements will result in your application being rejected. A checklist format has been used to assist you in requesting documentation and to ensure you meet all application requirements.

Licensure by Examination

Dental Therapists are eligible to apply for licensure by examination in Oregon within five (5) years of passage of an examination described in ORS 679.606 and/or established by the Board by rule.

IMPORTANT INFORMATION – ALL APPLICANTS

Affirmative Responses to Questions on Page 2 of the Application Form

If you answer "yes" to any of the questions, for any reason, you must submit additional supporting documentation for that question as indicated on the application. This documentation should include:

1. **Written letter of explanation** from you giving full details.

2. **Certified copies** of disciplinary action, police reports, court documents, and medical evaluations or any other pertinent information.

Application Valid 180 Days (OAR 818-021-0120):

1. If all information and documentation necessary for the Board to act on an application is not provided to the Board by the applicant within 180 days from the date the application is received by the Board, the Board shall reject the application as incomplete.

2. An applicant whose application has been rejected as incomplete must file a new application and must pay a new application fee.

3. **An applicant who fails the examination or who does not take the examination during the 180-day period following the date the Board receives the application, must file a new application, and must pay a new application fee.**

Fees Non-refundable – (ORS 679.615)

All fees paid to the Board are non-refundable or transferable.

Please anticipate a minimum of 6 – 8 weeks for complete application processing. Once requested, documentation from other states or jurisdictions and background checks can take several weeks for processing.

WHERE FORMS ARE TO BE SENT:

The Application and the Biennial Licensure Forms and their fees must be sent together to Oregon Board of Dentistry, Unit 23, PO Box 4395, Portland, Oregon 97208-4395. Payment can be made with one or more cashier's checks or money orders, as long as the total fees paid balances with the forms submitted.

All supplemental forms, Official Transcripts, and Certificates of Standing from other states, jurisdictions, and/or countries are to be sent directly to the Oregon Board of Dentistry, 1500 SW 1st Avenue, Suite 770, Portland, OR 97201.

LICENSURE BY EXAMINATION: DOCUMENTATION REQUIREMENTS

☐ **Application Form**

Application must be completed in full, notarized and submitted with the required fee to the Oregon Board of Dentistry, Unit 23, PO Box 4395, Portland, Oregon 97208-4395.

☐ **Photograph (Signed and Dated)**

Submit a current 2" X 2" photograph, signed and dated. Affix to page 2 of the application in the space provided.

☐ **Application Fee - $180**

Fees must be paid in U.S. funds, by cashier's check or money order, payable to the "Oregon Board of Dentistry," and submitted with the application form. Applications will not be processed without the appropriate fee. **Fees paid are neither transferable nor refundable**. **All fees are mandatory.**

☐ **Biennial Licensure Form**

The Biennial Licensure Form must be completed and submitted with the required fee to the Oregon Board of Dentistry, Unit 23, PO Box 4395, Portland, Oregon 97208-4395. When completing the form at least one address must be a physical street address.

☐ **Biennial Licensure Fee - $230**

This fee must be paid in U.S. funds, by cashier's check or money order, payable to the "Oregon Board of Dentistry," and submitted with the Biennial Licensure Fee form. A license will not be issued without the Biennial License Form and appropriate fee. **Fees paid are neither transferable nor refundable. All fees are mandatory.**

☐ **Transcript (With Degree Posted) or Certificate of Completion**

Transcripts must be posted with dental therapy degree from a CODA accredited dental therapy program, or a certificate of completion from a dental therapy education program approved by the Board and must be sent to the Board directly from the school or program

☐ **License Verifications**

License verifications must be requested by the applicant and submitted directly to the Oregon Board of Dentistry by every state, country, or jurisdiction in which the applicant is currently licensed or has held licensure. (Note: Many states, jurisdictions, and countries charge a fee for this service. Please contact the state and/or country directly prior to submitting your request to prevent delays in processing.)

☐ **Proof of Clinical Examination within Five (5) Years of Passage**

1. Regional: If the applicant passed a clinical examination administered by a regional testing agency, submit a photocopy of the original CRDTS, CDCA-WREB, or other Board-approved examination certificate.

2. State: If the applicant passed a state examination, verification from the state must be submitted directly to the Oregon Board of Dentistry, 1500 SW 1st Avenue, Suite 770, Portland, OR 97201.

3. National Testing Agency: If the applicant passed a clinical examination administered by a national testing agency, submit evidence of passage of the National Testing Agency clinical examination.

4. Other Board-recognized testing agency: If the applicant passed a clinical examination administered by any other Board-recognized testing agency, submit evidence of passage of the Board-recognized Testing Agency clinical examination.

☐ **Fingerprints – Live Scan**

Live Scan fingerprints can only be transmitted electronically. Once the Oregon Board of Dentistry receives your application and application fee, we will send you the Request for Transmission for Live Scan Fingerprints form.

☐ **Jurisprudence Examination**

Once the application and application fee are received, the Jurisprudence Examination will be mailed to you. This examination is “open book” and must be returned to the Board by mail.

☐ **Healthcare Provider BLS/CPR**

A photocopy of your Healthcare Provider BLS/CPR or its equivalent certification must be **submitted by you** to the Oregon Board of Dentistry (OBD).

☐ **Proof of liability insurance**

A photocopy of your liability insurance must be **submitted by you** to the Oregon Board of Dentistry (OBD).

OREGON
BOARD OF DENTISTRY

APPLICATION FOR LICENSURE

Date Application Received:	License No:
	Date License Issued:

1. Application must be completed on a computer or a typewriter. (**No handwritten applications will be accepted**).
2. If additional space is needed, attach a separate sheet.

4. **Mail completed application to the Oregon Board of Dentistry, Unit 23, PO Box 4395, Portland, OR 97208-4395. ALL FEES ARE MANDATORY!**

I HEREBY APPLY FOR A LICENSE TO PRACTICE:

Dental Therapy – Licensure by Exam

☐ Application fee (2108) $180

First Name	Middle Name	Last Name		
Other Names Used - Enter None if None			Telephone Number	
Mailing Address/City, State, ZIP Code			Social Security Number	
Place of Birth			Date of Birth	
College Education (Name and Location)		From (mm/yy)	To (mm/yy)	Degree
Dental/Dental Hygiene/Dental Therapy School(s) (Name and Location)		From (mm/yy)	To (mm/yy)	Degree

You must respond fully and truthfully to these questions. Failure to fully and truthfully respond to these questions may result in the denial of your application or another appropriate sanction as authorized by law. Fully and truthfully includes, but is not limited to, reporting DUII (Driving Under the Influence of Intoxicants) and MIP (Minor in Possession) violations, possession of a controlled substance, theft, shoplifting, domestic violence, or assault violations, or any other violation of the law, misdemeanor, or felony, of any state or federal law, regardless of the state or territory in which it happened. **This information must be reported whether or not the arrest/citation was dismissed, dismissed through diversion, set aside, or judged not guilty, regardless of how long ago it happened.**

1. Are you aware of any physical or mental conditions that would inhibit your ability to practice safely?	☐ Yes	☐ No
2. Have you ever been denied a license to practice dental therapy, dentistry, or dental hygiene or denied the right to take an exam for such licensure?	☐ Yes	☐ No
3. Have you ever voluntarily surrendered a license to practice dental therapy, dentistry, or dental hygiene?	☐ Yes	☐ No
4. Have you ever been the subject of any pending or final (formal, informal, or corrective) action regarding any dental therapy, dental, or dental hygiene license you now hold or have ever held? (Include any disciplinary actions by the U.S. Military, U.S. Public Health service, Drug Enforcement Administration, state licensing board, or any other entity).	☐ Yes	☐ No
5. Has there been any investigation or disciplinary action taken against you by any dental therapy, dental, or dental hygiene school or program?	☐ Yes	☐ No
6. a. Have you ever been cited, arrested, charged or convicted of any crime, offense, or violation of the law in any state or country, even if those charges were dismissed or set aside?	☐ Yes	☐ No
b. Are there any pending criminal actions against you that could result in your imprisonment in a state, local or federal institution (even if not imprisoned)?	☐ Yes	☐ No
7. Have you ever been convicted of any crime of any federal, state or local law relating to the possession, distribution, use, or dispensing of mind-altering or controlled substances?	☐ Yes	☐ No
8. Have you ever used or possessed illegal drugs, scheduled controlled drugs, or mind-altering substances, that would have been a crime by state or federal law?	☐ Yes	☐ No
9. Have you ever been evaluated for alcohol or drug abuse; or received treatment, counseling, or education for abuse of alcohol, drugs, or mind-altering substances?	☐ Yes	☐ No
10. a. Do you currently hold, or have you ever held, a license in this or any other state or country to practice a health care profession other than dental therapy, dentistry, or dental hygiene? If yes, list on page 3.	☐ Yes	☐ No
b. Has there been any disciplinary action, pending or final, regarding any health care professional license (other than dental therapy, dental, or dental hygiene) by a licensing board or equivalent authority?	☐ Yes	☐ No

Paste photograph here.
Must be a passport type of photo taken within one year of application.

Sign and date across the photograph in ink!

List all states/countries in which you are or have been licensed/certified or in which application is pending. **Enter "None" or "Not Applicable" if none**.	Type of License(s)				License No.	Date Issued	Status
State/Country	**Dental Therapy**	**Dental**	**Dental Hygiene**	**Other (Specify)**			

List in reverse chronological order all positions you have held in which you practiced dentistry, dental hygiene, or dental therapy as well as any residencies or other formal training not otherwise listed on this application. **Enter "None" or "Not Applicable" if none.**

Description	Name of Institution or Employer	Location	From (mm/yy)	To (mm/yy)

AFFIDAVIT OF APPLICANT

STATE OF _____

COUNTY OF _____

I, hereby declare that I am the person described in the attached application for licensure.

I have carefully read the questions in the attached application and have answered them completely, without reservations of any kind, and I declare under the penalty of perjury that my answers and all statements made by me are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice dental therapy/ dentistry/dental hygiene in the State of Oregon.

I hereby authorize all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Oregon Board of Dentistry any information, files, or records requested by the Board in connection with the processing of this application. I further authorize the Board to release to the organizations, individuals, and groups listed above any information, which is material to my application.

_____

Legal Signature

_____

Type name as it appears on the application

Subscribed and sworn to before me this ____ day of_____, 20____.

_____

Notary Public Signature

Notary Public for _____

My Commission Expires: _____

Rev. Code 2106

OREGON BOARD OF DENTISTRY
UNIT 23
PO BOX 4395
PORTLAND, OR 97208-4395

DENTAL THERAPY
BIENNIAL LICENSURE FEE

Enclose the biennial licensure fee of $230.00, payable by cashier's check or money order to the Oregon Board of Dentistry, with this form and mail to the above address.

a. Name (as you wish it to appear on your formal license)

_____

b. Mailing address _____
Street or P.O. Box

_____
City State Zip Code

Business address _____
Street

_____
City State Zip Code

Home address _____
Street

_____
City State Zip Code

c. Phone: Home _____
Area Code - Telephone Number

Business _____
Area Code - Telephone Number

Cell Phone _____
Area Code - Telephone Number

d. Email address: _____

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CERTIFICATE OF LICENSURE

(Not applicable if no state and/or out of country licenses/certificates have been obtained)

Name of Applicant (Please Print or Type)		
Street Address		
City	State	Zip Code:
License No:	Date Issued:	

I certify that _____ was granted license number _____to practice _____ in the State and/or Country of _____, on the basis of successfully passing _____examination.

STATUS OF LICENSE

- ☐ Current — Expiration Date _____
- ☐ Expired — Date _____
- ☐ Inactive — Expiration Date _____
- ☐ Revoked — Date _____

Type of License Issued

- ☐ Full
- ☐ Limited
- ☐ Conditional/Restricted (Please explain)

Legal/Disciplinary Action: ☐ Yes ☐ No

Legal/Disciplinary Action Pending ☐ Yes ☐ No ☐ Unable to disclose

If yes, please attach copies of any disciplinary/legal action or pending disciplinary/legal action.

_____
Signature of Official

SEAL

_____
Title

_____
Date Certificate Prepared

Return directly to:

Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, Oregon 97201

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INFORMATION REQUESTED

The 2001 Legislature passed Senate Bill 786 (ORS 676.400), which requires that health professional regulatory boards maintain information regarding racial, ethnic, and bilingual status of licensees and applicants and report to the data to the Legislature.

This law was the result of a study performed by the Governor's Racial and Ethnic Health Task Force, which determined that access to health care by racial and ethnic minorities is inadequate to address the chronic health issues these communities face. People of color and people with native languages other than English experience extreme difficulty accessing health services. Culturally competent health care providers are critical in providing appropriate health care and the collection of the information requested below will assist decision makers in developing programs to address the disparity in access to health care experienced by various communities.

See the reverse of this page for racial and ethnic definitions from the State of Oregon employment documents and the US Census Bureau.

Provision of this information is voluntary. If you choose not to provide the information, it will have no effect on the acceptance or processing of your application or renewal.

♦♦

Please print information

Name: ______________________________ **License No.** ______________________

RACE: *Please check one.*

- ☐ White/Caucasian (not of Hispanic origin)
- ☐ Black/African American (not of Hispanic origin)
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Native American Indian/Alaska Native
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Other: ____________________________

Ethnicity:____(e.g., American Indian tribe, Bengalese, Cambodian, Filipino, Guamanian, Haitian, Italian, Kenyan, Lebanese, Mexican, Norwegian, Polish, Russian, Samoan, Thai, etc.)

Languages: Please list languages, besides English, in which you are fully proficient or at least conversationally proficient, including American Sign Language.

______________________ ______________________ ______________________

Thank you for your assistance. Please return this survey with your application or renewal form, or you may mail or fax it at a later date.

OREGON BOARD OF DENTISTRY
1500 SW 1st Avenue, Suite 770
Portland, OR 97201
FAX: 971-673-3202

The following definitions are from the U. S. Census Bureau and Oregon Employment Documents.

Race - The concept of race as used by the Census Bureau reflects self-identification by people according to the race or races with which they most closely identify. These categories are sociopolitical constructs and should not be interpreted as being scientific or anthropological in nature. Furthermore, the race categories include both racial and national-origin groups.

***White*/Caucasian** - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as "White" or report entries such *as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish.*

Black/African American - A person having origins in any of the black racial groups of Africa. It includes people who indicate their race as "Black, African Am., or Negro," or provide written entries such as *African American, Afro American, Kenyan, Nigerian, or Haitian*

Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes "Asian Indian," "Chinese," "Filipino," "Korean," "Japanese," "Vietnamese," and "Other Asian."

Asian Indian - Includes people who indicate their race as "Asian Indian" or identify themselves as Bengalese, Bhara, Dravidian, East Indian, or Goanese.

Chinese - Includes people who indicate their race as "Chinese" or who identify themselves as Cantonese, or Chinese American. Written entries of Taiwanese are included with Chinese.

Filipino - Includes people who indicate their race as "Filipino" or who report entries such as Philipino, Philipine, or Filipino American.

Japanese - Includes people who indicate their race as "Japanese" or who report entries such as Nipponese or Japanese American.

Korean - Includes people who indicate their race as "Korean" or who provide a response of Korean American.

Vietnamese - Includes people who indicate their race as "Vietnamese" or who respond Vietnamese American.

Cambodian - Includes people who provide a response such as Cambodian or Cambodia.

Hmong - Includes people who provide a response such as Hmong, Laohmong, or Mong.

Laotian - Includes people who provide a response such as Laotian, Laos, or Lao.

Thai - Includes people who provide a response such as Thai, Thailand, or Siamese.

Other Asian - Includes people who provide a response of BangIadeshi, Burmese, Indonesian, Pakistani, or Sri Lankan.

Hispanic/Latino - A person having origins in any of the *Mexican, Puerto Rican, Cuban, Central or South American,* or other Spanish cultures, regardless of ethnicity.

Native American Indian and Alaska Native - A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment. It includes people who classify themselves as described below.

American Indian - Includes people who indicate their race as "American Indian," entered the name of an Indian tribe, or report such entries as Canadian Indian, French-American Indian, or Spanish-American Indian.

Alaska Native - Includes of Eskimos, Aleuts, and Alaska Indians as well as entries such as Arctic Slope, Inupiat, Yupik, Alutiiq, Egegik, and Pribilovian. The Alaska tribes are the Alaskan Athabaskan, Tlingit, and Haida.

Native Hawaiian and Other Pacific Islander -A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicate their race as "Native Hawaiian," "Guamanian or Chamorro," "Samoan," and "Other Pacific Islander."

Native Hawaiian - Includes people who indicate their race as "Native Hawaiian" or who identify themselves as "Part Hawaiian" or "Hawaiian."

Guamanian or Chamorro - Includes people who indicate their race as such, including Chamorro or Guam.

Samoan - Includes people who indicate their race as "Samoan" or who identified themselves as American Samoan or Western Samoan.

Other Pacific Islander - Includes people who provided a response of a Pacific Islander group such as Tahitian, Northern Mariana Islander, Palauan, Fijian, or a cultural group such as Melanesian, Micronesian, or Polynesian.

Some Other Race - Includes all other responses not included in the "White," "Black or African American," "American Indian and Alaska Native," "Asian," "Hispanic" and the "Native Hawaiian and Other Pacific Islander" race categories described above.

CODE: ***Race – Bold, underlined, italic print. (White, Black/African American, Asian, Hispania, etc.)***
Ethnicity – Italic print under the Race headings. (English, Dutch, Irish, Norwegian, Russian, etc)

Oregon
Kate Brown, Governor

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

PRIVACY ACT NOTIFICATION

As part of your application for an initial professional license, you are required to provide your Social Security Number to the Oregon Board of Dentistry (OBD). This is a mandatory requirement under Oregon Laws 1997, Chapter 746, section 117 (ORS 25.785) and under Federal Law USC section 666(a)(13)(a).

Failure to provide your Social Security Number will be a basis to refuse to issue your license.

The OBD will maintain a record of your Social Security Number in your licensing file.

The OBD is required to report your Social Security Number to the following entities:

- Division of Child Support – ORS 25.750 –25.785
- Oregon Department of Revenue – ORS 305.380 – 305.385
- United States Health Care Integrity Protection Data Bank (HIPDB) – 45 CFR, Part 61, established under Section 1128E of the Social Security Act.
- National Practitioners Data Bank (NPDB) – Section (5) Medicare and Medicaid Patient and Program Protection Act of 1987.

CRDTS DENTAL THERAPY CONTENT MENU

Content, Criteria and Scoring System Overview

SIMULATED PATIENT PROCEDURES – 100 POINTS

CONTENT	FORMAT
1. Primary Molar Pulpotomy Procedure (#A) 2. Primary Molar Stainless Steel Crown Placement (# J) 3. Primary Molar Stainless Steel Crown Preparation (#L) 4. Primary Molar Class II Amalgam Restoration (#T)	- Performed on a Manikin - Time: 6 hours

RESTORATIVE PATIENT-BASED EXAMINATION – 100 POINTS

CONTENT	FORMAT
Class II Amalgam –Preparation Class II Amalgam – Restoration OR Class II Composite –Preparation Class II Composite – Restoration OR Class II Slot Composite- Preparation Class II Slot Composite - Restoration AND Class III Composite –Preparation Class III Composite - Restoration	- Performed on a Patient - Time: 6 hours

RESTORATIVE SIMULATED PATIENT EXAMINATION - 100 POINTS

CONTENT	FORMAT
The Restorative Clinical Examination consists of four procedures: Place restorations in 2 pre-prepped teeth on #29 DO **or** #18MO and #23DL and prepare 2 teeth with simulated decay on #9DL and #14MO **or** #4DO. For the posterior procedures, candidates may choose to prepare/place a Class II Amalgam, or a Class II Composite: One (1) Class II Composite or Amalgam Preparation One (1) Class II Composite or Amalgam Restoration AND One (1) Class III Composite –Preparation One (1) Class III Composite – Restoration	-Performed on a Manikin -Time: 5 hours

CENTRAL REGIONAL DENTAL TESTING SERVICE

DENTAL THERAPY CANDIDATE MANUAL

This manual has been designed to assist in your preparation to be a participant in a clinical examination. Outlined below are general directives and information for the conduct of the examination.

Purpose: The purpose of this examination is to assess the candidate's professional knowledge, skills, abilities and judgment (KSAJ's) as applied in clinical treatment procedures that are a representative sample of the services that are provided by a dental therapist, based on the criticality of the procedure to the patient's systemic and oral health and the frequency with which that service is provided in general practice.

CRDTS: The Central Regional Dental Testing Service, Inc. (hereinafter abbreviated as CRDTS) is an independent testing agency which administers clinical competency examinations for the dental profession on behalf of its member and participating states. Regional testing agencies contract with individual state boards of dentistry to administer the clinical examination required for licensure in those states. Regional testing agencies do not have the authority to license individuals or to implement policy that goes beyond the laws of its member states. Regional testing agencies should not be confused with state boards of dentistry.

Jurisdictional Authority: State Boards of Dentistry are each established by state law as the regulatory agencies of the dental profession, accountable to the state legislature and charged with protection of the public. Although all state laws are somewhat different, there are commonalities in their responsibilities to regulate the profession through licensure requirements, to interpret and enforce the dental practice act, to discipline those licensees who practice unethically or illegally, and to assess the competence of applicants for licensure in their jurisdictions through theoretical and clinical examinations. In order to fulfill their mandate to evaluate competence, the CRDTS' member State Boards have joined together to develop and administer fair, valid and reliable clinical examinations.

Mission Statement: To provide the dental examination community with test construction and administrative standardization for national uniform clinical licensure examinations. The schedule of these examinations, when delivered in the Curriculum Integrated Format, allows for early identification of deficiencies or weaknesses within clinical skill sets and provides opportunities for remediation in an educational environment. These examinations will demonstrate integrity and fairness in order to assist State Boards with their mission to protect the health, safety and welfare of the public by assuring that only competent and qualified individuals are allowed to practice dentistry, dental therapy and dental hygiene.

Ethical Responsibilities: Licensure as a dental health professional, and the public trust, respect and status that accompanies it, is both a privilege and a responsibility. Implicit in a State Board's charge to protect the public is the responsibility to ensure that practitioners are not only competent, but also ethical. In addition to the American Dental Association's *Code of Ethics*, there are codes of professional conduct within state laws, and the requirements of many State Boards for periodic continuing education courses in ethics for maintenance and renewal of licenses.

During the examination process, there are policies, rules and standards of conduct that are part of the candidate's responsibility; the candidate is expected to read the entire Candidate's Manual and comply with all those rules and requirements.

The dental practitioner is entrusted with the oral health and welfare of a patient, and it is imperative that such trust be respected by candidates and that service to the patient's needs and well-being are always put first. In every step of the examination process, CRDTS has established policy and examination protocol to ensure that the welfare of patients is safeguarded.

1. CRDTS will provide a consent form that documents the treatment the patient will receive, the fact that the candidate is not a licensed dentist, and a statement that the services provided during the exam may not complete their treatment plan or totally fulfill their oral health needs. The consent form must be executed before the patient can be accepted.
2. CRDTS will provide a medical history form that screens for systemic conditions or medical considerations that might put the patient at risk during the examination or require premedication in order for them to participate. The medical history must be completely filled out and appropriate precautions taken before the patient can be accepted.
3. Once a preparation has been cut to "ideal" dimensions, any modifications that are necessary must be properly documented, and reviewed by an examiner before being carried out.
4. If an exposure should occur, or treatment is suspended or terminated for any reason, CRDTS will complete a Follow-Up Form to document what additional treatment is necessary, who will provide it, and who will be financially responsible. The patient is provided a copy of this form; and the candidate must come to the exam with a "follow-up" plan about how the patient will be provided a continuum of care after the exam, if such care should be needed.
5. In the event of a treatable exposure when the candidate can place a pulp cap and continue the exam, the patient will be given a form that advises them of what has happened and what additional treatment may be required in the future.
6. When patients are checked-in, examiners will review the medical history, consent form and treatment selection to see if it is appropriate, meets the criteria and is justified radiographically and clinically. Throughout the examination, examiners will be monitoring patients to see that they suffer no unnecessary discomfort.

The candidate should fully inform a prospective patient about the purpose, the process and the importance of a board examination, including the time involved, and the number of individuals who will be examining them. Copies of health histories and treatment consent forms should be downloaded from the internet at www.crdts.org and used to screen a patient's health condition and plan an appropriate response to any medical issues that may impact the patient's well-being during and after the examination. The patient should be fully informed about their entire treatment plan, advised of alternative options or courses of treatment that might be advantageous to them, and how the procedure(s) to be completed during the examination are sequenced in a plan "with due consideration given to the needs, desires and values of the patient." The patients should also be advised of any benefits that may reasonably be expected as a result of participation. In the process of soliciting and screening patients, candidates should remain in compliance with the ethical considerations promulgated by the ADA Council on Ethics, Bylaws and Judicial Affairs and refrain from the following:

1. Reimbursements between candidates and patients in excess of that which would be considered reasonable for remuneration for travel, lodging, meals or loss of hourly wages.
2. Remuneration between licensure applicants or dental practitioners for acquiring patients.
3. Utilizing patient brokering companies.
4. Delaying treatment beyond that which would be considered acceptable in a typical treatment plan (e.g. delaying treatment of a carious lesion for 24 months).
5. Allowing themselves to be "extorted" by individuals who agree to participate in the examination and then refuse to come at the appointed time unless they are paid a fee.

Board examinations are conducted for the sole purpose of protecting the public by assessing the competence of those who seek to practice within the profession of dentistry. It is hoped that the professional and ethical management of patients by both CRDTS and the candidates throughout the examination process will leave the volunteer patients in better oral health with an increased respect for the dental profession's diligence in maintaining high standards of competence.

Examination Completion and Obtaining Licensure: There are three agencies with which applicants are involved in the process of completing their CRDTS' examination and obtaining licensure. Dental Therapists will only be eligible for licensure in the state of Minnesota.

1. Central Regional Dental Testing Service, Inc. (CRDTS) - a testing service as described above; the results of a CRDTS examination can be submitted to the state when applying for licensure. COMPLETION OF THE CRDTS' EXAMINATION ALONE WILL NOT QUALIFY ANY CANDIDATE FOR LICENSURE. OTHER REQUIREMENTS WITHIN EACH OF THE STATES MUST BE MET.
2. Testing Site - a school which makes its clinical facility available for a CRDTS examination. The site may have its own forms or specific procedures which may be required of the candidate in order to participate in an examination at that site. In addition, the candidate must have cash or check as required by the respective institution, payable to that testing center (not CRDTS) for materials and equipment used during the examination. Payment must be made before the examination; and proof of payment must be provided at the conclusion of the exam. No scores will be released without satisfactory payment.
3. State Board of Dentistry - the agency to which a candidate must individually apply for licensure in a jurisdiction. Candidates must inform themselves of the requirements of the state(s) in which they wish to be licensed and complete an application with the individual jurisdiction(s).

The candidate should address questions to the appropriate agency.

The CRDTS Administrative Office will provide all information relevant to the examination requirements and procedures.

The testing site can respond to questions regarding facilities, equipment and testing site fees. (The testing site is not responsible for recruiting board patients or making their facilities available on any days other than examination dates.)

Questions regarding licensure or state requirements should be addressed to the appropriate State Board of Dentistry.

Test Development: The examination is developed and revised by the CRDTS Examination Review Committees. These committees are comprised of representatives from various member states, dental educators and special consultants, as required. With both practitioners and educators involved, the Committees have considerable content expertise on which to draw; the Committees also rely on practice surveys, current curricula, standards of competency and the *AADE's Guidance for Clinical Licensure Examinations in Dentistry* to assure that the content and protocol of the examination is current and relevant to practice. Determining the examination content is also guided by such considerations as patient availability, logistical restraints, and the potential to ensure that a skill can be evaluated reliably. The examination content and evaluation methodologies are reviewed annually.

Examination Overview: The examination consists of individual, skill-specific parts. Each examination part is listed below:

Restorative Procedures:

1. Anterior Composite Class III Preparation & Restoration

AND

2. Class II Amalgam Preparation & Restoration

OR

3. Class II Composite Preparation & Restoration

OR

4. Class II Composite Slot Preparation & Restoration

Manikin Procedures:

5. Primary Molar Pulpotomy Procedure (#A)
6. Primary Molar Stainless Steel Crown Placement (# J)
7. Primary Molar Stainless Steel Crown Preparation (#L)
8. Primary Molar Class II Amalgam Restoration (#T)

Examiners: Candidates will be evaluated by examiners from the jurisdictions which comprise CRDTS. These examiners may be members of their State Board of Dentistry or may have been selected by their Board to serve as examiners. There may also be examiners from other states. In addition, there are frequently observers at CRDTS' exams who may be faculty members from other schools, new CRDTS' examiners or examiners from other states. Such observers are authorized to participate in calibration and monitor all portions of the examination and may evaluate patients from time to time; however, they do not assign grades or participate in the grading process.

Examination Dates: Specific examination and deadline dates for participating dental schools can be found on the CRDTS website (www.crdts.org) and are also available through the Site Coordinator at each school.

Administrative/Application Policies and Rules are located online at the end of this manual and at www.crdts.org .

CONTENT, CRITERIA & SCORING SYSTEM - OVERVIEW

SIMULATED PATIENT PROCEDURES – 100 POINTS

CONTENT	FORMAT
1. Primary Molar Pulpotomy Procedure (#A) 2. Primary Molar Stainless Steel Crown Placement (# J) 3. Primary Molar Stainless Steel Crown Preparation (#L) 4. Primary Molar Class II Amalgam Restoration (#T)	- Performed on a Manikin - Time: 6 hours

RESTORATIVE PATIENT-BASED EXAMINATION - 100 POINTS CONTENT	FORMAT
Class II Amalgam –Preparation Class II Amalgam – Restoration OR Class II Composite –Preparation Class II Composite – Restoration OR Class II Slot Composite- Preparation Class II Slot Composite - Restoration AND Class III Composite –Preparation Class III Composite - Restoration	- Performed on a Patient - Time: 6 hours

RESTORATIVE SIMULATED PATIENT EXAMINATION - 100 POINTS CONTENT	FORMAT
The Restorative Clinical Examination consists of four procedures: Place restorations in 2 pre-prepped teeth on #29 DO **or** #18MO and #23DL and prepare 2 teeth with simulated decay on #9DL and #14MO **or** #4DO. For the posterior procedures, candidates may choose to prepare/place a Class II Amalgam, or a Class II Composite: One (1) Class II Composite or Amalgam Preparation One (1) Class II Composite or Amalgam Restoration AND One (1) Class III Composite –Preparation One (1) Class III Composite – Restoration	-Performed on a Simulated Patient -Time: 5 hours

SCORING SYSTEM

The examination scoring system was developed in consultation with three different measurement specialists; the scoring system is criterion-based and was developed using an analytical model. The examination is conjunctive in that its content is divided into separate Parts containing related skill sets and competence must be demonstrated in each one of the Parts. A compensatory scoring system is used within each Part to compute the final score for each Part, as explained below.

Only State Boards of Dentistry are legally authorized to determine standards of competence for licensure in their respective jurisdictions. However, in developing the examination, CRDTS has recommended a score of 75 to be a demonstration of sufficient competence; and participating State Boards of Dentistry have agreed to accept that standard. In order to achieve "CRDTS status" and be eligible for licensure in a participating state, candidates must achieve a score of 75 or more in each Part of the examination.

SCORING SYSTEM FOR MANIKIN AND PATIENT-BASED RESTORATIVE PROCEDURES

CRDTS and other testing agencies have worked together on a national level to draft and refine the performance criteria for each procedure in this examination. For the majority of those criteria, gradations of competence are described across a 4-level rating scale. Those criteria appear in this manual and are the basis of the scoring system. Those four rating levels may be generally described as follows:

SATISFACTORY
The treatment is of good to excellent quality, demonstrating competence in clinical judgment, knowledge and skill. The treatment adheres to accepted mechanical and physiological principles permitting the restoration of the tooth to normal health, form and function.

MINIMALLY ACCEPTABLE
The treatment is of acceptable quality, demonstrating competence in clinical judgment, knowledge and skill to be acceptable; however, slight deviations from the mechanical and physiological principles of the satisfactory level exist which do not damage the patient nor significantly shorten the expected life of the restoration.

MARGINALLY SUBSTANDARD
The treatment is of poor quality, demonstrating a significant degree of incompetence in clinical judgment, knowledge or skill of the mechanical and physiological principles of restorative dentistry, which if left unmodified, will cause damage to the patient or substantially shorten the life of the restoration.

CRITICALLY DEFICIENT
The treatment is of unacceptable quality, demonstrating critical areas of incompetence in clinical judgment, knowledge or skill of the mechanical and physiological principles of restorative dentistry. The tooth must be temporized, or the treatment plan must be altered and additional care provided in order to sustain the function of the tooth and the patient's oral health and well-being.

A rating is assigned for each criterion in every procedure by three different examiners evaluating independently. Based on the level at which a criterion is rated by at least two of the three examiners, points may be awarded to the candidate. In any instance that none of the three examiners' ratings are in agreement, the median score is assigned. However, if any criterion is assigned a rating of ***critically deficient*** by two or more of the examiners, ***no points are awarded for that procedure or for the Examination Part***, even though other criteria within that procedure may have been rated as satisfactory. A description of and the number of criteria that are evaluated for the procedures in each of those Parts appears below:

MANIKIN EXAMINATION – 100 Points

The Manikin-based examination consists of the following:

Primary Molar Pulpotomy Procedure (#A)	5 Criteria
Primary Molar Stainless Steel Crown Placement (# J)	7 Criteria
Primary Molar Stainless Steel Crown Preparation (#L)	10 Criteria
Primary Molar Class II Amalgam Restoration (#T)	8 Criteria

RESTORATIVE EXAMINATION – 100 Points

The patient-based Restorative Clinical Examination consists of four procedures as specified below:

Class II Amalgam Preparation	12 Criteria
Class II Amalgam Finished Restoration	8 Criteria*
OR	
Class II Composite Preparation	11 Criteria
Class II Composite Finished Restoration	8 Criteria*
OR	
Class II Composite Slot Preparation	9 Criteria
Class II Composite Slot Preparation	8 Criteria*
Class III Composite Preparation	7 Criteria
Class III Composite Finished Restoration	9 Criteria*

* 1 category split into 2 for clarity; scored as 1 criteria

To compute the score for each individual procedure, the number of points the candidate has earned for each criterion is totaled, divided by the maximum number of possible points for that procedure and the results are multiplied by 100. This computation converts scores for each procedure to a basis of 100 points. Any penalties that may have been assessed during the treatment process are deducted ***after*** the total score for the Examination Part has been converted to a basis of 100 points.

If no ***critical deficiency*** has been confirmed by the examiners, the total score for each portion of the examination is computed by adding the number of points that the candidate has earned ***across all procedures in that Part,*** and that sum is divided by the number of possible points for all procedures in that Part. If a ***critical deficiency*** has been confirmed by the examiners, an automatic failure is recorded for both the procedure and the Examination Part.

Although there are two Parts that are scored separately for restorative clinical skills, ***within each Part a compensatory system*** is used to compute the final score for that Part, as long as there is no ***critical deficiency.*** For both exam parts, the computed score for each procedure is ***not averaged,*** but instead is numerically weighted by the ratio of its number of scorable criteria to the total number of scorable criteria in the Part. For example, the Class III Composite Preparation has a total of 7 scorable criteria which represents 28 possible points out of the total of 136 possible points for the Restorative Procedures. If the candidate earned 130 out of 136 possible points for the four Restorative procedures, their final score would be 95.58 points. If any penalties were assessed, the points would be deducted as percentage points from the final score.

PENALTY DEDUCTIONS

Throughout the examination, not only clinical performance will be evaluated, but also the candidate's professional demeanor will be evaluated by Clinic Floor Examiners. A number of considerations will weigh in determining the candidate's final grades and penalties may be assessed for violation of examination standards, as defined within this manual, or for certain procedural errors as described below:

Any of the following may result in a deduction of points from the score of the entire examination Part or dismissal from the exam in any of the clinical procedures:

1. Violation of universal precautions or infection control; gross asepsis; operating area is grossly unclean, unsanitary or offensive in appearance; failure to dispose of potentially infectious material and clean the operatory after individual examinations
2. Poor Professional Demeanor--unkempt, unclean, or unprofessional appearance; inconsiderate or uncooperative with other candidates, examiners or testing site personnel
3. Poor Patient Management--disregard for patient welfare or comfort; inadequate anesthesia
4. Improper management of significant history or pathosis
5. Inappropriate request for extension or modification

6. Unsatisfactory completion of required modifications
7. Improper Operator/Patient/Manikin position
8. Improper record keeping
9. Improper treatment selection

Restorative Treatment Selection Penalty Points

a. Penalty points are assessed for Treatment Selections that do not meet the described criteria
b. 5 penalty points for 1st rejection on either procedure
c. No additional penalty points deducted for subsequent rejections but an acceptable Treatment Selection must be submitted within the allotted time limits

10. Improper liner placement
11. Inadequate isolation - The isolation dam is inappropriately applied, torn and/or leaking, resulting in debris, saliva and/or hemorrhagic leakage in the preparation, rendering the preparation unsuitable for evaluation or the subsequent manipulation of the restorative material.
12. Administration of anesthesia before approval of Medical History by Clinic Floor examiners
13. Corroborated errors for Treatment Management criteria on all Restorative procedures

The following infractions will result in a loss of ***all*** points for the entire examination Part:

1. Temporization or failure to complete a finished restoration
2. Violation of Examination Standards, Rules or Guidelines
3. Treatment of teeth or surfaces other than those approved or assigned by examiners
4. Gross damage to an adjacent tooth
5. Failure to recognize an exposure
6. Unavoidable mechanical exposure which is poorly managed or irreparable
7. Unjustified or irreparable mechanical exposure
8. Critical Lack of Diagnostic/Clinical Judgment Skills – This penalty would be applied when the prognosis of the treatment and/or the patient's well-being is seriously jeopardized. Examples include but are not limited to:
    a. Inability to differentiate between caries and a pulpal exposure
    b. Inability to carry out instructions for modifications that any competent practitioner should be able to complete
    c. Failure to recognize the need for a critical alteration of the preparation beyond the assigned surfaces, such as a fracture or defect that must be eliminated by the extension of the preparation

The penalties or deficiencies listed above do not imply limitations, since obviously some procedures will be classified as unsatisfactory for other reasons, or for a **combination** of several deficiencies. Corroborated errors for the treatment management criteria for each Restorative procedure – Manikin and Patient-based will be deducted as penalty points. If any restorative procedure is unacceptable for completion during the examination, any preparations must be temporized, the patient must be adequately informed of any deficiencies, and a "Follow-up Form" must be completed.

Professional Conduct – All substantiated evidence of falsification or intentional misrepresentation of application requirements, collusion, dishonesty, or use of unwarranted assistance during the course of the examination shall automatically result in failure of the entire examination by any candidate.

In addition, there will be no refund of examination fees and that candidate cannot apply for re-examination for one full year from the time of the infraction. Any of the following will result in failure of the entire examination:

- Falsification or intentional misrepresentation of application requirements
- Cheating (Candidate will be dismissed immediately);
- Any candidate demonstrating complete disregard for the oral structures, welfare of the patient and/or complete lack of skill and dexterity to perform the required clinical procedures.
- Misappropriation of equipment (theft);
- Receiving unwarranted assistance;
- Alteration of examination records and/or radiographs

SCHEDULE & DATES

Date(s): From Registration Confirmation as scheduled by candidate
Retest opportunities allowed: Two as scheduled by candidate

Schedule

Candidate Question & Answer Session

Candidates are expected to review the appropriate Candidate Orientation. There will be a question and answer session the day before the examination begins. Please review your confirmation materials for this schedule. Candidates must bring a government-issued photo ID, this Candidate's Manual, any application requirements that have not been previously submitted and a black ballpoint pen. Check-in will begin 15 minutes prior to the scheduled Q & A session.

Candidates will be informed of their group assignment in advance of the examination date. The examination schedule follows:

Manikin Exam		Restorative Exam	
TIME	**MANIKIN**	**TIME**	**RESTORATIVE**
8:00	Group A (B) Setup	**8:00**	Group B
8:30	**8:30 – 2:30** Manikin		
2:30	**EXAM STOPS**	**2:00**	**EXAM COMPLETED**

Manikin-based Exam

CANDIDATES	TIME	ASSIGNMENT
		Manikin Examination
Day 1: Groups A & B Day 2: Groups C & D	8:00 A.M. to 8:30 A.M. 8:30 A.M. to 2:30 P.M. 2:30 P.M. to 2:45 P.M.	Set-Up and Starting Checks Manikin Procedures (6 hours) Dismantle and turn in modules

Patient-based Restorative Exams

Candidates will have from 8AM - 2 P.M. to complete the two Restorative procedures. Designated groups will begin their and Restorative procedures as outlined below:

CANDIDATE **TIME** **ASSIGNMENT**

Day 1: Group C Day 2: Group A	8:00 A.M. 2:00 P.M.	Begin Restorative Examination Complete Restorative Examination
Day 1: Group D Day 2: Group B	8:00 A.M 2:00 P.M.	Begin Restorative Examination Complete Restorative Examination

Patient-based Deadlines:

- All **pre-approved** Restorative treatment selections must be submitted no later than 12:30 PM.
- All patients must be in line to be signed in for final evaluation of restorative preparations by 1:00 PM on the same day they were started.
- All patients with finished restorations must be in line to be signed in for evaluation by 2:00 PM on the same day they were started.

Daily Time Schedule

Each candidate must adhere to the published time schedule.

1. **Q & A and Admission. All candidates must be present for Admission and a Q & A session the day before the examination for specific instruction and distribution of examination materials** by the Chief Examiner. The candidate's identification must be recorded on all examination forms during this time.

   In order to receive an examination packet and be admitted to the orientation, the candidate **must** present a government-issued **photo ID** (ex: driver's license or student ID). Candidates who are retaking one or more examination(s) on one specific day must attend the orientation and present all the proper credentials. Candidates who do not have the required identification will **not** be admitted to the examination.

2. **The Manikin-based Examination** begins at 8:00 A.M. on the assigned day. Between 8:00 to 8:30 A.M. the Clinic Floor Examiner (CFE) must verify that the manikin head is properly assembled, and any defective equipment or materials identified and corrected or replaced. At 8:30 A.M. treatment begins for all candidates. There is no extension of time due to starting treatment after 8:30 A.M. Candidates will have until 2:30 P.M. (6.0 hours) to complete the required procedures, at which time they must dismantle and turn in their modules and examination forms.

3. **The Restorative Examination:** Candidates will have from 8AM - 2 P.M. to complete the Restorative procedures. Designated groups will begin their Restorative procedures as previously outlined. If multiple patients are used, a new patient may not be seated until the procedures for the previous patient have been completed and that patient has been dismissed.

   Each procedure requires a separate evaluation in the Evaluation Station and deadlines are published in this manual at which the patient **must be in line at the Exam desk** for the various final evaluation procedures. Candidates will not be allowed to begin their ***second*** preparation if the lesion has not been accepted ***30 minutes*** prior to the preparation submission deadlines outlined above.

Time Management

In scheduling patients and planning the utilization of time, the candidate should consider the fact that the time allowed for the entire examination **includes the time during which the patient(s) will be at the evaluation station for grading.** The minimum time patients will be in the evaluation station is 30 minutes per procedure—possibly longer, depending on the time of day. Times may vary according to the procedure being evaluated, the testing site and the number of candidates.

If patients with restorative preparations are not in line for final evaluation by the required time, the prepared teeth will need to be temporized. If patients with finished restorations are not in line by the

required deadline, the restorations will not be graded. The restoration will either be requested to be removed and the tooth preparation temporized by the candidate as directed by the Chief Examiner or be allowed to remain as a temporary restoration. The Chief Examiner will advise the candidate as to the decision and will also inform the patient. A Follow-up form must be completed.

STANDARDS FOR THE CONDUCT OF THE EXAMINATION

As a participant in an examination to assess professional competency, each candidate is expected to maintain professional standards. The candidate's conduct and treatment standards will be observed during the examination and failure to maintain appropriate conduct and/or standards may result in point penalties and/or dismissal from the exam.

Each candidate will be expected to conduct himself/herself in an ethical, professional manner and maintain a professional appearance at all times. Candidates are prohibited from using any study or reference materials during the examination. Any substantiated evidence of dishonesty; such as collusion, use of unauthorized assistance or intentional misrepresentation during registration, pre-examination or during the course of the examinations shall automatically result in dismissal from and failure of the entire examination and forfeiture of all examination fees for the current examination.

DISHONESTY CLAUSE: Candidates failed for dishonesty shall be denied re-examination for one full year from the time of the infraction. Additionally, all State Boards will be notified of the situation. In some states, candidates failed for dishonesty may be permanently ineligible for licensure. Therefore, candidates should address these matters with the state(s) where they desire licensure prior to retaking the examination.

The standards itemized below apply to all relevant portions of the examination. Failure to adhere to these standards will result in failure of the procedure in progress and/or the entire examination.

Standards for Manikin and Patient-based Examinations

1. **Anonymity.** The anonymous testing procedures for the examination shall exclude the possibility that any person who is involved with the grading of the examination may know, learn of, or establish the identity of a candidate, or relate or connect the patient or work-product graded or to be graded to a particular candidate. The candidate's name and school information should not appear on any examination forms, materials, or instruments. Grading examiners will be physically isolated from the candidates in a separate area of the clinic and the movement of patients from the clinical area to the grading area shall be controlled by the use of testing agency messengers/assistants. All examination forms and materials are identified by the candidates' identification number which is assigned prior to the examination.

2. **Approved Communication.** All approved communication must be in English. Candidates may communicate with their patient in another language but communication between candidates and Examination Officials must be in English.

3. **Assigned Operatories.** The candidate shall work only in the assigned clinic, operatory or laboratory spaces.

4. **Assigned Procedures.** The candidate must perform only the treatment and/or procedures assigned. Performing other treatment or procedures is strictly prohibited.

5. **Auxiliary Personnel: Use of Assistants.** *Auxiliary personnel are <u>not</u> permitted to assist at chairside during the manikin examinations. Auxiliary personnel are permitted to assist at chairside during periodontal and restorative examinations.* Dentists, dental hygienists and dental therapists (any graduate, licensed or unlicensed), final year dental, dental hygiene or dental therapy students may not act as chairside assistants during the restorative and periodontal examinations.

1. Assistants will be required to insert either a valid photo ID or a copy thereof into a provided badge to be worn during the examination.

2. For each clinical procedure the candidate must list the name of his/her assistant on the Progress Form.

3. Candidates are responsible for the conduct of their auxiliaries during the examination.

4. Auxiliaries are not permitted to advise, evaluate or perform the expanded duties normally provided by a dentist

6. **Check-Out Procedures.** The items specified below should be enclosed in the original Candidate packet envelope and provided to the examination representative at the completion of the examination:
   - Identification badge
   - Legal Consent/Medical History forms for all patients
   - Progress Forms
   - Radiographs

7. **Clinic Attire.** Clinic attire that meets CDC and OSHA standards must be worn in clinic areas. No bare arms or legs, or open-toed shoes are allowed in the clinic areas. Lab coats, lab jackets, and/or long-sleeved protective garments are all acceptable. Color and style are not restricted. There must be no personal or school identification on clinic attire other than the candidate identification badge.

8. **Electronic Equipment.** The use of cellular telephones, pagers, CD's, radios (with or without earphones) and other electronic equipment by candidates, patients and assistants is prohibited within the clinic and scoring areas. All cellular telephones must be off and stored with personal belongings. In addition, the use of electronic recording devices by the candidate, an auxiliary, or a patient during any part of the examination; or the taking of photographs during the evaluation or treatment procedures is prohibited.

9. **Equipment Failure.** In case of equipment failure, the Chief Examiner must be notified immediately so the malfunction may be corrected.

10. **Equipment: Use/Misappropriation/Damage.** No equipment, instruments, or materials shall be removed from the examination site without written permission of the owner. Nonpayment of fees for rental of space or equipment will be treated as misappropriation of equipment. Willful or careless damage of typodonts, manikins or shrouds may result in failure and any repair or replacement costs must be paid by the candidate before examination results will be released.

11. **Evaluation Procedures.** Candidate performance will be evaluated by three independent examiners. Candidates are not assigned specific examiners.

12. **Examination Completion and Start/Finish Times.** All procedures of the examination shall be completed within the specified time frame in order for the examination to be considered complete. Any examination procedures performed outside the assigned time schedule will be cause for the examination to be considered incomplete and will result in failure. Treatment procedures may not be initiated prior to the established starting time(s) and must be completed by the established finish time(s). Violation of this standard will result in failure of the examination.

13. **Examination Guidelines.** Violation of the published standards, guidelines and requirements for the examination will result in failure.

14. **Examination Materials.** CRDTS examination materials distributed by the testing agency may NOT be removed from the examining area, nor may the forms be reviewed by unauthorized personnel.

15. **Extraneous materials.** Only those materials distributed or authorized by CRDTS may be brought to the examining area. Authorized materials include <u>only</u> your Candidate's Manual which may

include hand written notes on the pages provided; additional pages, texts or documents are prohibited. Impressions, registrations, overlays, stents, or clear plastic shells of any kind as well as models or pre-preparations are not permitted to be brought to the examination site. Use of unauthorized materials will result in failure of the entire examination.

16. **Failure to Follow Directions.** Failure to follow directions and instructions from examiners will be considered unprofessional conduct. Unprofessional conduct and improper behavior is cause for dismissal from the examination and will result in failure of the examination. Additionally, the candidate shall be denied re-examination by CRDTS for one full year from the time of the infraction.

17. **Feedback Forms: Patient/Candidate.** Candidates and their patients have an opportunity to provide input about the examination. In an effort to continually improve our examination, feedback from the perspective of both the candidates and patients is one of the best ways to gather this information. The Feedback Forms for candidates and patients will be included in the candidate's packet. They are not required but will be collected separately from the candidate's packet to ensure that the candidate's examination results will in no way be affected by any feedback the candidate or the candidate's patients might have. Candidates and patients are encouraged to complete the forms honestly and thoughtfully before checking out.

18. **Identification Badges.** During the examinations, candidate ID badges must be worn at all times.

19. **Infection Control Standards.** During all patient treatment procedures *and during manikin clinical procedures*, the candidate, as well as the assisting auxiliary, must follow the most current recommended infection control procedures as published by the CDC. The operatory and/or operating field must remain clean and sanitary in appearance.(www.cdc.gov/oralhealth/infectioncontrol/guidelines)

20. **Instruments and Equipment.** All necessary materials and instruments for the clinical procedures, other than the operating chair, light and dental unit must be provided by the candidate. All equipment must be compatible with the testing site attachments. Arrangements for rental handpieces and/or other equipment may be made through the testing site. It is the responsibility of the candidate to arrange for his/her own handpiece and all other equipment necessary to complete the clinical examination. It is suggested that all candidates check well in advance with the Site Coordinator of the school selected for the equipment requirements at the testing site.

    The following instruments and equipment are specifically required and must be provided by the candidate for this examination:

    - Unscratched, untinted front-surface, non-disposable, #4 or #5 mouth mirror (Mouth mirrors that are clouded, tinted, or unclear will be rejected)
    - Metal periodontal probe – 1mm marks
    - a sharp #23 explorer OR other similar Shepherd's Hook-type explorer
    - Patient eye protection (personal eyewear is acceptable)
    - Patient napkin holder (chain, self-adhesives, clips, etc.)
    - Blood pressure measuring device
    - Instrument tray for transporting instruments

21. **Interpreters.** Candidates can employ the services of an interpreter when their patient does not speak English or is hearing impaired and their hearing loss cannot be corrected. (This is particularly important when the patient has a history of medical problems or is on medications.) Faculty members, dentists, dental therapists and dental hygienists (licensed or unlicensed), third or fourth year dental students, final year dental therapy students and final year dental hygiene students may not act as interpreters during the examinations. Candidates are responsible for the conduct and remuneration of their interpreter during the examination.

22. **Local Anesthesia.** Injectable local anesthetics may be administered to patients for the Periodontal and Restorative Examinations. Candidates must request and receive approval for the administration of local anesthetics prior to each separate administration. Inhalation, Kovonase (applied nasally) or intravenous analgesia/anesthetics are not permitted for the examinations.

23. **New Technology.** New and innovative technologies are constantly being developed and marketed in dentistry. However, until such time as these innovations become the standard of care and are readily available to all candidates at all testing sites, the use of such innovative technologies will not be allowed in this examination unless expressly written as allowed elsewhere in this manual.

24. **Radiographs.** Appropriate radiographs must meet the requirements as published in the examination guidelines. Any alteration of radiographs will result in failure of the examination.

25. **Submission of Examination Records.** All required records must be turned in at the Examiner Desk before the examination is considered complete.

26. **Test Site Fees.** Schools may charge a rental fee for use of instruments, clinic facilities, supplies and disposables. This fee is independent of the examination fee and is not collected by the testing agency. Testing site fees vary from school to school. If not paid in advance, candidates should have cash or a check, as may be required by the respective testing site, for materials and equipment used during the examination. Specific information regarding site fees will be included in the candidate's Confirmation Packet.

27. **Tissue Management.** There shall be no unwarranted damage to either hard or soft tissue during patient-based procedures or to simulated hard or soft tissues during manikin-based procedures. Incompetent or careless management of tissue will result in a score reduction.

28. **Tooth Identification.** The permanent dentition tooth numbering system 1-32 will be used throughout the examination. In this system, the maxillary right third molar is number 1 and mandibular left third molar is number 17. The primary dentition tooth lettering system A-T will also be used throughout the examination. In this system, the maxillary right second primary molar is letter A and mandibular left second primary molar is letter K.

29. **Treatment Consent.** In order for a patient to be acceptable for the clinical portions of the examination, the candidate must complete a "Treatment Consent Form" for each patient. The forms are included in the candidate's application packet and may be completed prior to the examination date; however, they must be presented to the examiners at the time of patient check-in. Patients under the age of legal consent for the state in which the examination is being given must have the Consent Form signed by the parent or guardian. This form must be completed for each clinical patient.
Standards that are specific to each examination are listed under each of the appropriate examination sections listed below.

GENERAL GUIDELINES FOR CLINICAL EXERCISES

1. **Progress Forms:** At the examination, color-coded Progress Forms will be issued which will contain a record of the treatment, examiner signatures for all completed portions of the examination, and progress notes from the candidate to examiner as appropriate to the course of treatment. A ***black ball-point pen*** shall be used for all notations on the Progress Forms.

2. **Unauthorized Personnel:** Only authorized personnel will be allowed in the examining and clinic areas. Only the patient, the candidate, the chairside assistant and the interpreter (if necessary) are allowed in the operatory during patient treatment sections. No visitors are allowed.

3. **Performance Standards:** The candidate's clinical performance on all sections will be rated according to specific criteria. The performance criteria and the standards by which the examination is conducted are provided to the candidate within this manual.

4. **Penalty Deductions:** Throughout the examination, the candidate's professional conduct and clinical performance will be evaluated. A number of considerations will weigh in determining the candidate's final grades and penalties may be assessed for violation of examination standards and/or for certain procedural errors, as defined and described within this manual.

6. **Reasons for Dismissal**: In addition to the standards of conduct expectations, the following list is provided as a quick reference guide for candidates. While the following is not an all-inclusive listing, it does provide examples of behaviors that may result in dismissal/failure of the examination:
    - Using unauthorized equipment at any time during the examination process.
    - Altering patient records or radiographs.
    - Performing required examination procedures outside the allotted examination time.
    - Failure to follow the published time limits and/or complete the examination within the allotted time.
    - Receiving assistance from another practitioner including but not limited to; another candidate, dentist, University/School representative(s), etc.
    - Exhibiting dishonesty.
    - Failure to recognize or respond to systemic conditions that potentially jeopardize the health of the patient and/or total disregard for patient welfare, comfort and safety.
    - Unprofessional, rude, abusive, uncooperative, or disruptive behavior to other candidates, patients and/or exam personnel.
    - Misappropriation or thievery during the examination.
    - Noncompliance with anonymity requirements.
    - Noncompliance with established guidelines for asepsis and/or infection control.
    - For the purpose of the board licensure examination, candidates found charging patients for services performed.
    - Use of unauthorized documents or materials in patient care or evaluation areas.
    - Use of cellular telephones, pagers or other electronic equipment in patient care areas.
    - Use of electronic recording devices by the candidate, an auxiliary, or a patient during any part of the examination; or the taking of photographs during the evaluation or treatment procedures.

7. **Patient's Agreement to Partial Treatment Plan:** It must be recognized that in many instances the treatment that is provided during a clinical examination represents only a portion of the care that is appropriate for the patient within a comprehensive treatment plan. The patient must be advised that only a portion of their individual treatment plan can be completed during the clinical Board examination and that further restorative care will likely be required either before or after the examination is completed. The patient will also be apprised of incomplete treatment in the Treatment Consent Form they are asked to sign prior to the examination.

8. **Follow-Up Care:** In the event that treatment provided during the examination cannot be satisfactorily completed, (such as an exposure requiring endodontic treatment), arrangements must be made for the patient to receive follow-up care. A Follow-Up Form will be provided so a record is maintained of the patient's needs. **The candidate should give prior consideration to what arrangements might need to be made for his/her patients to receive follow-up care. Such arrangements would include who will provide the treatment and who will be financially responsible.**

9. **Authorized Photography:** At some selected test sites, oral photographs may be taken randomly during the examination by an authorized photographer retained by CRDTS. The purpose is to capture a broad representation of actual procedures which can be used for examiner calibration exercises. The photographs will include no identification of either the patients or candidates. An announcement will be made or a notice will be distributed to inform patients and candidates when photographs are authorized at a site.

GENERAL REQUIREMENTS

Manikin Examination

1. **Typodont Requirements:** The manikin examination may be completed ***only*** on an Acadental™ mixed dentition typodont. It is the candidate's responsibility to provide the required items for the manikin section of the examination.

   The Acadental™ typodont and other required Acadental™ supplies may be purchased by the candidate at any time prior to the examination through the school or through Acadental, Inc. directly at www.Acadental.com.

2. **Manikin Requirements and Mounting:** A mounted manikin with full facial shroud will be provided by the testing site for insertion of the typodont. The manikin heads must accommodate the Acadental™ typodont which can be adapted to a chair-mounted post or a high-tech simulation lab unit with either screw or magnetic connectors. If the typodonts are to be chair-mounted, they ***must have an articulating hinge*** attached. If a simulation lab is being used, the typodonts must be adapted with materials.

3. **Occlusal/Axial Reduction:** Candidates will fabricate a polyvinyl siloxane (PVS) putty matrix during the exam, prior to the crown preparation. The matrix should extend gingivally to cover the simulated gingival tissue on both buccal and lingual surfaces. The matrix should extend from tooth #19 to #N. The matrix should be sectioned bucco-lingually over the center of the prepared #L tooth which will yield 2 separate pieces. The candidate number must be inscribed on both pieces of the matrix. This matrix will be used to establish appropriate occlusal and axial reduction, and must be submitted with your examination modules for evaluation. Examiners will use ***only*** this guide when evaluating occlusal/axial reduction. ***When the matrix is completed, it must be checked by the CFE prior to beginning the crown preparation.***

4. **Patient Simulation:** The correct patient/operator position must be maintained while operating. Throughout the manikin procedures, the treatment process will be observed by Clinic Floor Examiners and evaluated as if the manikin were a live patient. With the exception of having the manikin wear protective eyewear, the manikin is subject to the same treatment standards as any patient. The facial shroud may not be displaced other than with those retraction methods which would be reasonable for a patient's facial tissue. Some modifications in the treatment procedure are imposed due to the mechanical simulation conditions.

   The Candidate should use only air, but may use both air and water spray when preparing teeth. If water spray is utilized, a mechanism to collect and remove the water must be in place during the use of the water spray. Models or pre-preparations are not permitted to be brought to the examination site.

5. **Security Requirements:** No written materials may be in the operating area other than this Candidate Manual and CRDTS forms.

6. **Infection Control:** The candidate must follow the most current recommended infection control procedures as published by the CDC during all manikin clinical procedures. The only exception to

standard infection control precautions is that the candidate is ***not*** required to maintain protective eyewear on the manikin during manikin procedures. Infection control will be monitored by Clinic Floor Examiners. .(www.cdc.gov/oralhealth/infectioncontrol/guidelines)

7. **Assigned Teeth:** Once a procedure has been started, the procedure must be carried to completion on the assigned tooth/teeth with no substitutions permitted. Substitution of teeth or preparation of the wrong tooth/teeth during an exam will result in failure of the specific examination.

8. **Assistants:** Auxiliary personnel are not permitted to assist at chairside or in a laboratory during the manikin examination. Candidates may not assist each other, critique or discuss one another's work.

9. **Adjacent Damage:** The candidate's score will be penalized for any unwarranted damage to adjacent teeth or to the simulated gingival area during manikin-based procedures.

10. **Examination Sequence**: The candidate must set up the manikin for the manikin procedures and obtain the approval of a Clinic Floor Examiner between 8:00 and 8:30 A.M. The manikin procedures must be completed between 8:30 and 2:30 P.M. No later than 2:30 P.M., the typodonts must be dismantled and turned in to the examiner. During all manikin procedures, the typodont may *not be disassembled* without the permission of a Clinic Floor Examiner. Between 2:00 and 2:15, the candidate will dismantle the typodont and submit it to the examiners.

Requirements Specific to the Manikin Procedures

1. **Typodont Modules:**

   CRDTS will provide the following Acadental typodont:

   a. ModuPRO Pedo Model w/mixed dentition - Item # MP_P420

   b. Place the ID sticker provided on the typodont.

   c. The typodont will be mounted in a manikin with a shroud to be provided by the testing site. The typodont may be mounted on a post and strapped to an operatory chair or mounted in a simulation laboratory. Post-mounted typodonts will require an ***articulating hinge.*** Once the typodont is mounted in the manikin, request a Start Check from a Clinic Floor Examiner.

2. **Dismantling Manikin:** During both the manikin procedures, **the candidate may *not* disassemble the manikin without permission of the Clinic Floor Examiner.** Removal of the manikin, typodont or teeth during the examination without permission of the Clinic Floor Examiner will result in failure.

3. **Instruments**: Other than the instruments and materials provided by the testing site, the candidates are responsible for providing the instruments and materials of their choice.

4. **Evaluation:** When the procedures are complete, the candidate must request permission from the Clinic Floor Examiner to dismantle the manikin. The CFE will collect the typodont and occlusal index in the labeled box provided by CRDTS. The Manikin Progress Form must be submitted with the typodont.

5. **Preparation of Teeth:**

   a. Primary Molar Pulpotomy Procedure - #A: The artificial tooth must be used to complete access opening to the canals. Access opening to all canals must be completed. The size, shape and extent of the prepared access opening should reflect such anatomy and will be graded accordingly.

   If the tooth fractures during treatment, the procedure should be completed. If a crown fractures during treatment, place the fractured pieces in a sealable plastic bag and turn them in with the treated tooth. No occlusal reduction of clinical crowns may be done, other than the normal

access preparation. Any other alteration will result in a deduction of points.

b. Primary Molar Stainless Steel Procedures

The assigned teeth will be single layer teeth. The teeth should be prepared in the appropriate proportions, taper and depths as defined in the criteria.

The teeth must be prepared for full crowns with supragingival margins. When the feather edge margin is prepared, the preparation should not extend below the simulated free gingival margin.

The preparation on #J will not be evaluated, only the placement of the permanently cemented stainless steel crown will be evaluated.

Primary Molar Stainless Steel Crown Restoration- #J: must be **permanently cemented.**

c. Primary Molar Class II Amalgam Restoration – MOD #T: Candidates will complete an MOD restoration on #T.

6. **Isolation dam:** The pulpotomy procedure must be performed under an isolation dam. The dam must be removed at the completion of the procedure. No isolation dam is required for the crown preparations.
7. **Equilibration Prohibited**: No equilibration will be permitted on the typodont prior to or subsequent to any of the manikin restorative procedures.

PRIMARY MOLAR STAINLESS STEEL CROWN RESTORATION

Tooth # J – Cervical Margin and Draw

Margin/Extension

SAT	The extension of the crown into the simulated gingival sulcus is optimally 1.0mm.
ACC	The extension of the crown into the simulated gingival sulcus is over-extended greater than 1.0mm but less than 1.5mm. The extension of the crown into the simulated gingival sulcus is under-extended less than 1.0mm but does not extend occlusally above the free gingival margin.
SUB	The extension of the crown into the simulated gingival sulcus is over-extended greater than 1.5mm but less than 2.0mm. The extension of the crown into the simulated gingival sulcus is under-extended occlusally above the free gingival margin but not more than 0.5mm.
DEF	The extension of the crown into the simulated gingival sulcus is over-extended greater than 2.0mm. The extension of the crown into the simulated gingival sulcus is under-extended occlusally above the free gingival margin more than 0.5mm.

Margin/Definition

SAT	The crown margins have been properly crimped to exhibit adaptation to the tooth surface with isolated discrepancies less than 0.5mm.
ACC	The crown margins have been crimped to exhibit adaptation to the tooth surface with isolated discrepancies greater than 0.5mm but less than 1.0mm
SUB	The crown margins exhibit adaptation to the tooth surface with generalized prevalent discrepancies greater than 0.5 mm but less than 1.0mm
DEF	The crown margins exhibit minimal adaptation to the tooth surface with discrepancies greater than 1.0mm

Surface Finish

SAT	The crown surfaces, including margins, are well polished with no scratches or pliers marks.
ACC	The crown surfaces, including margins, are polished but show slight evidence of scratches or pliers marks.
SUB	The crown surfaces, including margins, are rough and/or show significant evidence of scratches or pliers marks.

Cement Removal

SAT	There is no evidence of cement visible on the crown surface, on the marginal areas, in the gingival sulcus, in the interproximal area of the adjacent tooth, on the gingival tissues or other adjacent teeth surfaces.
ACC	There is no evidence of cement visible on the marginal areas, in the gingival sulcus or in the interproximal area of the adjacent tooth. There is minimal evidence of cement remaining on the crown surface, the gingival tissues or other adjacent teeth surfaces.
SUB	There is no evidence of cement visible on the marginal areas, in the gingival sulcus or in the interproximal area of the adjacent tooth. There is moderate evidence of cement remaining on the crown surface, the gingival tissues or other adjacent teeth surfaces.
DEF	There is evidence of cement visible on the marginal areas, in the gingival sulcus or in the interproximal area of the adjacent tooth. There is significant evidence of cement remaining on the crown surface, the gingival tissues or other adjacent teeth surfaces.

PRIMARY MOLAR STAINLESS STEEL CROWN RESTORATION
Tooth # J - Contour, Contact and Occlusion

Interproximal Contact

SAT	Interproximal contact is present, the contact is visually closed and properly contoured; and there is definite, but not excessive, resistance to waxed dental floss when passed through the interproximal area.
ACC	Interproximal contact is present, the contact is visually closed and properly contoured but demonstrates little resistance to waxed dental floss when passed through the interproximal area.
SUB	Interproximal contact is visually closed, but the contact is deficient in size, shape, or position and demonstrates little resistance to waxed dental floss or shreds or breaks the floss.
DEF	The interproximal contact is visually open or will not allow waxed dental floss to pass through the contact area.

Centric/Excursive Contacts

SAT	When checked with articulating ribbon or paper, all centric and excursive contacts on the restoration are consistent in size, shape and intensity with such contacts on other teeth, in that quadrant.
SUB	When checked with articulating ribbon or paper, the restoration is in hyper-occlusion inconsistent in size, shape and intensity with the occlusal contacts on surrounding teeth, and requires adjustment.
DEF	There is gross hyperocclusion so that the restoration is the only point of occlusion in that quadrant.

Occlusal Anatomy

SAT	The crown is positioned properly on the tooth to replicate the normal physiological contours, marginal ridge height and alignment, not rotated or axially inclined.
ACC	The crown does not replicate the normal physiological contours, marginal ridge height and alignment, but would not be expected to adversely affect the tissue health.
DEF	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, and would be expected to adversely affect the tissue health.

PRIMARY MOLAR STAINLESS STEEL CROWN RESTORATION
Critical Errors

Fractured Restoration
The restoration is debonded and/or movable in the preparation.

PRIMARY MOLAR STAINLESS STEEL CROWN PREPARATION
Tooth #L - Cervical Margin and Draw

Margin/Extension

SAT	The margins should be at the crest of the simulated free gingival margin.
ACC	The cervical margin is no more than 0.5 mm apical or coronal to the crest of the simulated free gingival margin.
SUB	The cervical margin is [_] overextended more than 0.5 mm but not more than 1.0 mm apical to the crest of the simulated free gingival margin. The cervical margin is [_] underextended, more than 0.5 mm but no more than 1.0 mm coronal to the crest of the simulated free gingival margin.
DEF	The cervical margin is [_]overextended more than 1.0 mm apical to the crest of the simulated free gingival margin. The cervical margin is [_] underextended more than 1.0mm coronal to the crest of the simulated free gingival margin.

Margin/Definition

SAT	The cervical margin is smooth, continuous, well defined.
ACC	The cervical margin is continuous but slightly rough and lacks some definition.
SUB	The cervical margin has some continuity, is significantly rough and is poorly defined.
DEF	The cervical margin has no continuity and/or definition.

Line of Draw

SAT	The appropriate path of insertion varies less than 10^{o} from parallel to the long axis of the tooth on all axial surfaces and a line of draw is established.
ACC	The path of insertion/line of draw deviates 10^{o} to less than 20^{o} from the long axis of the tooth.
SUB	The path of insertion/line of draw deviates 20^{o} to less than 30^{o} from the long axis of the tooth.
DEF	The path of insertion/line of draw is grossly unacceptable, deviating 30^{o} or more from the long axis of the tooth.

PRIMARY MOLAR STAINLESS STEEL CROWN PREPARATION
Tooth #L - Walls, Taper and Finish Line

Axial Tissue Removal

SAT	Axial tissue removal is optimally 1.0 mm to be sufficient for convenience, retention and resistance form.
ACC	The axial tissue removal deviates no more than $\pm$ 0.5 mm from optimal.
SUB	The axial tissue removal is over-reduced no more than + 1.0 mm from optimal.
DEF	The axial tissue removal is grossly over-reduced more than 2mm or under-reduced less than 0.5 mm.

Axial Wall-Smoothness

SAT	Walls are smooth and well-defined.
ACC	The walls are slightly rough and lack some definition.
SUB	The axial walls are rough.

Taper

SAT	There is full visual taper (6^o – 16^o)
ACC	Taper is present, but nearly parallel ($<6^o$) or slightly excessive ($>16^o$, but $< 24^o$).
SUB	There is no taper or excessive taper ($>24^o$).
DEF	The taper is grossly over-reduced ($>30^o$).

Cervical Finish Line

SAT	The margin is knife-edge or feather-edge with no ledges present.
ACC	The margin, although predominantly knife-edge or feather-edge, has some areas of ledging that do not exceed 0.5mm in width.
SUB	The margin varies significantly from the knife-edge or feather-edge design exhibiting ledges and/or width no more than 1.0 mm.
DEF	The margin exhibits excessive shoulders, chamfers or ledges and/or width more than 1.0mm.

Occlusal Reduction

SAT	Reduction of the occlusal wall is optimally 1.0 mm.
SUB	Occlusal reduction deviates no more than $\pm$ 0.5 mm from optimal.
DEF	The occlusal wall is grossly over-reduced, greater than 1.5 mm; or grossly under-reduced, less than 0.5 mm, resulting in insufficient occlusal clearance for adequate restorative material.

Internal Line Angles

SAT	Internal line angles and cusp tips are rounded.
ACC	Internal line angles and cusp tip areas are not completely rounded and show a slight tendency of being sharp.
SUB	The internal line angles and cusp tip areas show only minimal evidence of rounding or are excessively sharp.

Occlusal Anatomy

SAT	The general occlusal anatomy is maintained.
SUB	The occlusal anatomy is flat.

PRIMARY MOLAR AMALGAM RESTORATION - #T
Margin Integrity and Surface Finish

MARGIN DEFICIENCY

SAT	There is no marginal deficiency. There is no evidence of voids or open margins.
ACC	There is a detectable marginal deficiency at the restoration-tooth interface either visually or with the tine of an explorer, but it is less than .5 mm.
SUB	The restoration-tooth interface is detectable visually or with the tine of an explorer. There is evidence of marginal deficiency, 0.5 mm up to 1 mm, which can include pits and voids at the cavosurface margin
DEF	There is evidence of marginal deficiency of more than 1 mm ~~or more~~, to include pits and voids at the cavosurface margin, and/or there is an open margin.

MARGIN EXCESS

SAT	There is no detectable excess at the cavosurface margin either visually or with the tine of an explorer.
ACC	There is a detectable marginal excess at the cavosurface margin either visually or with the tine of an explorer, but it is no greater than 1.0 mm.
SUB	The cavosurface margin is detectable visually or with the tine of an explorer. There is evidence of marginal excess of more than 1.0 mm and up to 2.0 mm.
DEF	There is evidence of marginal excess at the cavosurface margin of more than 2.0 mm.

GINGIVAL OVERHANG

SAT	The restoration exhibits no gingival overhang.
ACC	The restoration exhibits a slight gingival overhang but would not be expected to adversely affect the tissue health.
DEF	The restoration exhibits a significant gingival overhang and would be expected to adversely affect the tissue health.

SURFACE FINISH

SAT	The surface of the restoration is uniformly smooth and free of pits and voids.
ACC	The surface of the restoration is slightly grainy or rough, but it is free of significant pits and voids.
SUB	The surface of the restoration is rough and exhibits surface significant irregularities, pits or voids.

CONTIGUOUS TOOTH STRUCTURE

SAT	There is no evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration.
ACC	There is minimal evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration. (Enameloplasty)
SUB	There is evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration. (Enameloplasty)
DEF	There is gross enameloplasty resulting in the exposure of dentin.

PRIMARY MOLAR AMALGAM RESTORATION - #T
Contour, Contact and Occlusion

INTERPROXIMAL CONTACT

SAT	Interproximal contact is present, the contact is visually closed and is properly shaped and positioned; and there is definite, but not excessive, resistance to dental floss when passed through the interproximal contact area.
ACC	Interproximal contact is visually closed, and the contact is adequate in size, shape, or position but demonstrates little resistance to dental floss.
SUB	Interproximal contact is visually closed, but the contact is deficient in size, shape, or position and demonstrates little resistance to dental floss or shreds the floss.
DEF	The interproximal contact is visually open or will not allow floss to pass through the contact area.

CENTRIC/EXCURSIVE CONTACTS

SAT	When checked with articulating ribbon or paper, all centric and excursive contacts on the restoration are consistent in size, shape and intensity with such contacts on other teeth, in that quadrant.
SUB	When checked with articulating ribbon or paper, the restoration is in hyper-occlusion inconsistent in size, shape and intensity with the occlusal contacts on surrounding teeth, and requires adjustment.
DEF	There is gross hyperocclusion so that the restoration is the only point of occlusion in that quadrant.

ANATOMY/CONTOUR

SAT	The restoration reproduces the normal physiological proximal contours of the tooth, occlusal and marginal ridge anatomy.
ACC	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, but would not be expected to adversely affect the tissue health.
DEF	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, and would be expected to adversely affect the tissue health.

AMALGAM FINISHED RESTORATION
Critical Errors

Fractured Restoration

PRIMARY MOLAR PULPOTOMY PROCEDURE
Tooth #A – Access Opening

Placement

SAT	The placement of the access opening is the mesial triangular pit and central fossa of the tooth and would allow for straight-line access to the root canal system.
ACC	The placement of the access opening is not directly over the pulp chamber but would allow for straight-line access to the root canal system.
SUB	The placement of the access opening is not over the pulp chamber and would not allow straight-line access to the root canal system.
DEF	The placement of the access opening is not over the pulp chamber and would not allow access to the root canal system.

Size

SAT	The access opening is of optimal size and allows for complete debridement of the pulp chamber.
SUB	The access opening is underextended allowing for partial debridement of the pulp chamber.
DEF	The access opening is underextended so that debridement of the pulp chamber or access to one or more canal orifices is impossible.

Integrity of Occlusal Anatomy

SAT	The access opening preserves 1.0 mm or more of the mesial marginal ridge, oblique ridge, and all cusp tips.
SUB	The access opening is overextended but preserves at least 0.5 mm but less than 1.0 mm of the mesial marginal ridge, oblique ridge, and/or any cusp tip.
DEF	The access opening is overextended but preserves less than 0.5 mm of the mesial marginal ridge, oblique ridge, and/or any cusp tip or extends over the occlusal table.

Internal Form

SAT	The internal form tapers to the canal opening with no ledges.
SUB	The internal form lacks taper to the canal orifice(s), gouges are present that do not affect access to the canal orifice.
DEF	The internal form exhibits excessive ledging or gouges that do not allow access to the canal orifices and/or the pulp chamber is not entered and/or there is incomplete removal of the pulp chamber roof and/or there is a perforation of the crown or the floor of the pulp chamber.

Pulp Horn Removal

SAT	All pulp horns are removed through the access opening.
ACC	Pulp horns are not fully removed through the access opening.
SUB	Pulp horns are not entered.

MANIKIN PROCEDURES
Treatment Management
Penalty Points ONLY

Adjacent Tooth Damage

SAT	The adjacent and/or opposing teeth and/or restorations are free from damage.
ACC	Damage to adjacent tooth/teeth can be removed with polishing without adversely altering the shape of the contour and/or contact.
SUB	Damage to adjacent tooth/teeth requires recontouring which changes the shape and/or position of the contact. Opposing hard tissue shows evidence of damage and/or alteration inconsistent with the procedure.
DEF	There is gross damage to adjacent tooth/teeth which requires a restoration. There is evidence of gross damage and/or alteration to opposing hard tissue inconsistent with the procedure.

Soft Tissue Damage

SAT	The simulated gingiva and/or typodont is/are free from damage.
ACC	There is slight damage to simulated gingiva and/or typodont consistent with the procedure.
SUB	There is iatrogenic damage to the simulated gingiva and/or typodont inconsistent with the procedure.
DEF	There is gross iatrogenic damage to the simulated gingiva and/or typodont inconsistent with the procedure.

RESTORATIVE EXAMINATION

GENERAL REQUIREMENTS

Restorative Examination

1. **Patient Selection:** For patient-based procedures, candidates must furnish their own patients. Patient management is an important part of the examination.

   It is imperative that all assigned procedures be completed; incomplete procedures cannot be evaluated. Therefore, another consideration in patient selection is the cooperative attitude of the patient. Avoid selecting patients who are apprehensive, hypersensitive, have physical limitations or cannot remain until the examination is completed. Candidates must advise their patients of the time required to participate in this examination and ascertain that their patient is available for the entire day.

2. **Patient Management: Significant Medical History and Pathosis:** The candidate and assisting auxiliary must behave in an ethical and proper manner towards all patients. Patients shall be treated with proper concern for their safety and comfort. The candidate shall accurately complete the appropriate medical history form and establish a treatment plan as required for each selected patient. The patient's health status must be acceptable for clinical treatment and the lengthy examination process. Misinformation or missing information that would endanger the patient, candidate, auxiliary personnel, or examiners is considered cause for appropriate action including dismissal from the examination.

3. **Patient Acceptability Requirements - General & Medical History:** A medical history form must be completed for all clinical patients who are present for the examination. This form may be completed prior to the examination date; however, a medical history that reflects the patient's current health must be presented to the examiners at the time of patient check-in. All positive responses must be explored by the candidate with the patient and adequately explained on the Medical History.

   A screening blood pressure reading should be taken when the patient is selected and must be retaken the day of the examination. In addition, on the day of the examination the candidate must also update all medications, pills or drugs both prescription and non-prescription consumed within the last 24 hours.

   If a patient requires antibiotic premedication, it must be documented on the Progress Folder before patient check-in. If conditions indicate an alteration in treatment procedures or a need to consult the patient's physician, the candidate must obtain the necessary written clearance before the patient is accepted. In order to be accepted for treatment, patients must meet all of the following criteria:

   a. Minimum patient age is 16 years.

   b. No patient may be a dentist, dental hygienist, dental, dental hygiene or dental therapy student.

   c. Have a blood pressure reading of 159/94 or below to proceed without medical clearance. Patients with a blood pressure reading between 160/95 and 179/109 will be accepted only with written clearance from the patient's physician. Patients with a blood pressure reading greater than 180/110 will not be accepted for this examination even if a consult from a physician authorizes treatment.

   d. Candidates who are sharing a patient with a need for antibiotic prophylaxis must treat the patient the same clinical day. Treatment of the same patient on subsequent clinical days will not be permitted.

   e. No heart attack, stroke or cardiac surgery within the past six months.

f. Any cardiac or organ transplant requires a physician's consultation.

g. No active tuberculosis. A patient who has tested positive for TB, or is being treated for TB, but does not have the clinical symptoms is acceptable.

h. No chemotherapy treatment within the last 6 months.

i. Generally no history of taking IV administered bisphosphonate medications for the Restorative Examination (with the exception that taking the approved annual IV dosage for osteoporosis is acceptable). Patients currently taking or who have a history of taking orally administered bisphosphonates may sit for Restorative procedures.

j. No active incidence of bisphosphonate osteonecrosis of the jaw (BON), also known as osteochemonecrosis or, osteonecrosis of the jaw – ONJ

k. No condition or medication/drug history that might be adversely affected by the length or nature of the examination procedures.

l. Patients with latex sensitivity must have a sticker placed on the top left-hand corner of the Progress Form for that procedure. Contact a CFE for the appropriate sticker.

m. Any item on the Medical History with a "YES" response could require a Medical Clearance from a licensed physician if the explanation section indicates the possibility of a significant systemic condition that could affect the patient's suitability for elective dental treatment during the examination.

Candidates must follow the 2014 American Heart Association **antibiotic premedication** recommendations when treating patients at potential risk of infective endocarditis following dental treatment. A Medical Consult may be indicated to determine the patient's potential risk of infective endocarditis.

Additionally, candidates must follow 2015 AAOS (American Association of Orthopedic Surgeons) recommendations when treating patients with joint replacements/concerns unless the physician provides a consultation note indicating premedication is not needed.

Medical clearance, if necessary, must include:

- A legible statement from a physician written within 30 days of the examination clearly stating the medical concern.
- A positive statement of how the patient should be managed.
- The practitioner's name, address and phone number

The Medical History and any physician's statement will be reviewed by a Clinic Floor Examiner for the Restorative Clinical Examination, and must accompany the patient when the treatment procedure is submitted for evaluation. If the patient sits for more than one candidate, a separate Medical History and Consent Form must be completed for each examination.

4. **Treatment Consent:** A Consent Form (Consent for Performance of Dental Procedures) is provided by CRDTS and must be completed for each clinical patient. Patients under the age of legal consent for the state in which the examination is being given must have the Consent Form signed by the parent or guardian. O*nly the candidate number* should be recorded on the Consent Form; the candidate's *name* may be added *after* the examination is completed and *before* the packet is turned in.

5. **Anesthetic Record:** An anesthetic record is included in the candidate's Progress Form. Candidates are not allowed to administer anesthesia until authorization has been received and a Clinic Floor examiner has reviewed the medical history and approved anesthesia. At the time of the starting check for each clinical procedure requiring anesthesia, the anesthetic information must be indicated on the record. The record requires information as follows: The Type(s) of Injection pertains to the specific block and/or infiltration administered including non-injectable subgingival anesthetics. The Anesthetic(s) relates to the brand name used. The Vasoconstrictor, if present, must specify the type and concentration. The Quantity is specific to volume. If more than two

carpules (approximately 3.6 cc.) of local anesthetic are needed during any clinical procedure, the candidate must request approval from the Clinic Floor Examiner who will document and initial the request. This protocol must be followed for each subsequent carpule. An aspirating syringe and proper aspirating technique must be used for the administration of local anesthesia. Please be sure to complete the quantity actually administered prior to submitting patient to the evaluation area.

6. **Premedication Record:** A record must be noted for every patient who requires premedication prior to or during the course of the examination. For each patient treatment procedure, there is a place on the Health History form to record the type of medication administered and the dosage. In addition to premedication, ***all medications taken within the last 24 hours—***both prescribed and over-the-counter—must be recorded.

7. **Analgesia:** The administration of inhalation analgesia or parenteral sedation is not permitted for any clinical procedures.

8. **Radiographs:** The radiographs, which are appropriate for each part of the examination, must demonstrate sufficient contrast to clearly reveal the extent of caries and other pathoses. Initial submission of radiographs (film or digital prints) of poor quality will result in a request for a new radiograph. If a subsequent required retake radiograph is not of diagnostic quality there will be a point deduction. If a third radiograph is not of diagnostic quality, the examination is stopped. Additional radiographs may be required by the examiner during the course of the examination. The radiographic films or digital prints used in the examination may be collected at the end of the examination (either separately or on a disk) and become the property of the testing agency. Post-operative radiographs or digital prints are not routinely required. However, a post-operative radiograph may be requested at any time at the discretion of the examiners in the Evaluation Station or a Clinic Floor Examiner. Lack of, or alteration of radiographs or digital prints will result in failure of the examination. Any radiographs requested by a candidate after the start of a procedure must be approved and documented by the Chief Examiner.

9. **Digital Radiography:** Candidates may present these images on paper or a monitor view, if available. Candidates are required to check with the site to determine availability, upload and presentation requirements for monitor views. The school will provide a disk of all exam images at the completion of the exam.

   As a back-up, it is suggested that candidates have printed copies of the digital images available:
   - The films/images must be of diagnostic quality.
   - For restorative procedures, periapicals and bite-wings must be non-distorted images printed on premium quality photo paper. If possible, more than one image may be placed on the sheet of photo paper.
   - Enhancements that do not alter the data in the file of the original radiographic exposure. Any alterations to the original file data would be considered fraudulent.
   - A complete mouth series of digital radiographs must be printed on 8½" x 11" premium quality photo paper.
   - A regional school must verify the unaltered authenticity of the image(s) with an embossed seal on the photo paper of the radiographs. Incoming practitioners who are not associated with a dental therapy school must submit a signed, dated statement on the back of or with their radiographs attesting that the images are unaltered. Example: *"I hereby attest that this reproduction of digital radiographs is a copy of the original, unaltered exposure, and I agree that any subsequent evidence to the contrary will constitute a violation of CRDTS' examination guidelines".*
   - The patient's name, the date of exposure and the candidate's ID number must be written on the page.

10. **Communications from Examiners:** Clinic Floor Examiners are available for your benefit and to help facilitate the examination process. If you have any questions about any part of exam, ***please do not hesitate*** to confer with a Clinic Floor Examiner.

    Candidates may receive written instructions ("Instructions to the Candidate" form) from the Restorative Examiners to modify their treatment. If so, the candidate must ***immediately*** summon a Clinic Floor Examiner **prior to** carrying out any of the instructions. Candidates should not make the assumption that they have failed. The procedure may be acceptable even though modification is indicated. Conversely, candidates who receive no instructions to modify procedures may not necessarily assume their performance is totally satisfactory or will result in a passing grade. It is possible to have a deficient preparation which cannot be modified for the purposes of the examination. Such a preparation, while deficient in terms of CRDTS evaluation criteria, may still support a finished restoration without seriously jeopardizing the immediate prognosis of the treatment. In every instance, each procedure is evaluated as it is presented rather than as it may be modified. The examiner ratings are not converted to scores until after the examination is completed and all records are processed by computer. Examiners at the examination site do not know and cannot provide information on whether a candidate has passed or failed a specific Examination.

11. **Infection Control:** Candidates must follow all infection control guidelines required by the state where the examination is taking place and must follow the CDC's *Guidelines for Infection Control in Dental Health-Care Settings – 2003* (CDC MMWR: December 19, 2003, Vol. 52, No. RR-17.) (www.cdc.gov/oralhealth/infectioncontrol/guidelines)

    The current recommended infection control procedures as published by the CDC must be followed for all Examinations. These procedures must begin with the initial setting up of the unit, continue throughout the examinations and include the final cleanup of the operatory. It is the candidate's responsibility to assure that both the candidate and his/her auxiliary fully comply with these procedures. Failure to comply will result in loss of points and any violation that could lead to direct patient harm will result in termination of the examination and loss of all points.

Requirements Specific to the Restorative Examinations

General

Posterior Procedures: Candidates will place a Class II and a Class III Preparation & Restoration.

Restorative Instruments: A new unscratched, untinted front-surface, non-disposable, #4 or #5 mouth mirror (mouth mirrors that are clouded, tinted, or unclear will be rejected), a ***sharp*** traditional Shepherd's Hook-type explorer and a periodontal probe with 1mm markings are required for the restorative examination and must be provided by the candidate.

Recontouring: No recontouring of adjacent teeth or restorations will be permitted without prior approval. Candidates may request to recontour restorations on adjacent teeth from the CFE. The CFE will initial the progress form if recontouring is approved. Candidates are not permitted to request to recontour until ***after*** the preparation has been evaluated. Once recontouring is completed, the candidate will request the same CFE evaluate the finished procedure.

Post-op Radiographs: Post-operative radiographs are not required. However, a post-op radiograph may be requested at any time at the discretion of Restorative Examiners or Clinic Floor Examiners. The radiograph should be mounted, meet the same criteria as specified for pre-op radiographs, and returned to the requesting examiner for evaluation.

Caries Detection Agents: Caries detector liquid may be used. If used it must be completely removed prior to the submission of the preparation for evaluation.

Standardized Floss: CRDTS will provide standardized, approved floss for evaluation of the interproximal contact on the Class III Composite Restoration:

POH LiteWax Percept 630 Black Floss sachets
Go to www.oralhealthproducts.com for more information.

Patient/Treatment Selection and Approval (Start Checks)

Patient selection is very important; dental therapy candidates must receive **prior approval** by a CRDTS examiner with an active Minnesota dental license so their selected lesion(s) meet CRDTS Restorative Patient-based criteria. It is strongly suggested that substitute patients be available so that in the event the first patient is not available or has health history concerns, the substitute patient may be called. If the candidate is unable to complete a procedure due to patient management problems, the procedure cannot be evaluated and no credit will be assigned.

The criteria for tooth selection outlined in this Manual are the **guidelines** utilized by examiners for the approval of treatment selection. However, it must be recognized that criteria cannot cover every possible condition that may exist in each situation. Examiners must also be guided by medical/patient protection concerns so if there are these concerns arise, the examiners on site must make the final decision for approval of treatment selection.

Multiple **pre-approved** treatment selections/patients may be submitted for a procedure. Candidates may indicate an alternate **pre-approved** treatment selection on the same patient on the back of the Progress Form for that particular procedure.

At the time of the examination, a Clinic Floor Examiner will review the radiographs and medical history for each **pre-approved** treatment selection. If the Clinic Floor Examiner should determine that there is an issue with either of these items, the CFE will address them accordingly. If the first treatment selection is disapproved by two examiners due to medical history concerns, a substitute **pre-approved** treatment selection may be submitted. Under no circumstances can anesthetic solution be administered prior to assignment.

Candidates are responsible for certain criteria within the treatment selection process – Medical History management, diagnostic radiographs and patient condition. If the patient condition should change from the time of the prior approval to treatment time, the candidate should be prepared to bring these

changes to the attention of the clinic floor examiner. Should the candidate fail to recognize or document these changes, a 5 point penalty will be deducted.

The candidate should set up at least 15 minutes before the examination begins and have all materials prepared for examiners to begin starting checks promptly. The candidate may request only one starting check at a time, unless both lesions are on the same patient, then they may request both start checks. The candidate must carry the procedure through to the appropriate stage of completion before beginning the second procedure.

Treatment Selection **Exclusions**:

- Pulpal pathology or endodontic treatment.
- Current clinical conditions that may not have been evident at the time of the pre-approved treatment selection.
- Facial veneers.
- Mobility of Class III or more.
- Mandibular first premolars, including mesial surfaces. However, distal surface is acceptable for Class II amalgam.
- Distal surface of cuspids allowed for Class III composite only, not Class II.

For confirmation of the **pre-approved** tooth selection, the candidate will present:

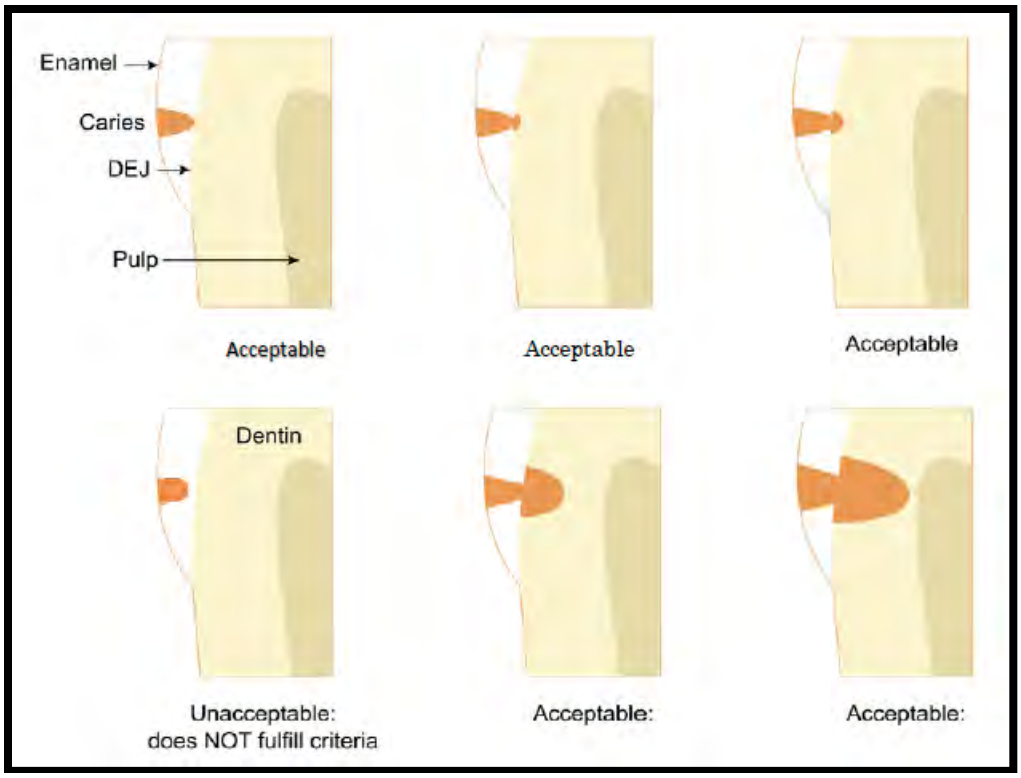
A. completed Medical History
B. mirror, sharp explorer, cotton pliers, periodontal probe
C. articulating paper and holder
D. tooth # and type of restoration circled on the Progress Form, outline existing restoration(s)
    1. A CFE will note the size of the lesion
E. radiographs (bitewing and periapical no more than 6 months old) which depict the current condition of the tooth and surrounding structures, properly mounted and taped to the Progress Form
F. Pre-approved examiner number on the Progress Form
G. the anesthetic record filled out on the Progress Form (but no anesthetic administered)

Radiographs

A periapical and a bitewing radiograph of the tooth selected for the Class II procedures must be presented at the time the treatment selection is presented for approval; only a periapical radiograph is required for the Class III composite procedure. These pre-op films must be of ***diagnostic quality***: the periapical film must include the entire crown of the tooth and at least 2 mm beyond the apex; both the mesial and distal contacts must be open on the tooth selected for treatment on either the periapical or bitewing exposure for the Class II procedure, only the contact selected for treatment must be open for the Class III procedure. If necessary, more than one radiograph may be submitted to satisfy these requirements. The radiographs cannot be more than 6 months old, and must depict the **current clinical condition of the tooth** to be treated as well as surrounding teeth. That is, there must have been no treatment between the time of taking the radiograph and the CRDTS' examination that would alter the situation depicted in the radiograph. Duplicate radiographs of diagnostic quality are acceptable.

At the examination, the films must be mounted/presented according to ADA procedures. Conventional films should be attached to a Progress Form provided by CRDTS. Digital radiographs may either be printed and attached to the Progress Form or be presented on monitors within the clinic and must also be available in the evaluation area. These radiographs must be turned in at the end of the examination, either attached to the Progress Form or on a disk, labeled with candidate ID; these will become the property of CRDTS.

The illustrations which appear below help define acceptable and unacceptable radiographic images of primary lesions. Radiographic appearance of caries must extend to the DEJ or beyond and/or there must be evidence of dentinal penetration.



Modification Requests

If during the preparation the tooth indicates a need for a significant change from the criteria outlined for Satisfactory, the candidate should make modification request(s) ***prior to performing them.*** The preparation ***must*** be prepared to the Satisfactory criteria and all pre-existing restorative material must be removed before submitting the first Modification Request. If removal of the pre-existing restorative material might result in a direct or indirect pulp exposure, refer to Indirect Pulp Cap Request/Policy section of the Manual. Requests to extend the preparation to an MOD or to place different material than the approved Treatment Selection should be made utilizing the Modification Request process. Exceptions include: modification to extend the proximal box because of tooth rotation or position. These do not require a request for modification but are listed in the Notes to Examiners area at the bottom of the Progress Form and must be initialed by a CFE. Each modification needs to be numbered and listed separately with the time noted and a brief explanation of the proposed modifications. The request to modify should include:

What: (Type of modification)
Where: (gingival axial line angle, mesial box) *See Illustration below*
Why: (due to caries, decalcification)
How much: (reference back to either ideal or to the start)

The request should be shown to a Clinic Floor Examiner who will direct the candidate through the authorization process for modifications; all requests for modifications will be placed under a rubber dam and sent to the Express Chair in the Evaluation Station. If the candidate feels a finger extension is appropriate and/or necessary to eliminate marginal decalcification, such a modification should also be submitted for approval. ***If the candidate anticipates or actually experiences a pulpal exposure, the Clinic Floor Examiner should be notified at once***.

Example Modification Request

Modification Request # 1
What: Extend
Where: axial wall
Why: remove caries
How Much: .5 mm
☐ **Granted** ☐ **Not Granted**

Isolation dams are required for Modification Requests. There will be one or more Express Chairs reserved in the Evaluation Station to process requests for modifications. When the patient is sent to the Evaluation Station, it must be made clear at the Exam Desk that the patient is there for the Express Chair.

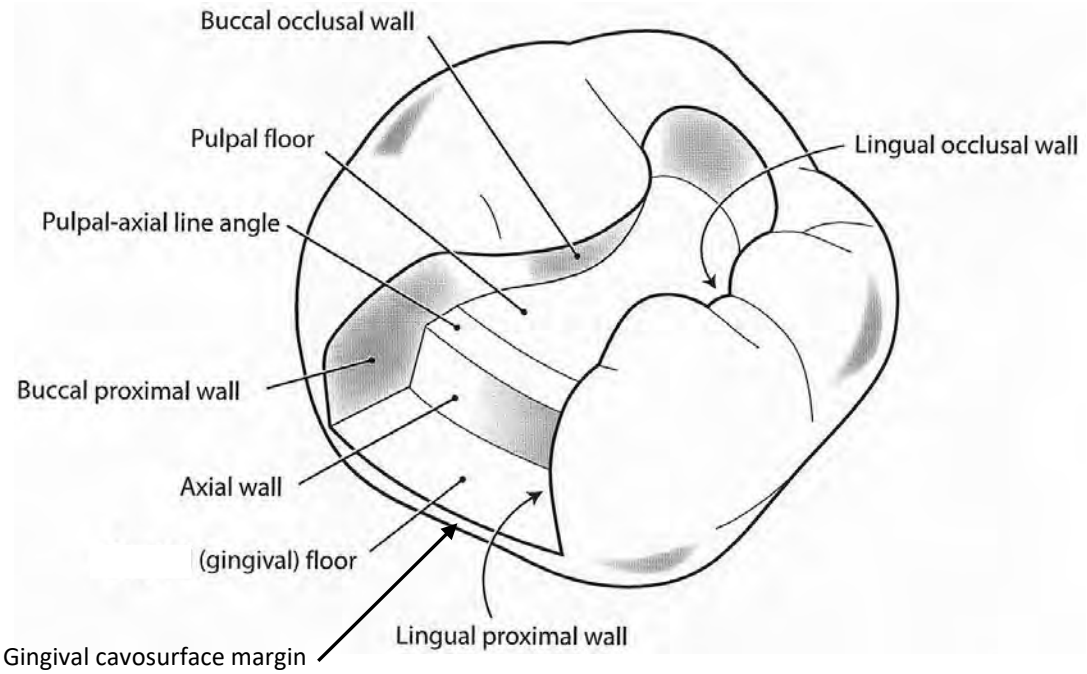
Instruct the assistant to notify the evaluation area that the patient is there for the Express Chair for a modification request and not for evaluation of the preparation. The examiners will record on the Modification Request Form whether the request is accepted or denied and forward notification to the candidate.

Carefully review the criteria for modification requests. Inappropriate requests for modification(s) will result in a small penalty for each modification not granted. Requests for a modification for removal of caries or decalcification when no caries or decalcification exists will receive a larger penalty. Modifications that have been approved and appropriately accomplished will not result in any penalties. ***Regardless of whether the modification is granted or not granted, the candidate must complete the preparation and send the patient to the Evaluation Station for evaluation of the final completed preparation.*** The copy of the modification request form that is returned to you must be submitted with your Preparation Evaluation form.

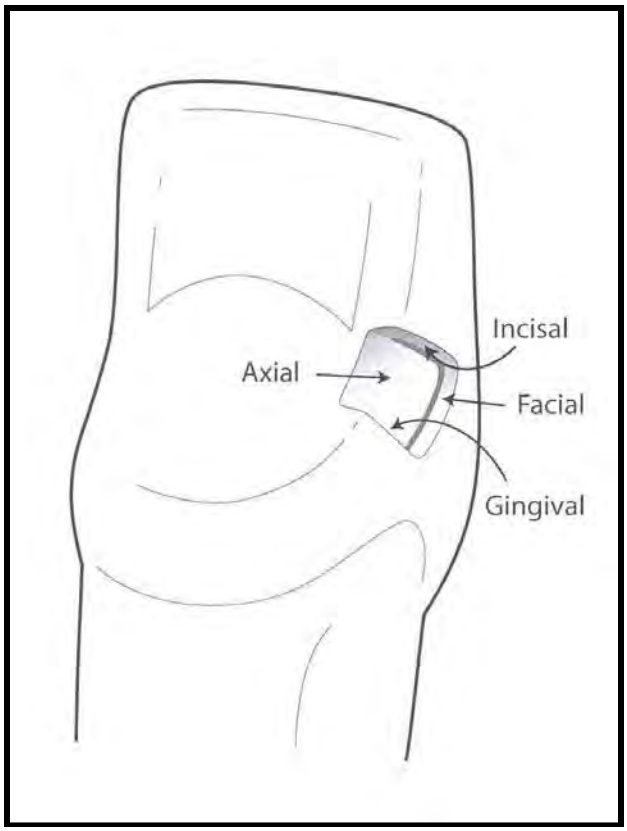
If more than one modification is anticipated at any time, it is to the candidate's advantage to submit them on the same form as no additional time is provided for evaluation of modification requests and multiple submissions may significantly decrease treatment time. Candidates will submit their copy of the Modification Request Form with their Finished Restoration Forms.

Terminology for Modification Requests

Class II Preparation



Class III Preparation



Instructions to Candidates

When the patient returns from the Evaluation Station, if the candidate does not receive an "Instruction to the Candidate" form, the candidate should continue to the next step of the treatment. If the candidate does receive an "Instruction to the Candidate" form, **the candidate must inform the Clinic Floor Examiner *before proceeding*** and follow the instructions that have been issued. **The Clinic Floor Examiner must evaluate the performance of the candidate, per the instructions, and initial the "Instructions to the Candidate" form when the instructions have been satisfactorily completed.**

Evaluation of Restorative Procedures

Preparations

With the isolation dam in place, the patient is sent to the Evaluation Station for evaluation of the preparation. On an instrument tray, the candidate should send:

1. completed Medical History Form
2. completed Restorative Progress Form (with completed anesthetic record) and any Modification Request Forms
3. a mirror
4. sharp explorer
5. a metal periodontal probe with 1mm markings,
6. cotton pliers
7. air/water syringe tip (if removable),

There are deadlines for preparations and restorations to be presented for final evaluation, as specified in the discussion of the Restorative Examination under **SCHEDULE/DATES**. The preparation must be presented at least one hour prior to the end of the Restorative Examination.

Isolation dam

1. A standard isolation dam should be used in all instances where an isolation dam is required. Cavity preparations may be made with or without the isolation dam.
2. All cavity preparation checks by the examiners for the Class II Amalgam and Class III composite, ***including modifications*** will be made with the dam intact, not torn or leaking.
3. Final evaluations for the finished restorations will be made with the isolation dam **removed**.
4. Isolation dam clamps are prohibited on patients taking oral bisphosphonates; the isolation dam must be ligated with floss.

Finished Restoration

1. The finished restoration must be presented by the required time as specified in the examination schedule or it will not be evaluated. Any wedges placed during treatment must be removed prior to evaluation. On a tray, the candidate should send to the Evaluation Station:
    a. a mirror, sharp explorer
    b. periodontal probe with 1 mm markings
    c. cotton plier
    d. articulating paper and holder
    e. floss (Class II only)
    f. air/water syringe tip (if removable)
    g. disinfected pen
    h. completed Medical History Form

i. completed Restorative Progress Form (with completed anesthetic record)

2. If the candidate receives no communication from the Evaluation Station, the patient may be dismissed. If the finished restoration is NOT acceptable as stated on the "Instruction to the Candidate" form, the candidate must contact a CFE. The restoration will either be requested to be removed and the tooth temporized by the candidate as directed by the Chief Examiner or be allowed to remain as a temporary restoration. The Chief Examiner will advise the candidate as to the decision and will also inform the patient. A Follow-up form must be completed by the candidate and Chief Examiner to ensure that the responsibility for further treatment is understood and that the patient will receive the proper care. All post-treatment required as a result of treatment rendered as a part of the examination process is the responsibility of the candidate and done at the expense of the candidate.

Requirements Specific to the Restorative Examination

Class II Procedures- Amalgam and Composite

1. Must be a Class II restoration and the tooth selected for either restoration must be a permanent posterior tooth that meets these requirements:
    - At least one proximal surface being restored must have a primary carious lesion OR a defective Class II restoration:
        - If a primary carious lesion is present:
            i. it must NOT have been previously excavated
            ii. it must be in contact with a sound enamel surface or a permanently restored surface of an adjacent tooth
        - If a defective existing restoration is present:
            i. defined as one which exhibits recurrent caries that is radiographically visible or detectable clinically with an explorer.
            ii. it must be in contact with a sound enamel surface or a permanently restored surface of an adjacent tooth
            iii. existing restoration may not include cuspal coverage or replacement
            iv. a picture of the existing restoration must be submitted with the radiographs for acceptance and grading.
            v. existing defective restorations must be completely removed before submitting the patient to the Evaluation Station for a modification request or evaluation of the completed preparation.
    - There may be a lesion on the proximal surface of the adjacent tooth provided that there is no breakdown of the contact before or during the preparation that would jeopardize proximal contour or contact of the finished restoration.
    - When in maximum intercuspation, the selected tooth must be in occlusion with an opposing tooth or teeth. Those opposing tooth/teeth may be natural dentition, a fixed bridge, or any artificial replacement thereof with cusp to fossa relationship. Crossbite occlusion that exhibits cusp to fossa relationship is acceptable.
    - An MOD Treatment selection that presents with only one qualifying proximal surface is acceptable:
        - Proximal contact that is visible radiographically is acceptable.
        - If the non-qualifying proximal surface is adjacent to a temporary material, that proximal surface should be restored to proper contour and/or contact
        - If the non-qualifying proximal surface demonstrates an open contact, that proximal surface should be restored to proper contour

- If caries dictates modifying a two surface preparation to a three surface preparation, the modified proximal surface, regardless of contact or contour, must be restored to proper contour and/or contact

2. Pre-existing restorations and any underlying liner must be entirely removed and the preparation must demonstrate acceptable principles of cavity preparation. A MOD treatment selection must have at least one proximal contact to be restored. In the event of a defect ***that would qualify as an acceptable lesion*** on the opposite proximal surface from the qualifying surface, the treatment plan must be a MOD unless there is an intact transverse or oblique ridge.
3. Proximal contact is a critical part of the evaluation and the candidate should be aware that the examiners will be checking the contact visually and with approved, standardized dental floss. Field trials have indicated that most amalgams can withstand floss being passed through the contact within 30 minutes after the matrix band has been removed. For either procedure, the candidate should be familiar with the properties of the material being used, and should be sure to allow sufficient time for any material requirements (i.e. amalgam set time) before sending the finished restoration to the Evaluation Station.
4. Slot Preparations are an acceptable treatment selection for the Class II Restorative Procedures if they meet the above and the following criteria:
    a. The occlusal grooves cannot be carious. The occlusal surface cannot have a cavitation or exhibit shadowing under the enamel surface.
        i. Grooves which are stained are not considered carious and can qualify for a slot preparation.
    b. There cannot be an existing occlusal restoration or sealant.
    c. Any tooth may have an existing restoration or lesion on the opposite surface if the oblique/transverse ridge remains intact. This includes mesial restorations on mandibular 1st premolars.
    d. If, upon preparation, it becomes evident that the occlusal grooves are carious or exhibit uncoalesced enamel contiguous with the preparation, a modification request to extend to include the occlusal surface is required. Extension to include the occlusal grooves without a modification request will be considered preparation of the wrong surface and will result in the failure of the Restorative Procedures
    e. **It is the candidates responsibility to check with the State Board for licensure regarding their statute/rules for this procedure as not all State Boards allow a slot preparation for licensure.**
    f. Please obtain a sticker from a CFE at Treatment Selection approval to place on the Posterior Composite Progress Sheet if a slot preparation is planned.
        i. Should the lesion require a Class II Posterior Composite be placed, the CFE will place another sticker over the "Slot" sticker for submission to the evaluation area.
5. A developed and mounted post-operative bitewing may be requested at any time at the discretion of a Restorative Examiner or Clinic Floor Examiner.
6. The candidate must decide if a treatment **liner** is indicated prior to sending the patient to the Evaluation Station for the preparation check. If a liner is to be placed, the candidate must indicate the placement of a liner in the Notes to Examiners section of the appropriate Progress Form & contact a CFE.

    In some instances, examiners may request that the candidate place a liner via an Instruction to Candidate form, but the candidate incurs no penalty for not requesting a liner. If the candidate has been directed to place a liner via an Instruction to Candidate form, the placement of the liner must be checked by the CFE.

a. Definition of Bases and Liners

i. Cavity Sealers**:** provide a protective coating for freshly cut tooth structure of the prepared cavity.

ii. Cavity Liners: Resin or cement coating of minimal thickness (usually less than 0.5 mm) to achieve a physical barrier and/or therapeutic effect (a chemical effect that in some way benefits the health of the tooth pulp). Examples include Dycal, Life, Cavitec, Hydroxyline, Vitrebond, and Fuji Lining LC.

iii. Cavity Bases: A replacement material for missing dentinal tooth structure, used for bulk buildup and/or for blocking out undercuts.

b. PLACEMENT CRITERIA

i. The liner must be placed only in those pulpal and/or axial wall areas that deviate from established ideal depth.

ii. The liner must not be placed on enamel or within 1.0 mm of any cavosurface margin.

iii. The liner must not compromise the internal retentive and resistant features of the cavity preparation.

iv. The liner must not be subject to dislodgment during placement of the permanent restoration.

v. Placement must reflect consideration of limitations of the materials used.

INDIRECT PULP CAP

1. At least one Modification Request to remove decay must be granted and completed prior to requesting placement of an indirect pulp cap
2. All decay must be removed except the area of imminent pulp exposure
3. Ask for an indirect pulp cap by using Modification Request form:
    a. What: Indirect pulp cap
    b. Where: *indicate location*
    c. Why: to prevent frank pulp exposure
    d. No other Modification Requests can be included with this request
4. Request is either approved or denied by the Express Chair
    a. If the Request is denied the penalties may be issued and the candidate will receive a notice that the request has been denied.
    b. If the Request is approved, the candidate will receive an Instruction to Candidate form with instructions to place an indirect pulp cap
    c. The completion of the procedure is managed by CFE's on the floor, any unsatisfactory results will be sent back to Express Chair
5. If a requested indirect pulp cap is approved, no further exploration or modification can occur to any part of the preparation and once placed, checked/approved by a CFE, the preparation must be immediately sent to the evaluation area for final evaluation.
6. Placement of an indirect pulp cap without submission of a prior Modification Request to remove decay will result in failure of the examination.

Requirements Specific to the Restorative Examination- Class III Composite Procedure

1. The composite must be a Class III restoration. The tooth selected for the composite restoration must be a permanent anterior tooth that meets the following requirements:
    - at least one proximal primary carious lesion which shows no signs of previous excavation and radiographically or clinically appears to extend at least to the DEJ (*see illustrations under the posterior procedure requirements).*
    - a defective existing restoration is present
        - defined as one which exhibits recurrent caries that is radiographically visible or detectable clinically with an explorer.
        - a picture printed on photo paper of the existing restoration must be submitted with the radiographs for acceptance and grading.
        - existing defective restorations must be completely removed before submitting the patient to the Evaluation Station for a modification request or evaluation of the completed preparation.
    - visually closed contact with the adjacent tooth on the proximal surface to be restored, although the area to be restored may or may not be in contact.
    - The approximating contact of the adjacent tooth must be natural tooth structure or restored with a permanent restoration.
    - There may be a lesion on the proximal surface of the adjacent tooth provided that there is no breakdown of the contact before or during the preparation that would jeopardize proximal contour or contact of the finished restoration.
        - Occlusion may or may not be present.
        - Single-sided (mesial/distal) restorations are acceptable.

2. Surface sealants will not be placed on the finished composite restoration.

3. Lesions which may initially be described as Class IV will not be accepted. However, Class III lesions that may require modifications resulting in Class IV restorations are acceptable.

4. Proximal contact is a critical part of the evaluation and the candidate should be aware that the examiners will be checking the contact with approved standardized dental floss provided by CRDTS.

   It is recommended that all wedges be removed ***well before*** the finished restoration is submitted to the Evaluation station. A developed and mounted post-operative bitewing may be requested at any time at the discretion of a Restorative Examiner or Clinic Floor Examiner.

AMALGAM PREPARATION
External Outline Form

PROXIMAL CLEARANCE

SAT	Contact is visibly open proximally.
ACC	Proximal contact is visibly open, and proximal clearance at the height of contour extends beyond 0.5 mm but not more than 1.0 mm on either one or both proximal walls.
SUB	Proximal contact is [_] not visually open; or proximal clearance at the height of contour [_] extends beyond 1.0 mm but not more than 2.0 mm on either one or both proximal walls.
DEF	The proximal clearance at the height of contour extends beyond 2.0 mm on either one or both proximal walls.

GINGIVAL CLEARANCE

SAT	Contact is open gingivally up to 0.5 mm.
ACC	The gingival clearance is greater than 0.5 mm but not greater than 2.0 mm.
SUB	The gingival clearance is greater than 2.0 mm but not more than 3.0 mm, or is not open.
DEF	The gingival clearance is greater than 3.0 mm.

OUTLINE SHAPE/CONTINUITY/EXTENSION

SAT	The outline form includes all carious and non-coalesced fissures.
SUB	The outline form is inappropriately overextended so that it compromises the remaining marginal ridge and/or cusp(s). The outline form is underextended and non-coalesced fissure(s) remain which extend to the DEJ and are contiguous with the outline form.
DEF	The outline form is overextended so that it compromises, undermines and leaves unsupported the remaining marginal ridge to the extent that the pulpal-occlusal wall is unsupported by dentin or the width of the marginal ridge is 1 mm or less.

ISTHMUS

SAT	The isthmus must be 1-2 mm wide, but not more than ¼ the intercuspal width of the tooth.
ACC	The isthmus is more than ¼ and not more than 1/3 the intercuspal width.
SUB	The isthmus is more than 1/3 and not more than ½ the intercuspal width.
DEF	The isthmus is greater than ½ the intercuspal width or less than 1 mm.

CAVOSURFACE MARGIN

SAT	The external cavosurface margin meets the enamel at 90°. There are no gingival bevels. The proximal gingival point angles may be rounded or sharp.
ACC	The proximal cavosurface margin deviates from 90°, but is unlikely to jeopardize the longevity of the tooth or restoration; this would include small areas of unsupported enamel.
SUB	The proximal cavosurface margin deviates from 90° and is likely to jeopardize the longevity of the tooth or restoration. This would include unsupported enamel and/or excessive bevel(s).

SOUND MARGINAL TOOTH STRUCTURE

SAT	The cavosurface margin terminates in sound natural tooth structure. There is no previous restorative material , including sealants, at the cavosurface margin. There is no decalcification on the gingival margin.
SUB	The cavosurface margin does not terminate in sound natural tooth structure; or, there is explorer penetrable decalcification remaining on any cavosurface margin, or the cavosurface margin terminates in a previously placed pit and fissure sealant.

AMALGAM PREPARATION
Internal Form

AXIAL WALLS

SAT	The axial wall follows the external contours of the tooth, and is entirely in dentin, .5 mm from the DEJ.
ACC	The depth of the axial wall is .5 mm to 1.5 mm beyond the DEJ.
SUB	The axial wall is more than 1.5 mm beyond the DEJ, but no more than 2.5 mm or the axial wall depth does not include the DEJ.
DEF	The axial wall is [_] more than 2.5 mm beyond the DEJ or [_] there is no gingival floor.

PULPAL FLOOR

SAT	The pulpal floor is optimally 1.5 to 2.0 mm from the cavosurface margin at its shallowest point.
SUB	The pulpal floor is less than 1.5 mm at its shallowest point or greater than 2.0 mm but not greater than 3.0 mm from the cavosurface margin.
DEF	The pulpal floor is more than 3.0 mm from the cavosurface margin or is 0.5 mm or less at its shallowest point.

PULPAL-AXIAL LINE ANGLE

SAT	The pulpal-axial line angle is rounded.
SUB	The pulpal-axial line angle is sharp.

CARIES/REMAINING MATERIAL

SAT	All caries and/or previous restorative material are removed.
DEF	Caries or previous restorative material remains in the preparation or preparation is not extended to include caries.

PROXIMAL BOX WALLS

SAT	The walls of the proximal box should be convergent occlusally and meet the external surface at a 90º angle.
ACC	The walls of the proximal box are parallel, but appropriate internal retention is present.
DEF	The walls of the proximal box diverge occlusally which offers no retention and will jeopardize the longevity of the tooth or restoration.

PREPARED SURFACES

SAT	All prepared surfaces are smooth and well-defined, and the gingival floor is perpendicular to the long axis of the tooth.
SUB	The prepared surfaces are irregular or ill-defined.

AMALGAM PREPARATION
Critical Errors

Wrong Tooth/Surface Treated
Retention, when used, grossly compromises the tooth or restoration
Unrecognized Exposure
Critical Lack of Clinical Judgment/Diagnostic Skills

AMALGAM FINISHED RESTORATION
Margin Integrity and Surface Finish

MARGIN DEFICIENCY

SAT	There is no marginal deficiency. There is no evidence of voids or open margins.
ACC	There is a detectable marginal deficiency at the restoration-tooth interface either visually or with the tine of an explorer, but it is less than .5 mm.
SUB	The restoration-tooth interface is detectable visually or with the tine of an explorer. There is evidence of marginal deficiency, 0.5 mm but up to 1 mm, which can include pits and voids at the cavosurface margin
DEF	There is evidence of marginal deficiency of more than 1 mm ~~or more~~, to include pits and voids at the cavosurface margin, and/or there is an open margin.

MARGIN EXCESS

SAT	There is no detectable excess at the cavosurface margin either visually or with the tine of an explorer.
ACC	There is a detectable marginal excess at the cavosurface margin either visually or with the tine of an explorer, but it is no greater than 1.0 mm.
SUB	The cavosurface margin is detectable visually or with the tine of an explorer. There is evidence of marginal excess of more than 1.0 mm and up to 2.0 mm.
DEF	There is evidence of marginal excess at the cavosurface margin of more than 2.0 mm.

GINGIVAL OVERHANG

SAT	The restoration exhibits no gingival overhang.
ACC	The restoration exhibits a slight gingival overhang but would not be expected to adversely affect the tissue health.
DEF	The restoration exhibits a significant gingival overhang and would be expected to adversely affect the tissue health.

SURFACE FINISH

SAT	The surface of the restoration is uniformly smooth and free of pits and voids.
ACC	The surface of the restoration is slightly grainy or rough, but it is free of significant pits and voids.
SUB	The surface of the restoration is rough and exhibits surface significant irregularities, pits or voids.

CONTIGUOUS TOOTH STRUCTURE

SAT	There is no evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration.
ACC	There is minimal evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration. (Enameloplasty)
SUB	There is evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration. (Enameloplasty)
DEF	There is gross enameloplasty resulting in the exposure of dentin.

AMALGAM FINISHED RESTORATION
Contour, Contact and Occlusion

INTERPROXIMAL CONTACT

SAT	Interproximal contact is present, the contact is visually closed and is properly shaped and positioned; and there is definite, but not excessive, resistance to dental floss when passed through the interproximal contact area.
ACC	Interproximal contact is visually closed, and the contact is adequate in size, shape, or position but demonstrates little resistance to dental floss.
SUB	Interproximal contact is visually closed, but the contact is deficient in size, shape, or position and demonstrates little resistance to dental floss or shreds the floss.
DEF	The interproximal contact is visually open or will not allow floss to pass through the contact area.

CENTRIC/EXCURSIVE CONTACTS

SAT	When checked with articulating ribbon or paper, all centric and excursive contacts on the restoration are consistent in size, shape and intensity with such contacts on other teeth, in that quadrant.
SUB	When checked with articulating ribbon or paper, the restoration is in hyper-occlusion inconsistent in size, shape and intensity with the occlusal contacts on surrounding teeth, and requires adjustment.
DEF	There is gross hyperocclusion so that the restoration is the only point of occlusion in that quadrant.

ANATOMY/CONTOUR

SAT	The restoration reproduces the normal physiological proximal contours of the tooth, occlusal and marginal ridge anatomy.
ACC	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, but would not be expected to adversely affect the tissue health.
DEF	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, and would be expected to adversely affect the tissue health.

AMALGAM FINISHED RESTORATION
Critical Errors

Fractured Restoration

POSTERIOR COMPOSITE PREPARATION

External Outline Form

PROXIMAL CLEARANCE

SAT	Proximal contact is visibly open up to 0.5 mm.
ACC	Proximal contact is visibly open, and proximal clearance at the height of contour extends beyond 0.5 mm but not more than 1.0 mm on either one or both proximal walls.
SUB	Proximal contact is [_] not visually open; or proximal clearance at the height of contour [_] extends beyond 1.0 mm but not more than 2.0 mm on either one or both proximal walls.
DEF	The proximal clearance at the height of contour extends beyond 2.0 mm on either one or both proximal walls.

GINGIVAL CLEARANCE

SAT	Contact is open gingivally up to 0.5 mm.
ACC	The gingival clearance is greater than 0.5 mm but not greater than 2.0 mm.
SUB	The gingival clearance is greater than 2.0 mm but not more than 3.0 mm, or is not open.
DEF	The gingival clearance is greater than 3.0 mm.

OUTLINE SHAPE/CONTINUITY/EXTENSION

SAT	The outline form includes all carious and non-coalesced fissures, and is smooth, rounded and flowing with no sharp curves or angles.
SUB	The outline form is inappropriately overextended so that it compromises the remaining marginal ridge and/or cusp(s). The outline form is underextended and non-coalesced fissure(s) remain which extend to the DEJ and are contiguous with the outline form.
DEF	The outline form is overextended so that it compromises, undermines and leaves unsupported the remaining marginal ridge to the extent that the cavosurface margin is unsupported by dentin or the width of the marginal ridge is 1.0 mm or less.

ISTHMUS

SAT	The isthmus may be up to 2 mm wide, but not more than ¼ the intercuspal width of the tooth.
ACC	The isthmus is more than ¼ and not more than 1/3 the intercuspal width.
SUB	The isthmus is more than 1/3 and not more than ½ the intercuspal width
DEF	The isthmus is greater than ½ the intercuspal width.

CAVOSURFACE MARGIN

SAT	The external cavosurface margin meets the enamel at 90o.
SUB	The proximal cavosurface margin deviates from 90o and is likely to jeopardize the longevity of the tooth or restoration. This would include unsupported enamel and/or excessive bevel(s).

SOUND MARGINAL TOOTH STRUCTURE

SAT	The cavosurface margin terminates in sound natural tooth structure. There is no previous restorative material , including sealants, at the cavosurface margin. There is no decalcification on the gingival margin.
SUB	The cavosurface margin does not terminate in sound natural tooth structure; or, there is explorer penetrable decalcification remaining on any cavosurface margin, or the cavosurface margin terminates in a previously placed pit and fissure sealant.

POSTERIOR COMPOSITE PREPARATION
Internal Form

AXIAL WALLS

SAT	The axial wall follows the external contours of the tooth, and is entirely in dentin, .5 mm from the DEJ.
ACC	The depth of the axial wall is .5 mm to 1.5 mm beyond the DEJ.
SUB	The axial wall is [_] more than 1.5 mm beyond the DEJ, but no more than 2.5 mm or the axial wall depth does not include the DEJ.
DEF	The axial wall is more than 2.5 mm beyond the DEJ or [_] there is no gingival floor.

PULPAL FLOOR

SAT	The pulpal floor depth must be at 1.5—2.0 mm in all areas; there may be remaining enamel.
SUB	The pulpal floor depth is greater than 0.5 mm but less than 1.5 mm or up to 3.0 mm.
DEF	The pulpal floor is [_] less than 0.5 mm or [_] is more than 3.0 mm from the cavosurface margin.

CARIES/REMAINING MATERIAL

SAT	All caries and/or previous restorative material are removed.
DEF	Caries or previous restorative material remains in the preparation or preparation is not extended to include caries.

PROXIMAL BOX WALLS

SAT	The walls of the proximal box should be parallel or converge occlusally.
SUB	The walls of the proximal box are divergent.
DEF	The walls of the proximal box are grossly [_] convergent so that the buccal-lingual gingival floor width is > than 2 times the buccal-lingual width of the occlusal access or [_] divergent so that the occlusal access is > two times the width of the buccal-lingual gingival floor.

PREPARED SURFACES

SAT	All prepared surfaces are smooth and well-defined, and the gingival floor is perpendicular to the long axis of the tooth.
SUB	The prepared surfaces are irregular or ill-defined.

POSTERIOR COMPOSITE PREPARATION
Critical Errors

Wrong Tooth/Surface Treated
Unrecognized Exposure
Critical Lack of Clinical Judgment/Diagnostic Skills

POSTERIOR COMPOSITE FINISHED RESTORATION
Margin Integrity and Surface Finish

MARGIN DEFICIENCY

SAT	There is no marginal deficiency. There is no evidence of voids or open margins.
ACC	There is a detectable marginal deficiency at the restoration-tooth interface either visually or with the tine of an explorer, but it is less than .5 mm.
SUB	The restoration-tooth interface is detectable visually or with the tine of an explorer. There is evidence of marginal deficiency, 0.5 mm up to 1 mm, which can include pits and voids at the cavosurface margin
DEF	There is evidence of marginal deficiency of more than 1 mm to include pits and voids at the cavosurface margin, and/or there is an open margin.

MARGIN EXCESS

SAT	There is no detectable marginal excess at the cavosurface margin either visually or with the tine of an explorer.
ACC	There is a detectable marginal excess at the cavosurface margin either visually or with the tine of an explorer, but it is no greater than 1.0 mm.
SUB	The cavosurface margin is detectable visually or with the tine of an explorer. There is evidence of marginal excess of more than 1.0 mm and up to 2.0 mm.
DEF	There is evidence of marginal excess at the cavosurface margin of more than 2.0 mm.

GINGIVAL OVERHANG

SAT	The restoration exhibits no gingival overhang.
ACC	The restoration exhibits a slight gingival overhang but would not be expected to adversely affect the tissue health.
DEF	The restoration exhibits a significant gingival overhang and would be expected to adversely affect the tissue health.

SURFACE FINISH

SAT	The surface of the restoration is uniformly smooth and free of pits and voids.
ACC	The surface of the restoration is slightly grainy or rough, but it is free of significant pits and voids.
SUB	The surface of the restoration is rough and exhibits surface significant irregularities, pits or voids.

CONTIGUOUS TOOTH STRUCTURE

SAT	There is no evidence of unwarranted or unnecessary removal or recontouring of tooth structure contiguous to the restoration. (Enameloplasty)
ACC	There is minimal evidence of unwarranted or unnecessary removal, or recontouring of tooth structure contiguous to the restoration. (Enameloplasty) Excess present that is not contiguous with the restoration no greater than 0.5mm.
SUB	There is evidence of unwarranted or unnecessary removal or recontouring of tooth structure contiguous to the restoration. (Enameloplasty) Excess present that is not contiguous with the restoration greater than 0.5mm.
DEF	There is gross enameloplasty resulting in the exposure of dentin.

POSTERIOR COMPOSITE FINISHED RESTORATION
Contour, Contact and Occlusion

INTERPROXIMAL CONTACT

SAT	Interproximal contact is present, the contact is visually closed and is properly shaped and positioned; and there is definite, but not excessive, resistance to dental floss when passed through the interproximal contact area.
ACC	Interproximal contact is visually closed, and the contact is adequate in size, shape, or position but demonstrates little resistance to dental floss.
SUB	Interproximal contact is visually closed, but the contact is deficient in size, shape, or position and demonstrates little resistance to dental floss or shreds the floss.
DEF	The interproximal contact is visually open or will not allow floss to pass through the contact area.

CENTRIC/EXCURSIVE CONTACTS

SAT	When checked with articulating ribbon or paper, all centric and excursive contacts on the restoration are consistent in size, shape and intensity with such contacts on other teeth, in that quadrant.
SUB	When checked with articulating ribbon or paper, the restoration is in hyper-occlusion inconsistent in size, shape and intensity with the occlusal contacts on surrounding teeth, and requires adjustment.
DEF	There is gross hyperocclusion so that the restoration is the only point of occlusion in that quadrant.

ANATOMY/CONTOUR

SAT	The restoration reproduces the normal physiological proximal contours of the tooth, occlusal and marginal ridge anatomy.
ACC	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, but would not be expected to adversely affect the tissue health.
DEF	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, and would be expected to adversely affect the tissue health.

POSTERIOR COMPOSITE FINISHED RESTORATION
Critical Errors

Fractured Restoration
The restoration is debonded and/or movable in the preparation.

POSTERIOR COMPOSITE SLOT PREPARATION

External Outline Form

PROXIMAL CLEARANCE

SAT	Proximal contact is visibly open up to 0.5 mm.
ACC	Proximal contact is visibly open, and proximal clearance at the height of contour extends beyond 0.5 mm but not more than 1.0 mm on either one or both proximal walls.
SUB	Proximal contact is [_] not visually open; or proximal clearance at the height of contour [_] extends beyond 1.0 mm but not more than 2.0 mm on either one or both proximal walls.
DEF	The proximal clearance at the height of contour extends beyond 2.0 mm on either one or both proximal walls.

GINGIVAL CLEARANCE

SAT	Contact is open gingivally up to 0.5 mm.
ACC	The gingival clearance is greater than 0.5 mm but not greater than 2.0 mm.
SUB	The gingival clearance is greater than 2.0 mm but not more than 3.0 mm, or is not open.
DEF	The gingival clearance is greater than 3.0 mm.

OUTLINE SHAPE/CONTINUITY/EXTENSION

SAT	The outline form is smooth, rounded and flowing with no sharp curves or angles.
DEF	The outline form is [_] underextended and non-coalesced fissure(s) remain which extend to the DEJ and are contiguous with the outline form. [ ] The outline at the occlusal surface is overextended and extends past the triangular fossa

CAVOSURFACE MARGIN

SAT	The external cavosurface margin meets the enamel at 90o.
SUB	The proximal cavosurface margin deviates from 90o and is likely to jeopardize the longevity of the tooth or restoration. This would include unsupported enamel and/or excessive bevel(s).

SOUND MARGINAL TOOTH STRUCTURE

SAT	The cavosurface margin terminates in sound natural tooth structure. There is no decalcification on any cavosurface margin
SUB	The [_]cavosurface margin does not terminate in sound natural tooth structure; or, there is [_] explorer penetrable decalcification remaining on any cavosurface margin

POSTERIOR COMPOSITE SLOT PREPARATION
Internal Form

AXIAL WALLS

SAT	The axial wall follows the external contours of the tooth, and is entirely in dentin, .5 mm from the DEJ.
ACC	The depth of the axial wall is .5 mm to 1.5 mm beyond the DEJ.
SUB	The axial wall is [_] more than 1.5 mm beyond the DEJ, but no more than 2.5 mm or the axial wall depth does not include the DEJ.
DEF	The axial wall is more than 2.5 mm beyond the DEJ or [_] there is no gingival floor.

CARIES/REMAINING MATERIAL

SAT	All caries and/or previous restorative material are removed.
DEF	Caries or previous restorative material remains in the preparation or preparation is not extended to include caries.

PROXIMAL BOX WALLS

SAT	The walls of the proximal box should be parallel or converge occlusally.
SUB	The walls of the proximal box are divergent.
DEF	The walls of the proximal box are grossly [_] convergent so that the buccal-lingual gingival floor width is > than 2 times the buccal-lingual width of the occlusal access or [_] divergent so that the occlusal access is > two times the width of the buccal-lingual gingival floor.

PREPARED SURFACES

SAT	All prepared surfaces are smooth and well-defined, and the gingival floor is perpendicular to the long axis of the tooth.
SUB	The prepared surfaces are irregular or ill-defined.

POSTERIOR COMPOSITE SLOT PREPARATION
Critical Errors

Wrong Tooth/Surface Treated
Unrecognized Exposure
Critical Lack of Clinical Judgment/Diagnostic Skills

POSTERIOR COMPOSITE SLOT RESTORATION
Margin Integrity and Surface Finish

MARGIN DEFICIENCY

SAT	There is no marginal deficiency. There is no evidence of voids or open margins.
ACC	There is a detectable marginal deficiency at the restoration-tooth interface either visually or with the tine of an explorer, but it is less than .5 mm.
SUB	The restoration-tooth interface is detectable visually or with the tine of an explorer. There is evidence of marginal deficiency, 0.5 mm up to 1 mm, which can include pits and voids at the cavosurface margin
DEF	There is evidence of marginal deficiency of more than 1 mm, to include pits and voids at the cavosurface margin, and/or there is an open margin.

MARGIN EXCESS

SAT	There is no detectable marginal excess at the cavosurface margin either visually or with the tine of an explorer.
ACC	There is a detectable marginal excess at the cavosurface margin either visually or with the tine of an explorer, but it is no greater than 1.0 mm.
SUB	The cavosurface margin is detectable visually or with the tine of an explorer. There is evidence of marginal excess of more than 1.0 mm and up to 2.0 mm.
DEF	There is evidence of marginal excess at the cavosurface margin of more than 2.0 mm.

GINGIVAL OVERHANG

SAT	The restoration exhibits no gingival overhang.
ACC	The restoration exhibits a slight gingival overhang but would not be expected to adversely affect the tissue health.
DEF	The restoration exhibits a significant gingival overhang and would be expected to adversely affect the tissue health.

SURFACE FINISH

SAT	The surface of the restoration is uniformly smooth and free of pits and voids.
ACC	The surface of the restoration is slightly grainy or rough, but it is free of significant pits and voids.
SUB	The surface of the restoration is rough and exhibits surface significant irregularities, pits or voids.

CONTIGUOUS TOOTH STRUCTURE

SAT	There is no evidence of unwarranted or unnecessary removal or recontouring of tooth structure contiguous to the restoration. (Enameloplasty)
ACC	There is minimal evidence of unwarranted or unnecessary removal, or recontouring of tooth structure contiguous to the restoration. (Enameloplasty) Excess present that is not contiguous with the restoration no greater than 0.5mm.
SUB	There is evidence of unwarranted or unnecessary removal or recontouring of tooth structure contiguous to the restoration. (Enameloplasty) Excess present that is not contiguous with the restoration greater than 0.5mm.
DEF	There is gross enameloplasty resulting in the exposure of dentin.

POSTERIOR COMPOSITE SLOT RESTORATION
Contour, Contact and Occlusion

INTERPROXIMAL CONTACT

SAT	Interproximal contact is present, the contact is visually closed and is properly shaped and positioned; and there is definite, but not excessive, resistance to dental floss when passed through the interproximal contact area.
ACC	Interproximal contact is visually closed, and the contact is adequate in size, shape, or position but demonstrates little resistance to dental floss.
SUB	Interproximal contact is visually closed, but the contact is deficient in size, shape, or position and demonstrates little resistance to dental floss or shreds the floss.
DEF	The interproximal contact is visually open or will not allow floss to pass through the contact area.

CENTRIC/EXCURSIVE CONTACTS

SAT	When checked with articulating ribbon or paper, all centric and excursive contacts on the restoration are consistent in size, shape and intensity with such contacts on other teeth, in that quadrant.
SUB	When checked with articulating ribbon or paper, the restoration is in hyper-occlusion inconsistent in size, shape and intensity with the occlusal contacts on surrounding teeth, and requires adjustment.
DEF	There is gross hyperocclusion so that the restoration is the only point of occlusion in that quadrant.

ANATOMY/CONTOUR

SAT	The restoration reproduces the normal physiological proximal contours of the tooth, occlusal and marginal ridge anatomy.
ACC	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, but would not be expected to adversely affect the tissue health.
DEF	The restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, and would be expected to adversely affect the tissue health.

POSTERIOR COMPOSITE SLOT RESTORATION
Critical Errors

Fractured Restoration
The restoration is debonded and/or movable in the preparation.

ANTERIOR CLASS III COMPOSITE PREPARATION
External Outline Form

OUTLINE EXTENSION

SAT	Outline form provides adequate access for complete removal of caries and/or previous restorative material and insertion of composite resin. Access entry is appropriate to the location of caries and tooth position. If a lingual approach is initiated, facial contact may or may not be broken as long as the margin terminates in sound tooth structure.
ACC	The wall opposite the access, if broken, may extend no more than 1.0 mm beyond the contact area. The outline form is overextended mesiodistally 0.5-1 mm beyond what is necessary for complete removal of caries and/or previous restorative material.
SUB	The outline form is underextended making caries removal or insertion of restorative material questionable. The outline form is overextended mesiodistally more than 1mm, but no more than 2 mm beyond what is necessary for complete removal of caries and/or previous restorative material. The incisal cavosurface margin is overextended so that the integrity of the incisal angle is compromised. The wall opposite the access opening extends more than 1 mm beyond the contact area.
DEF	The outline form is underextended making it impossible to manipulate and finish the restorative material. The outline form is overextended mesiodistally more than 2.0 mm beyond what is necessary for complete removal of caries and/or previous restorative material. The incisal cavosurface margin is overextended so that the incisal angle is removed or fractured. A Class IV restoration is now necessary without justification. The wall opposite the access opening extends more than 2.5 mm beyond the contact area.

GINGIVAL CONTACT BROKEN

SAT	The gingival contact must be broken. The incisal contact need not be broken, unless indicated by the location of the caries.
ACC	The gingival clearance does not exceed 1.5 mm.
SUB	The gingival clearance is greater than 1.5 mm. The gingival contact is not visibly broken.
DEF	The gingival clearance is greater than 2.0 mm.

MARGIN SMOOTHNESS/CONTINUITY/BEVELS

SAT	Cavosurface margins form a smooth continuous curve with no sharp angles. Enamel cavosurface margins may be beveled.
ACC	The cavosurface margins are slightly irregular. Enamel cavosurface margin bevels, if present, do not exceed 1.0 mm in width.
SUB	The cavosurface margin is rough and severely irregular. Enamel cavosurface margin bevels, if present, exceed 1.0 mm in width, are not uniform or are inappropriate for the size of the restoration.

SOUND MARGINAL TOOTH STRUCTURE

SAT	The cavosurface margin terminates in sound natural tooth structure. There is no previous restorative material, including sealants, at the cavosurface margin. All unsupported enamel is removed unless it compromises facial esthetics.
ACC	There is a small area of unsupported enamel which is not necessary to preserve facial esthetics.
SUB	There are large or multiple areas of unsupported enamel which are not necessary to preserve facial esthetics. The cavosurface margin does not terminate in sound natural tooth structure; or, the cavosurface margin terminates in previous restorative material.

ANTERIOR CLASS III COMPOSITE PREPARATION
Internal Form

AXIAL WALLS

SAT	The axial wall follows the external contours of the tooth and the depth does not exceed .5 mm beyond the DEJ.
ACC	The depth of the axial wall is no more than 1.5 mm beyond the DEJ.
SUB	The axial wall is more than 1.5 mm beyond the DEJ.
DEF	The axial wall is more than 2.5 mm beyond the DEJ.

INTERNAL RETENTION

SAT	If used, rounded internal retention is placed in the dentin of the gingival and incisal walls just axial to the DEJ as dictated by cavity form. Retention is tactilely and visually present.
SUB	When used, retention is excessive and undermines enamel or jeopardizes the incisal angle or encroaches on the pulp.

CARIES/REMAINING MATERIAL

SAT	All caries and/or previous restorative material are removed.
DEF	Caries or previous restorative material remains in the preparation or preparation is not extended to include caries.

ANTERIOR COMPOSITE PREPARATION
Critical Errors

Wrong Tooth/Surface Treated
Unrecognized Exposure
Critical Lack of Clinical Judgment/Diagnostic Skills

ANTERIOR CLASS III COMPOSITE FINISHED RESTORATION
Margin Integrity and Surface Finish

MARGIN DEFICIENCY

SAT	There is no marginal deficiency. No marginal deficiency is detectable at the restoration-tooth interface either visually or with the tine of an explorer. There is no evidence of voids or open margins.
ACC	There is a detectable marginal deficiency at the facial or lingual restoration-tooth interface either visually or with the tine of an explorer, but it is less than .5 mm.
SUB	The restoration-tooth interface is detectable visually or with the tine of an explorer. There is evidence of marginal deficiency, 0.5 mm up to 1 mm, which can include pits and voids at the cavosurface margin
DEF	There is evidence of marginal deficiency of more than 1 mm, to include pits and voids at the cavosurface margin, and/or there is an open margin.

MARGIN EXCESS

SAT	No marginal excess is detectable at the cavosurface margin either visually or with the tine of an explorer.	No marg explorer.
ACC	There is a detectable marginal excess at the cavosurface margin either visually or with the tine of an explorer, but it is no greater than 1.0 mm..	There is an explo
SUB	The cavosurface margin is detectable visually or with the tine of an explorer. There is evidence of lingual marginal excess, more than 1.0 mm and up to 2 mm. There is facial and/or lingual flash with contamination underneath, but it is not internal to the cavosurface margin, and could be removed by polishing or finishing.	The lingu lingual m contamin polishing
DEF	There is evidence of marginal excess at the cavosurface margin of more than 2 mm, and/or there is internal contamination at the facial and/or lingual interface between the restoration and the tooth.	There is is interna

INGIVAL OVERHANG

SAT	The restoration exhibits no gingival overhang.
ACC	The restoration exhibits a slight gingival overhang but would not be expected to adversely affect the tissue health.
DEF	The restoration exhibits a significant gingival overhang and would be expected to adversely affect the tissue health.

SURFACE FINISH

SAT	The surface of the restoration is uniformly smooth and free of pits and voids.
ACC	The surface of the restoration is slightly grainy or rough, but it is free of significant pits and voids.
SUB	The surface of the restoration is rough and exhibits surface significant irregularities, pits or voids.

CONTIGUOUS TOOTH STRUCTURE

SAT	There is no evidence of unwarranted or unnecessary removal or recontouring of tooth structure contiguous to the restoration.
ACC	There is minimal evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure contiguous to the restoration. (Enameloplasty) Excess present that is not contiguous with the restoration no greater than 0.5mm.
SUB	There is evidence of unwarranted or unnecessary removal or recontouring of tooth structure contiguous to the restoration. (Enameloplasty) Excess present that is not contiguous with the restoration greater than 0.5mm.
DEF	There is gross enameloplasty resulting in the exposure of dentin.

SHADE SELECTION

SAT	The shade of the restoration blends with the surrounding tooth structure.
SUB	The shade of the restoration contrasts markedly with the surrounding tooth structure.

ANTERIOR CLASS III COMPOSITE FINISHED RESTORATION
Contour, Contact and Occlusion

INTERPROXIMAL CONTACT

SAT	Interproximal contact is present, the contact is visually closed and is properly shaped and positioned; and there is definite, but not excessive, resistance to dental floss when passed through the interproximal contact area.
ACC	Interproximal contact is visually closed, and the contact is adequate in size, shape, or position but demonstrates little resistance to dental floss.
SUB	Interproximal contact is visually closed, but the contact is deficient in size, shape, or position and/or demonstrates little resistance to dental floss, shreds the floss or is visually open but deflects floss.
DEF	The interproximal contact allows standardized dental floss to pass without deflection or resistance or will not allow dental floss to pass through the contact area.

CENTRIC/EXCURSIVE CONTACTS

SAT	When checked with articulating ribbon or paper, all centric and excursive contacts on the restoration are consistent in size, shape and intensity with such contacts on other teeth, in that quadrant.
SUB	When checked with articulating ribbon or paper, the restoration is in hyper-occlusion inconsistent in size, shape and intensity with the occlusal contacts on surrounding teeth, and requires adjustment.
DEF	There is gross hyperocclusion so that the restoration is the only point of occlusion in that quadrant.

ANATOMY/CONTOUR

SAT	The restoration reproduces the normal anatomical contours of the tooth, including facial, lingual, proximal and marginal ridge anatomy when compared to contiguous tooth structure.
ACC	The restoration deviates slightly from the normal anatomical contours of the tooth, when compared to contiguous tooth structure but would not be expected to adversely affect the tissue health.
DEF	The restoration deviates significantly from the normal anatomical contours of the tooth, including facial, lingual, proximal or marginal ridge anatomy, and/or would be expected to adversely affect the tissue health.

ANTERIOR COMPOSITE RESTORATION
Critical Errors

Restoration is debonded.

RESTORATIVE PROCEDURES
Treatment Management
Penalty Points <u>Only</u>

CONDITION OF ADJACENT TEETH

SAT	The adjacent teeth and/or restorations are free from damage.
ACC	Damage to adjacent tooth/teeth can be removed with polishing without adversely altering the shape of the contour and/or contact.
SUB	Damage to adjacent tooth/teeth requires recontouring which changes the shape and/or position of the contact.
DEF	There is gross damage to adjacent tooth/teeth which requires a restoration.

CONDITION OF SOFT TISSUE

SAT	The soft tissue is free from damage or there is tissue damage that is consistent with the procedure.
SUB	There is iatrogenic soft tissue damage that is inconsistent with the procedure.
DEF	There is gross iatrogenic damage to the soft tissue inconsistent with the procedure and pre-existing condition of the soft tissue.

EXAMINATION CHECK-OUT

Patient/Candidate Feedback Forms

Candidates and their patients have an opportunity to provide input to CRDTS about the examination. CRDTS wishes to continually improve its examination program, and feedback from the perspective of both candidates and patients is one of the best ways for CRDTS to gather ideas on how to do this. The Feedback Forms for candidates and patients have been included in the candidate's packets. They are not required, and will be collected separately from the candidate's packet to ensure that the candidate's examination results will in no way be affected by any feedback the candidate or the candidate's patients might have. Therefore, CRDTS encourages candidates and patients to complete the forms honestly and thoughtfully before checking out.

Check-Out Procedure

When the candidates are ready to check out, they must go to the examiners' desk and get a clearance check that all procedures are completed or accounted for. The packets may be collected at the desk. The following items must be enclosed **in the candidate's packet envelope:**

1. Pre-operative and post-operative radiographs (if any were requested and returned to the candidate) of teeth restored during the examination must be submitted, clearly marked for identification. (If the testing site requires that radiographs be returned with board patient records, the candidates must submit duplicates of the required radiographs).
2. Completed Progress Forms
3. Identification badge.
4. Consent Forms for each clinical patient
5. Medical History forms for each clinical patient.
5. Testing Site Fee Receipt.

EXAMINATION APPLICATION POLICIES

Qualified candidates may apply to take the examination by submitting an application upon request. Once an application is completed, it is considered a contract with CRDTS. If a candidate fails to fulfill all requirements of the application, or is unable to take the exam, the policies below will apply. Additional portions of the application must be submitted by mail. Detailed information regarding required documents/fees, test sites and examination dates/deadlines are outlined on the CRDTS website and in this Manual. A fully executed application complete with the appropriate documentation and fee is required to take the examination.

Read the entire application form before submitting any information. Be accurate and complete. If directions are not followed, the application may not be accepted.

1. **Application Deadline:** The application deadline is approximately 40 days before the date of the examination. Applications and all documentation must be received on or before the published application deadline date. (See www.crdts.org or inside cover of Manual for exam/deadline dates.)

2. **Social Security Number:** Candidates must enter their US government-issued social security number when applying. Candidates without a social security number must contact CRDTS Central Office. The social security number will remain a part of the candidate's secure record. A 10-digit CRDTS ID number will be assigned, appear on all the candidate's examination forms and become the Username for login to CRDTS website. When logged-in, candidates will be able manage their information and view application documents, examination results. This 10-digit CRDTS ID number will connect the results back to the candidate's permanent record.

3. **Initial Examination/Application Fee**: The appropriate examination fee must be paid at the time of application. ***Payment submitted must be for the exact amount and can be paid online via VISA or Mastercard or be paid by cashier's check or money order with the applicant's CRDTS ID number written in the lower left-hand corner. If paying via credit card, please contact Central Office.*** PERSONAL CHECKS WILL NOT BE ACCEPTED AND WILL BE RETURNED TOGETHER WITH THE APPLICATION TO THE APPLICANT.

   The examination fee is $1700 and includes application for one attempt at the Manikin and Restorative portions of the examination. Specifically, the initial offering of the manikin-based examination and the initial offering of the restorative examination.

4. **Administrative Fee:** An administration fee of $200 is included in all examination fees described herein. This administrative fee is non-refundable and deducted from all returned application fees. Under certain circumstances, an additional administrative fee may be imposed. In such cases the candidate will be notified accordingly.

5. **Site Fee:** The school may charge a site fee/rental fee for use of instruments, clinic facilities, manikin heads, supplies, and disposables. Some sites require that all instruments be supplied by the school. A rental charge or deposit imposed by the testing site must be remitted directly to the school.

   Candidates taking the examination at a school other than their own are encouraged to visit the site prior to the time of the examination to become familiar with the school. It is the responsibility of the candidate to make arrangements with the school for the provision of instruments, radiographic equipment and to ascertain whether the Acadental Typodont will be mounted in a lab or at the operatory chair so that the appropriate equipment for mounting can be available.

6. **Retest Examination Fee**: A Candidate must reapply for each failed and/or incomplete part of the examination. ***A new application and the appropriate fee for each part,*** must be filed for any retest of a failed or incomplete part. Candidates are permitted to apply for only one

examination at a time and may not submit another application until after the results of the prior examination have been distributed. The retake fees are outlined below:

Manikin-based Exams	$850
Patient-based Exam	$850

Maximum ***initial retest*** fee, regardless of the number of Parts candidate is retaking: $1700. Subsequent failures will require appropriate retest fees as specified above.

REQUIRED DOCUMENTATION

After fully executing the application, the following items must be received in CRDTS Central Office prior to the Application Deadline:

1. **Proof of Graduation:**
   a. **Accredited Graduates:** If candidates are taking the examination for the first time, they must present proof of enrollment in or graduation from an accredited dental therapy program. Candidates applying must furnish proof of graduation from an accredited dental therapy program or provide a Letter of Certification (a form provided by CRDTS). The Letter of Certification must be completed by the Dean or Program Director of the school to verify that the candidate has demonstrated sufficient clinical competence, is in good standing, and it is anticipated that all school requirements are current and up to date and the student will be recommended for graduation based on their current standing. Alterations to this letter or misrepresentation of any application requirements may result in elimination of the candidate's application

2. **Social Security Number:** The social security number must be recorded accurately and legibly on the application form. Applications which do not include the social security number will be returned as incomplete. The social security number will be encoded for security purposes, and a new 10-digit number will be generated that will appear on all the candidate's examination forms. When the candidate's examination results are processed, the 10-digit computer number will connect the results back to the candidate's permanent record.

3. **Applicant Certification Sheet:** The Applicant Certification Sheet is available by request.
   a. **2" x 2" Photographs:** Candidates applying must submit and attach two (2) 2"x2" photographs to the Applicant Certification Sheet. Candidates applying to retest must submit and attach (2) 2"x2" photographs to the Applicant Certification Sheet. The photographs MUST BE RECENT and may be in black & white or color.
   b. **Signature of Candidate and Notary:** The Applicant Certification Sheet must be signed by the candidate and dated; a Notary Public must sign, stamp and date the form. Applicant Certification Sheets which are not signed or notarized will be returned to the candidate. This form must be mailed and must be received by CRDTS by the application deadline.

ADMINISTRATIVE POLICIES

Once an application has been received or accepted for examination, the policies described in this section become effective.

1. **Dental Therapy Candidates**

   a. **Site Selection:** The initial offering of these examinations, administered during the Spring testing period will be at select dental therapy schools. Unsuccessful candidates are allowed a maximum of two retest opportunities.

   b. **Examination Completion:** Candidates must successfully complete all Parts of the Examination within 12 months of the date of their initial clinical examination. Candidates who do not successfully complete the examination within these time limits must retake the entire examination.

2. **Retests:** A score is reported for each of the Parts of the CRDTS dental therapy examination. If one or more Parts are failed, all procedures in that Part must be retaken, ***not*** just the procedures with deficient performance. Candidates applying for re-examination must provide documentation that all school requirements have been completed and the candidate has graduated.

   Retest opportunities for the Manikin and Restorative Examinations will be administered at select schools that may or may not be the candidate's school of attendance. Applicants from the school where the examination is administered receive priority for assignment to that site.

   Candidates who are *retaking* the examination must fulfill *current examination requirements* since the examination format is periodically redesigned. In every instance of re-examination, the candidate must complete a new application and remit the current examination fee.

3. **Remediation requirements:** It is the responsibility of each state or licensing jurisdiction to enforce its own remediation policy. There is no state which requires remediation after only one failure; some states may require remediation after two failures. Any candidate intending to seek licensure in one of the states that accepts the results of the CRDTS examination should check with the appropriate State Board regarding its remediation and re-examination requirements.

   It is the responsibility of the candidate to obtain and complete all requirements for remedial education in accordance with the requirements of the licensing jurisdictions in which they seek to obtain licensure. CRDTS does not assume any responsibility in providing this information or in monitoring the completion of such requirements prior to examination. After three or more failures, CRDTS requires that the candidate submit documentation from a state participating in the CRDTS examination verifying that the candidate has completed the remediation requirements of the state and that the state will consider the results of the re-examination for licensure.

4. **Incomplete Applications:** It is the candidate's responsibility to ensure that all application requirements are met and that all required items are received in CRDTS Central Office **prior** to the Application Deadline. All applications with incorrect or missing information, documentation or fees will be assessed a $200 fee and held until the missing item(s) and/or fees are received in Central Office. Once an exam site has closed, no additional applications will be processed and forfeiture of fees may apply.

   It should be noted that for applications, fees ***and*** required documentation, the testing agency uses the ***date of receipt*** and assumes no responsibility for insufficient postage or delays caused by the post office or other delivery agencies. Applications will be processed on a first-come, first serve basis for candidates who are not students at the testing site.

   The following items must be mailed in to CRDTS in order to complete the application:

   - Examination Fee payable to CRDTS (via VISA/Mastercard, Cashier's Check or MoneyOrder) Retake Fee: *See Retake Examination Fee*

- Notarized copy of diploma or Certification letter for 1st time applicants

5. **Disqualification:** Disqualification: After applying, a candidate may be disqualified to sit for the exam by their Program Director (or designated school official) for any reason within their discretion. Notification of disqualification by the Program Director must be sent to and received at CRDTS Central Office in writing via email prior to the start date of the candidate's scheduled examination.

   Depending on timing of the notice, CRDTS refund policy will apply. Candidates who are disqualified shall have access to the examination upon graduation and presentation of a diploma or in a subsequent academic year in which the candidate has been appropriately certified by the Director (or designated school official). A new application must be submitted with all required documentation and appropriate fee.

6. **Schedule Changes:** The examination assignment schedule (Day 1 and Day 2 assignments) is considered final when issued and mailed to the candidate. Request for change will not be considered or made once the schedule has been distributed. School personnel do not have the authority to accept a candidate for examination at their site or to make assignment changes within an examination series. Such arrangements concluded between school personnel and candidate may preclude the candidate from being admitted to the examination as well as forfeiture of fee. The CRDTS Chief Examiner is the only authorized individual who may consider a request for schedule change. If unusual circumstances warrant such change and space is available, it is the decision of the CRDTS Chief Examiner to approve such a request. This decision is made on site, on the day of examination. Prior requests are not accepted or considered.

7. **Fee Deferral:** Under extenuating circumstances a request for the examination fee to be deferred to a later examination will be considered on an individual basis when **RECEIVED BEFORE THE SCHEDULED EXAMINATION DATE**. Requests **must** be made in writing to the testing agency and **must** include original documentation in support of the request. Should a fee deferral be granted, the candidate will be informed of the terms and conditions for future examination. Requests for fee deferral on or after the date of the scheduled examination will not be honored and the fee will be forfeited. A non-refundable administrative processing fee of $200 is applicable at all times and under all circumstances.

8. **Fee Refunds:** Refunds will be made, minus a $200 administrative fee, if notification of cancellation is received in the CRDTS Central Office 30 days prior to the ***first*** day of the examination. A 50% refund will be made if notification is made at least 6 business days prior to the first day of the examination. After that time, any cancellations will result in forfeiture of the entire examination fee. Once a candidate has paid the entire examination fee and has taken any Part of the examination, there will be no refund of fees for the Parts that have not yet been taken, should the candidate decide to cancel or withdraw from other Parts of the examination. In addition, failure to appear for the exam will result in a forfeiture of the entire examination fee. This policy applies to all cancellations, regardless of reason.

9. **Confirmation Notification:** Candidates will receive a notice confirming their examination schedule; this notice may be distributed or posted by the school. Candidates will receive an email approximately 30 days prior to the examination. This email will contain:

   1. A letter confirming the exam site to which you have been assigned, the date and the exam schedule.
   2. A letter from the clinical facility serving as a testing site providing general information about the site, its facilities, policies and usage fees. This letter may also contain information related to nearby hotels. *(Candidates that are current students at the exam site will not receive the site information letter)*
   3. Other information and/or forms which will be needed to take the examination.

   For candidates who are *not* attending the dental/dental therapy school where the examination is being administered, it will be necessary to make arrangements with the school for the provision

of instruments, type of manikins, etc. Most schools charge a fee for the use of the clinic facilities, manikin heads, supplies and disposables. Any deposit or fee for the use of the testing site must be remitted to the school, NOT to the testing agency. No candidate should come to the examination unless confirmation containing the above information has been received.

10. **Release of Scores:** Scores are not released at any time other than to the candidate, the candidate's school and the CRDTS recognizing jurisdictions, unless authorization is received from the candidate.

    a. Candidates: Scores will be reported to candidates both online and via mail to the candidate's permanent address. For online access to Restorative scores, candidates may Log-In at www.crdts.org using their assigned CRDTS ID and password. The 'Candidates' tab will allow access to scores. Manikin-based scores will be reported via mail. Scores will also be reported to the school of graduation if the candidate is a current graduate. Candidates whose total score on any part is less than 75 will receive an individual printout with an itemization of their deficiencies. The manikin-based examinations and the patient-based examinations are reported within three to four weeks after the date of the candidate's examination. If the manikin procedures are evaluated off-site, results are reported 3-4 weeks after evaluation is completed. No actual examination papers or clinical evaluation forms will be released in order to maintain security of the examination.

No scores will be released by telephone and calling the Administrative Office will only delay the release of scores. Any address changes since the time of original application should be provided to the CRDTS' Administrative Office immediately.

COMPLAINT REVIEW PROCESS

CRDTS maintains a complaint review process whereby a candidate may submit a request for a review of documentation, concerns or protocols affecting his/her individual examination results. This is a formalized process conducted by a special committee whose charge is to review the facts to determine if the examiners' findings substantiate the results. Any request for such a review MUST BE FILED and received at CRDTS Central Office **no later than 14 days** following the official date on which the scores were provided to the candidate or the candidate's school. The Committee is required to complete its review within 60 days from the time of receiving a formal request; during that time, the candidate may apply for re-examination. If the candidate files a formal complaint, then retests and passes the examination before the complaint has been fully processed, the complaint review will be terminated. Forms may be obtained from CRDTS' Administrative Office or from the CRDTS website; documentation for the complaint must be typed or written on this form.

In determining whether to file a petition, the candidate should be advised that all reviews are based on a reassessment of documentation of the candidate's performance on the examination. The review ***does not include a regrading*** of that performance; it is limited to a determination of whether or not there exists substantial evidence to support the judgment of the three calibrated examiners conducting independent evaluations at the time of the examination. The review will not take into consideration other documentation that is not part of the examination process, such as; post-treatment photographs, radiographs, models, character references or testimonials, dental therapy school grades, faculty recommendations or the opinions of other "experts" solicited by the candidate. In addition, the review will be limited to consideration of the results of only one examination at a specific test site. If a candidate has completed more than one CRDTS' examination, the results of two or more examinations may **not** be selectively combined to achieve an acceptable final score.

Candidates who contact the Administrative Office regarding their examination results must clearly indicate whether they simply wish to express a concern relating to the examination or are interested in initiating a formal petition for review. A $250 filing fee will be charged by CRDTS to file and process a formal review petition.

POLICY FOR TESTING OF DISABLED CANDIDATES

Any candidate with a documented physical and/or learning disability that impairs sensory, manual or speaking skills which require a reasonable deviation from the normal administration of the examination may be accommodated. All reasonable efforts will be used to administer the examination in a place and manner accessible to persons with disabilities or an attempt will be made to offer alternative accessible arrangements for such individuals. Efforts will be made to ensure that the examination results accurately reflect the individual's impaired sensory, manual or speaking skills, except where those skills are factors the examination purports to measure. Also, attempts will be made to provide appropriate auxiliary aids for such persons with impaired sensory, manual or speaking skills unless providing such auxiliary aids would fundamentally alter the measurement of the skills or knowledge the examination is intended to test or would result in an undue burden. To ensure that an auxiliary aid or other requested modification exists and can be provided, it is a requirement that any candidate with a disability requesting such modification or auxiliary aid must:

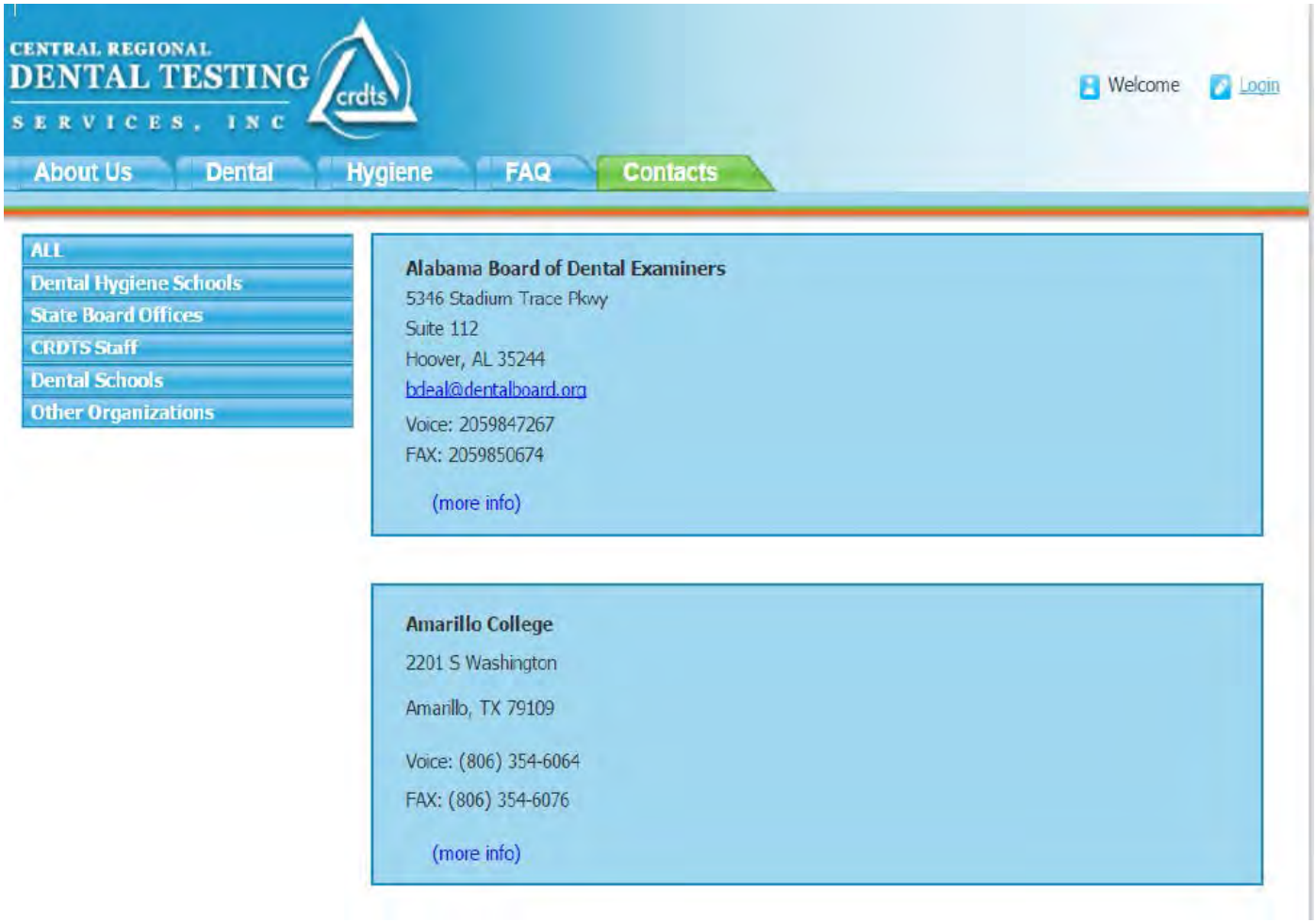
- Timing of request: Submit, in writing together with the application, a request and all documentation for the auxiliary aid or modification. Requests received after the application date or retroactive requests will not be considered.
- Documentation verifying disability: Provide documentation of the need for the auxiliary aid or modification. If the candidate is a student in an accredited school, a letter from a school official fulfills this requirement. Otherwise, a letter from the appropriate health care professional is required.
- Modification(s) needed: Request in writing the exact auxiliary aids or modifications needed and indicate the exact portion(s) of the examination for which such auxiliary aid or modification will be needed.

In providing such auxiliary aids or modifications, the testing agency reserves the ultimate discretion to choose between effective auxiliary aids or modifications and reserves the right to maintain the security of the examination. All information obtained regarding any physical and/or learning disability of a candidate will be kept confidential with the following exceptions:

1. Authorized individuals administering the examination may be informed regarding any auxiliary aid or modification; and
2. First aid and safety personnel at the test site may be informed if the disability might require emergency treatment.

LOCATION OF TESTING SITES & LICENSURE INFORMATION

Contact information for the above can be found online at www.crdts.org >Contacts tab



CHECKLIST OF
REQUIRED MATERIALS AND INSTRUMENTS

ORIENTATION:

- ☐ Picture ID for admission to orientation
- ☐ This Candidate Manual

CLINICAL EXAMINATION:

- ☐ This Candidate Manual
- ☐ Ball Point Pens (black)
- ☐ Sphygmomanometer
- ☐ Pre-op Restorative Radiographs
- ☐ Completed Medical Histories and Consent Forms
- ☐ Metal periodontal probe with 1 mm markings
- ☐ Sharp traditional explorer for caries detection (such as a Shepherd's Hook)
- ☐ Dental mirror, clean unscratched
- ☐ Cotton Pliers
- ☐ Articulating paper and holder
- ☐ Waxed dental floss
- ☐ Handpiece compatible with testing site attachments
- ☐ Operating instruments
- ☐ Instrument Tray

Glossary of Words, Terms and Phrases

Abfraction	The deep V-shaped groove usually noted at the CEJ which is caused by bruxism. This may be visible or below the gingival margin.
Abrasion	Abnormal wearing of tooth substance or restoration by mechanical factors other than tooth contact.
Abutment	A tooth used to provide support or anchorage for a fixed or removable prosthesis.
Acrylic Resin	Synthetic resin derived from acrylic acid used to manufacture dentures/denture teeth and provisional restorations.
Adjustment	Selective grinding of teeth or restorations to alter shape, contour, and establish stable occlusion.
Angle	A corner; **cavosurface angle**: angle formed between the cavity wall and surface of the tooth; **line angle:** angle formed between two cavity walls or tooth surfaces.
Apical	the tip, or apex, of a root of a tooth and its immediate surroundings.
Attached Gingiva	The portion of the gingiva that extends apically from the base of the sulcus to the mucogingival junction.
Attrition	loss of tooth substance or restoration caused by mastication or tooth contact.
Axial wall	An internal cavity surface parallel to the long axis of the tooth.
Base	A replacement material for missing dentinal tooth structure, used for bulk buildup and/or for blocking out undercuts. Examples include ZOIB&T, IRM and zinc-phosphate cement.
Bevel	A plane sloping from the horizontal or vertical that creates a cavosurface angle which is greater than 90°.
Bonding Agent	See Sealers.
Bridge	Permanently fixed restoration that replaces one or more missing natural teeth.

Build Up	A restoration associated with a cast restoration, which replaces some, but not all, of the missing tooth structure coronal to the cementoenamel junction. The buildup provides resistance and retention form for the subsequent cast restoration. Also called Pin Amalgam Build Up (PABU) or Foundation.
Calculus	A hard deposit attached to the teeth, usually consisting of mineralized bacterial plaque.
Caries	An infectious microbiological disease that results in localized dissolution and destruction of the calcified tissues of the teeth. The diagnosis of dentinal caries is made by tactile sensation with light pressure on an explorer, described as (1) a defect with a soft, sticky base, or (2) a defect that can be penetrated or altered by the tine of the explorer.
Cavity Preparation	Removal and shaping of diseased or weakened tooth tissue to allow placement of a restoration.
Cavosurface Margin	The line angle formed by the prepared cavity wall with the unprepared tooth surface. The margin is a continuous entity enclosing the entire external outline of the prepared cavity. Also called the cavosurface line angle.
Cementoenamel Junction	Line formed by the junction of the enamel and cementum of a tooth.
Centric occlusion	That vertical and horizontal position of the jaws in which the cusps of the maxillary and mandibular teeth interdigitate maximally.
Centric relation	That operator guided position of the jaws in which the condyles are in a rearmost and uppermost position in the fossae of the temporomandibular joint.
Contact Area	The area where two adjacent teeth approximate.
Convenience Form	The shape or form of a cavity preparation that allows adequate observation, accessibility, and ease of operation in preparing and restoring the cavity.
Convergence	The angle of opposing cavity walls which, when projected in a gingival to occlusal direction, would meet at a point some distance occlusal to the occlusal or incisal surface.
Core	A restoration associated with a cast restoration which replaces <u>all</u> coronal tooth structure and is usually associated with a post of one type or another. The core provides resistance and retention form for the subsequent cast restoration.
Crown	Cast-metal restoration or porcelain restoration covering most of the surfaces of an anatomical crown.

Cusp (functional)	Those cusps of teeth which by their present occlusion, provide a centric stop which interdigitates with a fossa or marginal ridge of an opposing tooth/teeth.
Cusp (non-functional)	Those cusps of teeth which by their present occlusion, do not provide a centric stop which interdigitates with a fossa or marginal ridge of an opposing tooth/teeth.
Debris	Scattered or fragmented remains of the cavity preparation procedure. All debris should be thoroughly removed from the preparation before the restoration is placed.
Decalcification	Demineralized area of enamel that may appear white and chalky or may be discolored. It is considered unsound tooth structure if it can be penetrated by an explorer or is less than ½ the thickness of the enamel.
Defective Restoration	Any dental restoration which is judged to be causing or is likely to cause damage to the remaining tooth structure if not modified or replaced.
Dentin	Calcified tissue surrounding the pulp and forming the bulk of the tooth.
Deposits - subgingival	Deposits which are apical to the gingival margin.
Deposits - supragingival	Deposits which are coronal to the gingival margin.
Divergence	The angle of opposing cavity walls which, when projected in an occlusal to gingival direction, would meet at a point some distance gingival to the crown of the tooth.
Embrasure	A "V" shaped space continuous with an interproximal space formed by the point of contact and the subsequent divergence of these contacting surfaces in an occlusal (incisal), gingival, facial or lingual direction.
Enameloplasty	The selected reshaping of the convolutions of the enamel surface (fissures and ridges) to form a more rounded or "saucer" shape to make these area more clean able, finish able, and allow more conservative cavity preparation external outline forms.
Erosion	Abnormal dissolution of tooth substance by chemical substances. Typically involves exposed cementum at the CEJ.
Exposure	*See "Pulp Exposure"*
Finish Line	The terminal portion of the prepared tooth
Fissure	A developmental linear fault in the occlusal, buccal or lingual surface of a tooth, commonly the result of the imperfect fusion of adjoining enamel lobes.

Flash	Excess restorative material extruded from the cavity preparation extending onto the unprepared surface of the tooth.
Foundation	See Build Up
Gingival Recession	The visible apical migration of the gingival margin, which exposes the CE junction and root surface.
Gingival wall	An internal cavity surface perpendicular to the long axis of the tooth near the apical or cervical end of the crown of the tooth or cavity preparation.
Gingivitis	Inflammation of the gingiva
Glass Ionomer	Material containing polyacrylic acid and aluminosilicate glass that that can be used as restorative, lining or luting material.
Grainy	The rough, perhaps porous, poorly detailed surface of a material.
Ill-defined	A cavity preparation which, while demonstrating the fundamentals of proper design, lacks detail and refinement in that design.
Infra-occlusion	A tooth or restoration which lacks opposing tooth contact in centric when such contact should be present.
Interproximal contact	The area of contact between two adjacent teeth; also called proximal contact.
Isthmus	A narrow connection between two areas or parts of a cavity preparation.
Keratinized Gingiva	In healthy mouths, this includes both the free marginal and attached gingiva which are covered with a protective layer of keratin. It is the masticatory oral mucosa which withstands the frictional stresses of mastication and toothbrushing; and provides a solid base for the movable alveolar mucosa for the action of the cheeks, lips and tongue.
Line angle	The angle formed by the junction of two surfaces. In cavity preparations there can be internal and external line angles which are formed at the junction of two cavity walls.
Line of draw	The path or direction of withdrawal or seating of a removable or cast restoration.
Liner	Resin or cement coating of minimal thickness (usually less than 0.5 mm) to achieve a physical barrier and/or therapeutic effect (a chemical effect that in some way benefits the health of the tooth pulp). Examples include Dycal, Life, Cavitec, Hydroxyline, Vitrebond, and Fuji Lining LC.
Liner - treatment	An appropriate dental material placed in deep portions of a cavity preparation to produce desired effects on the pulp such as insulation, sedation, stimulation of odontoblasts, bacterial reduction, etc. Also called therapeutic liner.

Long axis An imaginary straight line passing through the center of the whole tooth occlusoapically.

Marginal deficiencies Failure of the restorative material to properly and completely meet the cut surface of the cavity preparation; the marginal discrepancy does not exceed .5 mm, and the margin is sealed. May be either voids or under-contour.

Marginal excess Restorative material which extends beyond the cavosurface margin of the cavity walls. Marginal excess may or may not extend onto the unprepared surface(s) of the tooth. See also: over-contoured, flash, over-extension.

Mobility The degree of looseness of a tooth.

Occluso-axial line angle In a casting preparation, the angle formed by the junction of the prepared occlusal and axial (lingual, facial, mesial, distal) surfaces.

Open margin A cavity margin or section of margin at which the restorative material is not tightly adapted to the cavity preparation wall(s). Margins are generally determined to be open when they can be penetrated by the tine of a sharp dental explorer.

Outline Form (external) The external boundary or perimeter of the area of the tooth surface to be included within the outline or enamel margins of the finished cavity preparation

Outline Form (internal) The internal details and dimensions of the finished cavity preparation.

Over-contoured Excessive shaping of the surface of a restoration so as to cause it to extend beyond the normal physiologic contours of the tooth when in health.

Over-extension (preparation) The placement of final cavity preparation walls beyond the position required to properly restore the tooth as determined by the factors which necessitated the treatment.

Over-extension (restoration) Restorative material which extends beyond the cavosurface margin of the cavity walls. Marginal excess may or may not extend onto the unprepared surface(s) of the tooth. See also; Over-contoured, Flash, Marginal excess.

Overhang (restoration) The projection of restorative material beyond the cavosurface margin of the cavity preparation but which does not extend on to the unprepared surface of the tooth; also, the projection of a restoration outward from the nominal tooth surface. See also Flash.

Path of insertion The path or direction of withdrawal or seating of a removable or cast restoration. See Line of Draw.

Periapical Area around the root end of a tooth.

Periodontitis	Inflammation of the supporting tissues of the teeth. Usually a progressively destructive change leading to loss of bone and periodontal ligament. An extension of inflammation from gingiva into the adjacent bone and ligament.
Pits (surface)	Small voids on the polished surface (but not at the margins) of a restoration.
Polishing (restoration)	The act or procedure of imparting a smooth, lustrous, and shiny character to the surface of the restoration
Pontic	The suspended portion of a fixed bridge that replaces the lost tooth or teeth.
Porous (restoration)	To have minute orifices or openings in the surface of a restoration which allows fluids or light to pass through.
Provisional restoration	Any restoration, which by it's intent, is placed for a reduced period of time or until some event occurs. Any restorative material can be placed as a provisional restoration. It is only the intent or the restoration and not the material which determines the provisional status.
Pulp cap (direct)	The technique of placing a base over the exposed pulp to promote reparative dentin formation and the formation of a dentinal bridge across the exposure. The decision to perform a pulp cap or endodontics and the success of the procedure is determined by the conditions under which the pulp was exposed.
Pulp cap (indirect)	The technique of deliberate incomplete caries removal in deep excavation to prevent frank pulp exposure followed by basing of the area with an appropriate pulpal protection material to promote reparative dentin formation. The tooth may or may not be re-entered in 6-8 weeks to remove the remaining dentinal caries.
Pulp exposure (carious)	The frank exposure of the pulp through clinically carious dentin.
Pulp exposure (general)	The exposure of the pulp chamber or former pulp chamber of a tooth with or without evidence of pulp hemorrhage.
Pulp exposure (irreparable)	Generally, a pulp exposure in which most or all of the following conditions apply: The exposure is greater than 0.5 mm; the tooth had been symptomatic; the hemorrhage is not easily controlled; the exposure occurred in a contaminated field; the exposure was relatively traumatic.
Pulp exposure (mechanical) (unwarranted)	The frank exposure of the pulp through non-carious dentin caused by operator error, misjudgment, pulp chamber aberration, etc.
Pulp exposure (reparable)	Generally, a pulp exposure in which most or all of the following conditions apply: the exposure is less than 0.5 mm; the tooth had been asymptomatic; the pulp hemorrhage is easily controlled; the exposure occurred in a clean, uncontaminated field; the exposure was relatively atraumatic.

Pulpal wall — An internal cavity surface perpendicular to the long axis of the tooth. Also pulpal floor.

Pulpoaxial line angle — The line angle formed by the junction of the pulpal wall and axial wall of a prepared cavity.

Pulpotomy — The surgical amputation of the vital dental pulp coronal to the cementoenamel junction in an effort to retain the radicular pulp in a healthy, vital state.

Resistance Form — The features of a tooth preparation that enhance the stability of a restoration and resist dislodgement along an axis other than the path of placement.

Retention Form — The feature of a tooth preparation that resists dislodgment of a crown in a vertical direction or along the path of placement.

Root planing — A definitive treatment procedure designed to remove cementum or surface dentin that is rough, impregnated with calculus, or contaminated with toxins or microoganisms.

Scaling — Instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces.

Surface Sealant - composite resin restoration coating — After polishing, the application of the unfilled resin (bonding agent) of the composite resin system to the surface of the restoration to fill porosities or voids in the body of the restoration or at the margins or to provide a smooth surface to the restoration followed by curing.

Sealers — Cavity sealers provide a protective coating for freshly cut tooth structure of the prepared cavity.

a. **Varnish:** A natural gum, such as copal rosin, or a synthetic resin dissolved in an organic solvent, such as acetone, chloroform, or ether. Examples include Copalite, Plastodent, Varnish, and Barrier.
b. **Resin Bonding Agents:** Include the primers and adhesives of dentinal and all-purpose bonding agents. Examples include All-Bond 2, Scotchbond MP+, Optibond, ProBond, Amalgambond, etc.

Shade (restoration) — The color of a restoration as defined by hue, value, and chroma which is selected to match as closely as possible the natural color of the tooth being restored.

Shoulder Preparation — Finish line design for tooth preparation in which the gingival floor meets the external axial surfaces at approximately a right angle.

Sonic scaler — An instrument tip attached to a transducer through which high frequency current causes sonic vibrations (approximately 6,000 cps). These vibrations, usually accompanied by the use of a stream of water, produce a turbulence which in turn removes adherent deposits from the teeth.

Sound Tooth Structure	Enamel that has not been demineralized or eroded; it may include proximal decalcification that does not exceed ½ the thickness of the enamel and cannot be penetrated by an explorer.
Stain - Extrinsic	Stain which forms on and can become incorporated into the surface of a tooth after development and eruption. These stains can be caused by a number of developmental and environmental factors.
Stain - Intrinsic	Stain which becomes incorporated into the internal surfaces of the developing tooth. These stains can be caused by a number of developmental and environmental factors.
Sterilization	A heat or chemical process to destroy microorganisms.
Supra-occlusion	A tooth or restoration which has excessive or singular opposing tooth contact in centric or excursions when such contact should not be present and should be balanced with the other contacts in the quadrant or arch.
Taper	To gradually become more narrow in one direction
Temporary restoration	See Provisional Restoration.
Tissue Trauma	Unwarranted iatrogenic damage to extra/intraoral tissues resulting in significant injury to the patient, such as lacerations greater than 3mm, burns, amputated papilla, or large tissue tags.
Transported Canal	The prepared root canal is over-instrumented, causing deviation from the natural pathway of the anatomical canal.
Ultrasonic scaler	An instrument tip attached to a transducer through which high frequency current causes ultrasonic vibrations (approximately 30,000 cps). These vibrations, usually accompanied by the use of a stream of water, produce a turbulence which in turn removes adherent deposits from the teeth.
Uncoalesced	The failure of surfaces to fuse or blend together such as the lobes of enamel resulting in a tooth fissure.
Under-contoured	Excessive removal of the surface of a restoration so as to cause it to be reduced beyond the normal physiologic contours of the tooth when in health.
Undercut	a. Feature of tooth preparation that retains the intra-coronal restorative material. b. An undesirable feature of tooth preparation for an extra-coronal restoration.
Under-extension (preparation)	Failure to place the final cavity preparation walls at the position required to properly restore the tooth as determined by the factors which necessitated the treatment.

Under-extension (restoration)	Restorative material which fails to extend to the cavosurface margin of the cavity walls thereby causing exposure of the prepared cavity wall.
Undermined enamel	During cavity preparation procedures; an enamel tooth surface (particularly enamel rods) which lacks dentinal support. Also called unsupported enamel.
Unsound Marginal Enamel	Loose or fragile cavosurface enamel that is usually discolored or demineralized, which can be easily removed with hand instruments when mild to moderate pressure is applied.
Varnish	See Sealers
Void(s)	An unfilled space within the body of a restoration or at the restoration margin which may or may not be present at the external surface and therefore may or may not be visible to the naked eye.

INSTRUCTIONS:
- Use blue or black INK to complete this form
- Have patient complete this form PRIOR to the exam
- Bring this completed form with you to the exam

CANDIDATE NUMBER

CRDTS PATIENT HEALTH HISTORY SCREENING FORM

Patient name:_____

Birthdate:_____Weight:_____ Pre-exam Screening Blood Pressure _____/_____

* Day of Exam Blood Pressure _____/_____

INSTRUCTIONS TO PATIENT: Please answer the following questions as completely and accurately as possible. All information is CONFIDENTAL.

1. Physician's name:_____Physician's Phone:(_____)_____

2. Date of last physical examination:_____

3. Are you under the care of a physician at the present time, or have you been treated by a physician/PA in the last six months?

   If YES, please specify:_____ YES NO

4. Are you allergic or had any adverse reactions to any medicines, drugs, local anesthetics, or other substances? YES NO

   If YES, please identify: _____

5. Do you have a known allergy or sensitivity to Latex? YES NO

6. Are you receiving or have you ever received/taken INTRAVENOUS Bisphosphonates? YES NO

   i.e. Have you taken any of the following drugs INTRAVENOUSLY for the treatment of Osteoporosis or cancer? Clondronate (Bonefos®, Clasteon®, or Ostac®), Pamidronate (Aredia®), Zolendronic acid (Zometa® or Aclasta®), Neridromate (Nerixia®),or Reclast®. This list of IV Bisphosphonate medications should not be considered complete as new drugs are continually being developed.

7. Do you have or have you had any of the following diseases/conditions?

A. Cardiac/Organ Transplant	YES	NO	
B. Osteocraneonecrosis of the jaw	YES	NO	
C. Tuberculosis (active/currently)	YES	NO	
D. Heart Attack	YES	NO	If YES Date:_____
E. Heart Surgery (including stents)	YES	NO	If YES Date:_____
F. Stroke	YES	NO	If YES Date:_____
G. Chemotherapy	YES	NO	If YES Date:_____
H. Pregnant (currently pregnant)	YES	NO	If YES Due Date:_____
I. Artificial /Damaged Heart Valve(s)	YES	NO	
J. History of Infective Endocarditis	YES	NO	
K. Congenital Heart Conditions	YES	NO	
L. Joint Replacement	YES	NO	
M. Immune Suppression/HIV/AIDS	YES	NO	
N. Heart Condition (including pacemaker)	YES	NO	
O. Asthma/Lung/Breathing Disorder	YES	NO	
P. Bleeding Disorder	YES	NO	
Q. Cancer	YES	NO	
R. Diabetes	YES	NO	If YES Type: _____
S. Epilepsy/Seizures	YES	NO	
T. Hepatitis	YES	NO	If YES Type:_____
U. High Blood Pressure	YES	NO	
V. Kidney/Renal Disease	YES	NO	

W. Do you have any disease or condition not listed above that we should know about? YES NO

If YES, please specify:_____

_____

Please explain any YES answers here

Question # _____
Explanation:

_____

_____

_____

Question # _____
Explanation:

_____

_____

_____

Question # _____
Explanation:

_____

_____

_____

If more space is needed, please use the back of this form.

***Please list ALL medications/drugs, dose and time taken: prescription, over the counter, non-prescription, recreational, that you have taken in the last 24 hours:**

_____

_____

_____

_____

Any item on the medical history with a YES response may require a medical clearance letter if the explanation section indicates the possibility of a significant systemic condition that could adversely affect the patient's suitability to take part in the examination.

Securely attach any medical clearance letters to this form.

I certify that I have read and understand the above. I acknowledge that I have answered these questions accurately and completely. I will not hold the testing agency responsible for any action taken or not taken because of errors I may have made when completing this form.

PATIENT SIGNATURE:_____

(Parent or Guardian if patient is a minor)

DATE SIGNED:_____

If needed, additional information:

_____

_____

_____

_____

_____

All items marked with an asterisk must be completed the DAY OF THE EXAMINATION

Exam Site_____

Candidate Number

Central Regional Dental Testing Service, Inc.

TREATMENT CONSENT FORM

DENTAL THERAPY EXAMINATION

*Fill in the Candidate name below **after** the examination is over and **before** you turn in your packet.*

I, _____, authorize Candidate #_____, Candidate Name (added later) _____, a dental examinee and whomever the dental examinee may designate as an assistant or assistants, to perform upon myself the following dental procedure(s):

☐ **Posterior Restorative Preparation and Restoration**
☐ **Anterior Restorative Preparation and Restoration**

I understand that the dental examinee may not be a licensed dentist. I further understand that such procedure(s) will be performed by the examinee as part of an examination conducted to determine the qualification of the dental examinee for licensure. I recognize that medical information which could be pertinent to the oral health care I receive in the course of the examination may be communicated to examiners.

The nature and purpose of the dental procedure(s) as well as the risks and possible complications have been explained to me. My questions with regard to the dental procedure(s) have been answered. I acknowledge that no guarantee or warranty has been made as to the results to be obtained. I understand that the treatment provided during the examination does not necessarily fulfill all my oral health needs or represent my entire treatment plan, and that further restorative and/or periodontal treatment may be necessary. I have been informed of the availability of services to complete treatment.

I understand that if I am taking certain medications (as indicated on the Medical History form) that are associated with chronic conditions following dental treatment, I may not be accepted as a patient for this examination. Patients who are taking oral bisphosphonate medications may be at risk for oral osteochemonecrosis of the jaws after dental treatment or as a result of dental infections.

I consent to the taking of appropriate radiographs (X-Rays) and dental examinations.

I consent to having CRDTS examiners or school personnel take photographs of my teeth and gums for use in future examiner calibration provided my name is not in any way associated with these photographs.

I understand that as a part of the dental procedure(s), it may be necessary to administer anesthetics and I consent to the use of such anesthetics by the dental examinee.

_____DATE _____ 20_____.
Patient's Signature

_____ (_____)_____
Patient's Address, City, State, Zip Patient's Phone

This form may be copied as necessary for each patient utilized in the examination.

Test Site # | CRDTS | Candidate # ID#

AMALGAM RESTORATION
1st SUBMISSION

Patient's Name_____ Assistant's Name_____


CANDIDATE: *Circle Type of Restoration and Tooth Number, note & outline any existing restorations.*

MO DO MOD

1	2	3	4	5		12	13	14	15	16
32	31	30	29	28		21	20	19	18	17

Tx Sel Rejection

Size: S ___ M___ L ___ **Existing Restoration: Yes N..**

Comments:_____

Acceptable **Unacceptable**

1st | **TREATMENT SELECTION, LEGAL CONSENT, HEALTH HISTORY, ANESTHESIA RECORD** | **1st**

Authorizing CFE #:	1	2	3	4	5	6
Verifying CFE #:	1	2	3	4	5	6
Candidate Initials:	1	2	3	4	5	6

Mod Request

Ex 1	Ex 2	Ex 3

REST Ex ID: Mod Req Reviewed

Request to Recontour: Approved to Recontour _____ **CFE #**

Recontour Acceptable _____ **CFE #**

_____ **Exposure Processed:** *(any pulpal exposure must be checked by Clinic Floor Examiner)*

_____ _____ _____ **FINISHED PREPARATION:** *(without liner; under rubber dam, checked Mod Requests)*

_____ _____ _____ **FINISHED, CARVED RESTORATION:** *(without rubber dam)*

ANESTHETIC RECORD
Has the patient previously received anesthetic the same day for another procedure? ☐Yes ☐ No Dose: _____ Time: _____
Type(s) of Injection *(Infiltration/Block)*
Anesthetic(s) *(Brand/Generic Name)*
Vasoconstrictor-*(Concentration)*
Quantity of Anesthetic *(cc Expected to Use)*
Quantity Actually Used *(cc)*
Examiner Initials *(Additional Anesthetic)*

NOTES TO EXAMINERS *(Use ink. Please number each note. Notes should be written clearly and include specific information, i.e. description, location, etc.)*	*Ex. ID#*		
1.			

Test Site #

CRDTS

Candidate #

POSTERIOR COMPOSITE RESTORATION
1st SUBMISSION

Slot Prep

Patient's Name_____Assistant's Name_____

CANDIDATE: *Circle Type of Restoration and Tooth Number, outline any existing restorations.*

MO	DO	MOD	1	2	3	4	5		12	13	14	15	16
			32	31	30	29	28		21	20	19	18	17

Tx Sel Rejection

Size: S ___ M___ L ___

Cavosurface Bevel: Yes No **Existing Restoration: Yes No**

Comments: _____

Acceptable **Unacceptable**

TREATMENT SELECTION, LEGAL CONSENT, HEALTH HISTORY, ANESTHESIA RECORD

Authorizing CFE #:	1	2	3	4	5	6	
Verifying CFE #:	1	2	3	4	5	6	
Candidate Initials:	1	2	3	4	5	6	Ex 1 Ex 2 Ex 3

Mod Request

REST Ex ID: Mod Req Reviewed

Request to Recontour: Approved to Recontour ____ **CFE #**

Recontour Acceptable ____ **CFE #**

____ **Exposure Processed:** *(any pulpal exposure must be checked by Clinic Floor Examiner)*

____ ____ ____ **FINISHED PREPARATION:** *(without liner; under rubber dam, checked Mod Requests)*

____ ____ ____ **FINISHED RESTORATION:** *(without rubber dam)*

ANESTHETIC RECORD
Has the patient previously received anesthetic the same day for another procedure? ☐Yes ☐ No Dose: _____ Time: _____
Type(s) of Injection *(Infiltration/Block)*
Anesthetic(s) *(Brand/Generic Name)*
Vasoconstrictor-*(Concentration)*
Quantity of Anesthetic *(cc Expected to Use)*
Quantity Actually Used *(cc)*
Examiner Initials *(Additional Anesthetic)*

NOTES TO EXAMINERS *(Use ink. Please number each note. Notes should be written clearly and include specific information, i.e. description, location, etc.)*	*Ex. ID#*

Test Site # | **CRDTS** | Candidate # ID#

ANTERIOR COMPOSITE RESTORATION
1st SUBMISSION

Patient's Name_____ Assistant's Name_____

CANDIDATE: *Circle Surfaces to Be Restored, Access and Tooth Number, outline any existing restoration(s).*

D M **ACCESS** 6 7 8 | 9 10 11 / 27 26 25 | 24 23 22

Size: S M L **Lingual Facial**

Tx Sel Rejection

Cavosurface Bevel: Yes No **Existing Restoration: Yes No**

Acceptable **Comments:** _____ **Unacceptable**

1st [ ] **TREATMENT SELECTION, LEGAL CONSENT** 1st [ ] [ ]

HEALTH HISTORY, ANESTHESIA RECORD

Authorizing CFE #:	1	2	3	4	5	6
Verifying CFE #:	1	2	3	4	5	6
Candidate Initials:	1	2	3	4	5	6

Ex 1 Ex 2 Ex 3

REST Ex ID: Mod Req Reviewed

Mod Request

Request to Recontour: Approved to Recontour [ ] **CFE #**

Recontour Acceptable [ ] **CFE #**

[ ] **Exposure Processed:** *(any pulpal exposure must be checked by Clinic Floor Examiner)*

[ ] [ ] [ ] **FINISHED PREPARATION:** *(under rubber dam)*

[ ] [ ] [ ] **FINISHED RESTORATION:** *(without rubber dam)*

ANESTHETIC RECORD
Has the patient previously received anesthetic the same day for another procedure? ☐Yes ☐ No
Dose: _____ Time: _____
Type(s) of Injection (*Infiltration/Block*)
Anesthetic(s) *(Brand/Generic Name)*
Vasoconstrictor-*(Concentration)*
Quantity of Anesthetic (*cc Expected to Use*)
Quantity Actually Used *(cc)*
Examiner Initials *(Additional Anesthetic)*

NOTES TO EXAMINERS *(Use ink. Please number each note. Notes should be written clearly and include specific information, i.e. description, location, etc.)*	*Ex. ID#*

	Test Site #	CRDTS	Candidate #	

DENTAL THERAPIST MANIKIN RESTORATIVE PROCEDURES

START TIME:_____ **FINISH TIME:**_____

NOTE: A single box must be signed by a Clinic Floor Examiner. A triple box must be signed by three examiners at the Evaluation Station.

CRDTS will provide the typodont containing the appropriate teeth on which the candidate must complete the Manikin Restorative Procedures. The preparation for a Primary Stainless Steel crown is completed on tooth #L; the preparation and restoration for a Primary Stainless Steel crown is completed on tooth #J and needs to be permanently cemented; and the restoration for a Primary Molar Class II Amalgam Restoration is completed on tooth #T. The teeth should be prepared in the appropriate proportions, taper and depths as defined in the criteria.

The Posterior Primary Pulpotomy procedure is completed on tooth #A. This procedure must be completed under isolation dam. A Clinic Floor Examiner must approve the mounting and occlusion of the typodont; the typodont may be dismantled only with the authorization of a Clinic Floor Examiner.

CFE	**TYPODONT MOUNTING/OCCLUSION APPROVED**
CFE	**PUTTY MATRIX COMPLETED**
CFE	**CFE AUTHORIZES DISMANTLING TYPODONT** **CFE Removes Typodont for Evaluation** **CFE Collects Typodont, Progress Form**

			FINAL EVALUATION MANIKIN RESTORATIVE PROCEDURES
Examiner #1	Examiner #2	Examiner #3	

NOTES and COMMENTS:

Candidates:	Examiners Only:

CRDTS ID: _____ **Test Site #**_____

CANDIDATE #

MODIFICATION REQUEST FORM

SEE CLINIC FLOOR EXAMINER BEFORE PROCEEDING

NOTE:

Regardless of whether the modification is granted or not granted, the candidate must complete the preparation and send the patient to the Evaluation Station for evaluation of the final completed preparation.

Examiner # 1 _____ **Examiner # 2** _____

AMALGAM **Prep** ☐

POST COMP **Prep** ☐ **Slot** ☐

ANT COMP **Prep** ☐

TIME: _____ **Day 1** ☐ **Day 2** ☐

Modification Request # 1
What:
Where:
Why:
How Much:
☐ **Granted** ☐ **Not Granted**

Modification Request # 2
What:
Where:
Why:
How Much:
☐ **Granted** ☐ **Not Granted**

Modification Request # 3
What:
Where:
Why:
How Much:
☐ **Granted** ☐ **Not Granted**

Modification Request # 4
What:
Where:
Why:
How Much:
☐ **Granted** ☐ **Not Granted**

Modification Request # 5
What:
Where:
Why:
How Much:
☐ **Granted** ☐ **Not Granted**

Yellow Copy – Candidate **Pink Copy – CFE** **Top/White Copy - Proctor**

The Dental Therapy Examination for initial licensure is designed to test clinical competencies consistent with the dental therapist's scope of practice. This examination is divided into 3 sections: a manikin exam, a restorative exam, and an OSCE. This Dental Therapy Examination was developed at the request of the Minnesota Board of Dentistry and has been administered since 2018.

Examination Overview

The Examination consists of 6 parts and is divided into 3 sections:

- Manikin: 3 parts
- Restorative Exam (Patient or CompeDont™): 2 parts
- Dental Therapy OSCE

Manikin Examination: 6 hours

The Manikin portion of the Dental Therapy Exam is composed of 3 parts, each of which is skill-specific. All parts are graded separately. The candidate must pass each part of the examination to pass the Manikin Examination.

1. ENDODONTICS:
    - Pulpotomy Tooth #A

2. RESTORATION:
    - Class II Amalgam Restoration Tooth #T

3. STAINLESS STEEL CROWNS:
    - Stainless Steel Crown Preparation Tooth #L
    - Stainless Steel Crown Placement and Cementation Tooth #J

Note:

- The Stainless-Steel Crown procedures are considered one skill set, therefore, both procedures need to be passed, to pass this skill set. If the candidate is unsuccessful in their challenge of one of the Stainless-Steel crown procedures both procedures will need to be retaken.
- Any part of the examination that is not successfully challenged, may be taken at a subsequent exam.
- Only the skill set that is not successfully challenged needs to be retaken.

Restorative Examination: 7 HOURS

The Dental Therapy Restorative Examination is given in conjunction with the ADEX Dental Restorative Examination and mimics its content and criteria. This process assures the anonymity of Dental Therapy candidates as they are not evaluated as a separate cohort.

The Restorative Examination requires the successful challenge of two procedures that are evaluated independently of each other: Anterior Preparation and Restoration and Posterior Preparation and Restoration. Each procedure is evaluated for:

- lesion acceptance
- preparation of the lesion
- restoration of the prepared tooth
- treatment management

1. ANTERIOR RESTORATION
    - Class III composite preparation
    - Class III composite restoration

2. POSTERIOR RESTORATION
    - Class II composite or amalgam preparation
    - Class II composite or amalgam restoration

Note:

- Candidate performance is evaluated separately for each type of restoration
- Any part of the examination that is not successfully challenged, may be taken at a subsequent exam. Only the skill set that is not successfully challenged needs to be retaken
- If the candidate is unsuccessful in their first restoration, they will not be allowed to start their second restorative procedure and the examination will be terminated

Scoring System Overview

Evaluations and scoring of candidate performance in these examinations are made in a "triple-blind" manner at specified steps. Three examiners must independently evaluate each presentation of candidate performance and enter their evaluations Each examiner is unable to see the evaluations of the other two examiners and examiners are prohibited from discussing their evaluations during the examination. Examiners are randomly assigned by an electronic distribution system so that the same three examiners do not repeatedly examine the same preparations or restorations.

Evaluations are made according to defined criteria. The candidate's performance level is electronically computed for each item evaluated, based on the entries of the three examiners, and by this method, the candidate's overall score is computed for each procedure.

Dental Therapy OSCE

The DT OSCE is a 100-question multiple-choice computerized examination delivered at Prometric Test Centers.

DENTAL THERAPY OSCE CONTENT	
1. Medical/Dental Assessment and Medical Emergencies	**10%**
Evaluate a patient's health history and record vital signs Analyze and adjust treatment as necessary based on the patient's health history Evaluate a patient's oral health history Recognize and manage common medical emergencies occurring in the dental healthcare setting	
2. Intra and Extraoral Examination	**8%**
Recognize and identify normal, abnormal, and common conditions	
3. Soft Tissue, Bone, and Tooth Anomalies	**10%**
Identify conditions related to soft tissue, bone, and tooth abnormalities using clinical exams, radiographs, and patient history Evaluate and identify growth & developmental abnormalities Evaluate functional abnormalities	
4. Radiography/Imaging	**6%**
Identify oral structures Evaluate and interpret radiographs	
5. Dental Treatment	**55%**
Preventive Care Restorative Treatment Periodontics Oral Surgery Endodontics Pediatric Dentistry	
6. Local Anesthesia and Nitrous Oxide	**4%**
Technique, Pharmacology, and Administration of agents Concepts and Management of Pain and Anxiety Pre and Post-Op Management of the Patient Prevention, recognition, and management of complications	
8. Infection Control	**3%**
Understand and apply the CDC recommendations and OSHA standards relevant to the dental healthcare setting through all phases of treatment	
9. Applied Pharmacology	**4%**
Assess the potential impact, oral implications, and side effects of medications Assess the need for and application of preventive and therapeutic agents Understand analgesics, anti-inflammatories, and antibiotics usage and indications	

To pass the Dental Therapy Examination for initial licensure, the candidate must achieve a score of 75 or greater on all parts of the Examination.

NORTHWEST PORTLAND AREA
INDIAN HEALTH BOARD
Indian Leadership for Indian Health

February 16, 2022

Sarah Kowalski, RDH, MS
Dental Pilot Project Program
Oregon Health Authority

Re: Oregon Pilot Project #100

Dear Ms. Kowalski:

We are writing to request a modification to Oregon Dental Pilot Project #100: to extend the pilot by one additional year. Pilot Project #100 is scheduled to end on May 31st, 2022. Due to delays in the Oregon licensure process, Pilot Project #100 requests an extension of the project until May 31st, 2023. This will allow existing Dental Health Aide Therapists the opportunity to continue to provide care to their communities without interruption. Thank you for considering this modification request.

Please contact me or Miranda Davis at mdavis@npaihb.org if you have any questions.

We look forward to your response.

Sincerely,

Laura Platero, JD
Executive Director

ORS 679 – UPDATED WITH DENTAL THERAPY STATUTES

Chapter 679 — Dentists

2021 EDITION

DENTAL THERAPY

PENALTIES

GENERAL PROVISIONS

679.010 Definitions. As used in this chapter and ORS 680.010 to 680.205, unless the context requires otherwise:

(1) “Dental assistant” means a person who, under the supervision of a dentist or dental therapist, renders assistance to a dentist, dental therapist, dental hygienist, dental technician or another dental assistant or who, under the supervision of a dental hygienist, renders assistance to a dental hygienist providing dental hygiene.

(2) “Dental hygiene” is that portion of dentistry that includes, but is not limited to:

(a) The rendering of educational, preventive and therapeutic dental services and diagnosis and treatment planning for such services;

(b) Prediagnostic risk assessment, scaling, root planing, curettage, the application of sealants and fluoride and any related intraoral or extraoral procedure required in the performance of such services; and

(c) Prescribing, dispensing and administering prescription drugs for the services described in paragraphs (a) and (b) of this subsection.

(3) “Dental hygienist” means a person who, under the supervision of a dentist, practices dental hygiene.

(4) “Dental technician” means a person who, at the authorization of a dentist, makes, provides, repairs or alters oral prosthetic appliances and other artificial materials and devices that are returned to a dentist and inserted into the human oral cavity or that come in contact with its adjacent structures and tissues.

(5) “Dental therapist” means a person licensed to practice dental therapy under ORS 679.603.

(6) “Dental therapy” means the provision of preventive dental care, restorative dental treatment and other educational, clinical and therapeutic patient services as part of a dental care team, including the services described under ORS 679.621.

(7) “Dentist” means a person who may perform any intraoral or extraoral procedure required in the practice of dentistry.

(8) “Dentist of record” means a dentist that either authorizes treatment for, supervises treatment of or provides treatment for a patient in a dental office or clinic owned or operated by an institution as described in ORS 679.020 (3).

(9)(a) “Dentistry” means the healing art concerned with:

(A) The examination, diagnosis, treatment planning, treatment, care and prevention of conditions within the human oral cavity and maxillofacial region, and of conditions of adjacent or related tissues and structures; and

(B) The prescribing, dispensing and administering of prescription drugs for purposes related to the activities described in subparagraph (A) of this paragraph.

(b) “Dentistry” includes, but is not limited to:

(A) The cutting, altering, repairing, removing, replacing or repositioning of hard or soft tissues and other acts or procedures as determined by the Oregon Board of Dentistry and included in the curricula of:

(i) Dental schools accredited by the Commission on Dental Accreditation of the American Dental Association;

(ii) Post-graduate training programs; or

(iii) Continuing education courses.

(B) The prescription and administration of vaccines.

(10) “Direct supervision” means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.

(11) “Expanded practice dental hygienist” means a dental hygienist who performs dental hygiene services in accordance with ORS 680.205 as authorized by an expanded practice dental hygienist permit issued by the board under ORS 680.200.

(12) “General supervision” means supervision requiring that a dentist authorize the procedures by standing orders, practice agreements or collaboration agreements, but not

requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.

(13) "Indirect supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed. [Amended by 1983 c.169 §1; 1997 c.251 §4; 1999 c.188 §1; 2003 c.83 §1; 2005 c.52 §2; 2007 c.379 §1; 2011 c.716 §3; 2013 c.310 §1; 2015 c.15 §1; 2015 c.349 §1; 2019 c.58 §4; 2021 c.530 §13]

679.020 Practice of dentistry or operating dental office without license prohibited; exceptions. (1) A person may not practice dentistry without a license.

(2) Only a person licensed as a dentist by the Oregon Board of Dentistry may own, operate, conduct or maintain a dental practice, office or clinic in this state.

(3) The restrictions of subsection (2) of this section, as they relate to owning and operating a dental office or clinic, do not apply to a dental office or clinic owned or operated by any of the following:

(a) A labor organization as defined in ORS 243.650 and 663.005 (6), or to any nonprofit organization formed by or on behalf of such labor organization for the purpose of providing dental services. Such labor organization must have had an active existence for at least three years, have a constitution and bylaws, and be maintained in good faith for purposes other than providing dental services.

(b) The School of Dentistry of the Oregon Health and Science University.

(c) Public universities listed in ORS 352.002.

(d) Local governments.

(e) Institutions or programs accredited by the Commission on Dental Accreditation of the American Dental Association to provide education and training.

(f) Nonprofit corporations organized under Oregon law to provide dental services to rural areas and medically underserved populations of migrant, rural community or homeless individuals under 42 U.S.C. 254b or 254c or health centers qualified under 42 U.S.C. 1396d(l)(2)(B) operating in compliance with other applicable state and federal law.

(g) Nonprofit charitable corporations as described in section 501(c)(3) of the Internal Revenue Code and determined by the Oregon Board of Dentistry as providing dental services by volunteer licensed dentists to populations with limited access to dental care at no charge or a substantially reduced charge.

(h) Nonprofit charitable corporations as described in section 501(c)(3) of the Internal Revenue Code and determined by the Oregon Board of Dentistry as having an existing program that provides medical and dental care to medically underserved children with special needs at an existing single fixed location or multiple mobile locations.

(i) Nonprofit charitable corporations as described in section 501(c)(3) of the Internal Revenue Code and determined by the board as providing dental services to individuals who are 65 years of age or older and individuals who are unable to stand or walk unassisted.

(4) For the purpose of owning or operating a dental office or clinic, an entity described in subsection (3) of this section must:

(a) Except as provided in ORS 679.022, name an actively licensed dentist as its dental director, who shall be subject to the provisions of ORS 679.140 in the capacity as dental director. The dental director, or an actively licensed dentist designated by the director, shall have responsibility for the clinical practice of dentistry, which includes, but is not limited to:

(A) Diagnosis of conditions within the human oral cavity and its adjacent tissues and structures.

(B) Prescribing drugs that are administered to patients in the practice of dentistry.

(C) The treatment plan of any dental patient.

(D) Overall quality of patient care that is rendered or performed in the practice of dentistry.

(E) Supervision of dental hygienists, dental assistants or other personnel involved in direct patient care and the authorization for procedures performed by them in accordance with the standards of supervision established by statute or by the rules of the board.

(F) Other specific services within the scope of clinical dental practice.

(G) Retention of patient dental records as required by statute or by rule of the board.

(H) Ensuring that each patient receiving services from the dental office or clinic has a dentist of record.

(I) The prescription and administration of vaccines.

(b) Maintain current records of the names of licensed dentists who supervise the clinical activities of dental hygienists, dental assistants or other personnel involved in direct patient care utilized by the entity. The records must be available to the board upon written request.

(5) Subsections (1) and (2) of this section do not apply to an expanded practice dental hygienist who renders services authorized by a permit issued by the board pursuant to ORS 680.200.

(6) Nothing in this chapter precludes a person or entity not licensed by the board from:

(a) Ownership or leasehold of any tangible or intangible assets used in a dental office or clinic. These assets include real property, furnishings, equipment and inventory but do not include dental records of patients related to clinical care.

(b) Employing or contracting for the services of personnel other than licensed dentists.

(c) Management of the business aspects of a dental office or clinic that do not include the clinical practice of dentistry.

(7) If all of the ownership interests of a dentist or dentists in a dental office or clinic are held by an administrator, executor, personal representative, guardian, conservator or receiver of the estate of a former shareholder, member or partner, the administrator, executor, personal representative, guardian, conservator or receiver may retain the ownership interest for a period of 12 months following the creation of the ownership interest. The board shall extend the ownership period for an additional 12 months upon 30 days' notice and may grant additional extensions upon reasonable request. [Amended by 1977 c.192 §1; 1985 c.323 §3; 1995 c.286 §29; 1997 c.251 §6; 2003 c.322 §1; 2009 c.223 §1; 2011 c.637 §284; 2011 c.716 §4; 2013 c.310 §2; 2015 c.391 §1; 2019 c.58 §5; 2021 c.366 §11]

Note: The amendments to 679.020 by section 12, chapter 366, Oregon Laws 2021, become operative January 1, 2023. See section 13, chapter 366, Oregon Laws 2021. The text that is operative on and after January 1, 2023, is set forth for the user's convenience.

679.020. (1) A person may not practice dentistry without a license.

(2) Only a person licensed as a dentist by the Oregon Board of Dentistry may own, operate, conduct or maintain a dental practice, office or clinic in this state.

(3) The restrictions of subsection (2) of this section, as they relate to owning and operating a dental office or clinic, do not apply to a dental office or clinic owned or operated by any of the following:

(a) A labor organization as defined in ORS 243.650 and 663.005 (6), or to any nonprofit organization formed by or on behalf of such labor organization for the purpose of providing dental services. Such labor organization must have had an active existence for at least three years, have a constitution and bylaws, and be maintained in good faith for purposes other than providing dental services.

(b) The School of Dentistry of the Oregon Health and Science University.

(c) Public universities listed in ORS 352.002.

(d) Local governments.

(e) Institutions or programs accredited by the Commission on Dental Accreditation of the American Dental Association to provide education and training.

(f) Nonprofit corporations organized under Oregon law to provide dental services to rural areas and medically underserved populations of migrant, rural community or homeless individuals under 42 U.S.C. 254b or 254c or health centers qualified under 42 U.S.C. 1396d(l)(2)(B) operating in compliance with other applicable state and federal law.

(g) Nonprofit charitable corporations as described in section 501(c)(3) of the Internal Revenue Code and determined by the Oregon Board of Dentistry as providing dental services by volunteer licensed dentists to populations with limited access to dental care at no charge or a substantially reduced charge.

(h) Nonprofit charitable corporations as described in section 501(c)(3) of the Internal Revenue Code and determined by the Oregon Board of Dentistry as having an existing program that provides medical and dental care to medically underserved children with special needs at an existing single fixed location or multiple mobile locations.

(4) For the purpose of owning or operating a dental office or clinic, an entity described in subsection (3) of this section must:

(a) Except as provided in ORS 679.022, name an actively licensed dentist as its dental director, who shall be subject to the provisions of ORS 679.140 in the capacity as dental director. The dental director, or an actively licensed dentist designated by the director, shall have responsibility for the clinical practice of dentistry, which includes, but is not limited to:

(A) Diagnosis of conditions within the human oral cavity and its adjacent tissues and structures.

(B) Prescribing drugs that are administered to patients in the practice of dentistry.

(C) The treatment plan of any dental patient.

(D) Overall quality of patient care that is rendered or performed in the practice of dentistry.

(E) Supervision of dental hygienists, dental assistants or other personnel involved in direct patient care and the authorization for procedures performed by them in accordance with the standards of supervision established by statute or by the rules of the board.

(F) Other specific services within the scope of clinical dental practice.

(G) Retention of patient dental records as required by statute or by rule of the board.

(H) Ensuring that each patient receiving services from the dental office or clinic has a dentist of record.

(I) The prescription and administration of vaccines.

(b) Maintain current records of the names of licensed dentists who supervise the clinical activities of dental hygienists, dental assistants or other personnel involved in direct patient care utilized by the entity. The records must be available to the board upon written request.

(5) Subsections (1) and (2) of this section do not apply to an expanded practice dental hygienist who renders services authorized by a permit issued by the board pursuant to ORS 680.200.

(6) Nothing in this chapter precludes a person or entity not licensed by the board from:

(a) Ownership or leasehold of any tangible or intangible assets used in a dental office or clinic. These assets include real property, furnishings, equipment and inventory but do not include dental records of patients related to clinical care.

(b) Employing or contracting for the services of personnel other than licensed dentists.

(c) Management of the business aspects of a dental office or clinic that do not include the clinical practice of dentistry.

(7) If all of the ownership interests of a dentist or dentists in a dental office or clinic are held by an administrator, executor, personal representative, guardian, conservator or receiver of the estate of a former shareholder, member or partner, the administrator, executor, personal representative, guardian, conservator or receiver may retain the ownership interest for a period of 12 months following the creation of the ownership interest. The board shall extend the ownership period for an additional 12 months upon 30 days' notice and may grant additional extensions upon reasonable request.

679.022 Exemption from naming licensed dentist as director for accredited institutions and programs. (1) ORS 679.020 (4)(a) does not apply to institutions or programs accredited by the Commission on Dental Accreditation of the American Dental Association to provide education and training.

(2) Institutions or programs described in subsection (1) of this section must:

(a) Maintain a list of the dentists of record that provide dental care in a dental clinic or office owned or operated by the institution or program; and

(b) Provide the list maintained under this subsection to the Oregon Board of Dentistry when requested by the board. [2013 c.310 §3]

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, 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.

(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 employed by public health agencies 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) Dentists licensed in another state or 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 paragraph and the application is approved by the board.

(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]

679.026 [1971 c.48 §2; 1975 c.693 §20; 1977 c.192 §2; 1981 c.185 §1; repealed by 1983 c.169 §34]

679.027 Enjoining violations. The Attorney General, or the prosecuting attorney of any county, or the Oregon Board of Dentistry, in its own name, may maintain an action for an injunction against any person violating any provision of ORS 679.020, 679.025, 679.170 or 679.176. Any person who has been so enjoined may be punished for contempt by the court issuing the injunction. An injunction may be issued without proof of actual damage sustained by any person. An injunction shall not relieve a person from criminal prosecution for violation of any provision of ORS 679.020, 679.025, 679.170 or 679.176 or from any other civil, criminal or disciplinary remedy. [1957 c.552 §2; 1963 c.284 §2; 1979 c.284 §192; 1983 c.169 §3]

679.030 [Amended by 1953 c.574 §5; repealed by 1977 c.192 §13]

679.040 [Amended by 1963 c.284 §3; repealed by 2003 c.83 §12]

679.050 Nonresident dentists giving or receiving instruction; hospital permits. (1) If a reputable and duly licensed practitioner in dentistry of another state or country is asked to appear and demonstrate, receive or give instruction in the practice of dentistry before any qualified dental college or dental organization or dental study group recognized by the Oregon Board of Dentistry, the secretary of the board shall issue on written request of an authorized officer of such college or dental organization or dental study group, without fee, a permit for such purpose. A permit shall be issued upon such terms as the board shall prescribe.

(2) If a reputable and duly licensed practitioner in dentistry of another state has been granted staff privileges, either limited, special or general, by any duly licensed hospital in this state, the secretary of the board shall issue on written request and verification of an authorized officer of such hospital, a permit for such nonresident practitioner to practice dentistry in said hospital. [Amended by 1963 c.284 §4; 1965 c.122 §3; 1967 c.282 §1; 1973 c.390 §2; 2013 c.114 §2]

LICENSING

679.060 Application for license; fees; grounds for refusal of license. (1) Any person desiring to practice dentistry in this state shall file an application with the Oregon Board of Dentistry.

(2) At the time of making the application, the applicant shall:

(a) Pay to the board the required application and examination fee.

(b) Furnish the board with evidence satisfactory to the board of details of any convictions recorded in any police records. Such details are subject to the findings required by ORS 670.280.

(c) Present to the board a diploma or evidence satisfactory to the board of having graduated from an accredited dental education program approved by the board.

(3) If an applicant has been in practice in another state or states the applicant shall furnish an affidavit from the secretary of the board of dental examiners or similar body of such state or states that the applicant has been engaged in the legal practice of dentistry in such state or states for a period of time prescribed by the rules of the Oregon Board of Dentistry.

(4) The board may refuse to issue a license to or renew a license of an applicant who has been convicted of a violation of the law if the board makes the findings required by ORS 670.280. A certified copy of the record of conviction is conclusive evidence of conviction.

(5) The board may refuse to issue a license to or renew a license of an applicant who has been disciplined by a state licensing or regulatory agency of this or another state regarding any health care profession when, in the judgment of the board, the act or conduct resulting in the disciplinary action bears a demonstrable relationship to the ability of the licensee or applicant to practice dentistry in accordance with the provisions of this chapter. A certified copy of the record of the disciplinary action is conclusive evidence of the disciplinary action.

(6) The board may refuse to issue a license to or renew a license of an applicant who has falsified a license application, or any person for any cause described under ORS 679.140 or 679.170.

(7) Fees paid are not refundable. [Amended by 1963 c.284 §5; 1973 c.390 §3; 1973 c.827 §69; 1973 c.829 §62a; 1977 c.444 §1; 1981 c.232 §1; 1983 c.169 §6; 1985 c.323 §4; 1995 c.199 §1; 2003 c.83 §2]

679.065 Qualifications of applicants; rules. (1) An applicant for a dental license shall be entitled to take the examination to practice dentistry in Oregon if the applicant:

(a) Is 18 years of age or older; and

(b) Is a graduate of a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency, if any, which must have been approved by the Oregon Board of Dentistry.

(2) Foreign trained graduates of dental programs may apply for the dental licensure examination, providing the applicant meets the board's requirements, by rule, as will reasonably assure that an applicant's training and education are sufficient for licensure. [1983 c.169 §5]

679.070 Examination; acceptable results. (1) The Oregon Board of Dentistry may administer written, laboratory or clinical examinations to test professional knowledge and skills.

(2) The examination must be elementary and practical in character but sufficiently thorough to test the fitness of the applicant to practice dentistry. It must include, written in the English language, questions on any subjects pertaining to dental science.

(3) If a test or examination was taken within five years of the date of application and the applicant received a passing score on the test or examination, as established by the board by rule, the board:

(a) To satisfy the written examination authorized under this section, may accept the results of national standardized examinations.

(b) To satisfy the laboratory or clinical examination authorized under this section:

(A) Shall accept the results of regional and national testing agencies or clinical board examinations administered by other states; and

(B) May accept the results of board-recognized testing agencies.

(4) The board shall accept the results of regional and national testing agencies or of clinical board examinations administered by other states, and may accept results of board-recognized testing agencies, in satisfaction of the examinations authorized under this section for applicants who have engaged in the active practice of dentistry in other states, in Oregon or in the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for at least 3,500 hours in the five years immediately preceding application and who meet all other requirements for licensure. [Amended by 1965 c.122 §4; 1983 c.169 §7; 1999 c.489 §1; 2001 c.193 §1; 2003 c.83 §3; 2005 c.229 §1; 2019 c.467 §1]

679.080 Reexamination of applicants; rules. The Oregon Board of Dentistry may adopt rules requiring additional education and examination of applicants who have failed the licensing examination three times. [Amended by 1973 c.829 §63; 1977 c.444 §2; 1983 c.169 §8; 2003 c.83 §4]

679.090 Issuance of license. The Oregon Board of Dentistry shall, upon the applicant's satisfactory completion of the educational requirements and written, laboratory and clinical examinations authorized under this chapter and upon receipt of the requisite fees, issue or renew the appropriate dental license. [Amended by 1963 c.284 §6; 1971 c.34 §1; 1983 c.169 §9]

679.100 [Repealed by 1963 c.284 §17]

679.105 [1997 c.662 §1; repealed by 2003 c.83 §12]

679.110 [Repealed by 1983 c.169 §34]

679.115 Licensing of dental instructor; requirements. (1) Notwithstanding any other provision of this chapter, the Oregon Board of Dentistry shall issue a dental instructor's license to practice dentistry to any person who furnishes the board with evidence satisfactory to the board that the applicant meets the requirements of subsection (2) of this section.

(2) An applicant for a dental instructor's license must be a full-time instructor of dentistry engaged in dental activities, including but not limited to participation in a faculty practice plan, within the scope of the applicant's employment at Oregon Health and Science University and either:

(a) Be a graduate of an accredited dental school; or

(b) If the applicant is not a graduate of an accredited dental school, have a certificate or degree showing successful completion of an advanced dental education program of at least two years' duration from an accredited dental school and:

(A) Be licensed to practice dentistry in another state or a Canadian province;

(B) Have held an instructor's or faculty license to practice dentistry in another state or a Canadian province immediately prior to becoming an instructor of dentistry at Oregon Health and Science University;

(C) Have successfully passed any clinical examination recognized by the board for initial licensure; or

(D) Be certified by the appropriate national certifying examination body in a dental specialty recognized by the American Dental Association.

(3) The board may refuse to issue or renew a dental instructor's license to an applicant or licensee:

(a) Who has been convicted of an offense or disciplined by a dental licensing body in a manner that bears, in the judgment of the board, a demonstrable relationship to the ability of the applicant or licensee to practice dentistry in accordance with the provisions of this chapter;

(b) Who has falsified an application for licensure; or

(c) For cause as described under ORS 679.140 or 679.170.

(4) A person issued a dental instructor's license is restricted to the practice of dentistry for or on behalf of Oregon Health and Science University.

(5) A license issued to an applicant qualifying for a dental instructor's license who is a specialist by virtue of successful completion of an advanced dental education program is restricted to the specialty in which the dentist was trained.

(6) As used in this section, "accredited" means accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency, if any. [1999 c.578 §8; 2001 c.188 §1; 2013 c.413 §1; 2015 c.394 §1]

679.120 Fees; waiver of fee; rules; renewal of license; notice of change of address. (1) The Oregon Board of Dentistry may impose application fees for the following:

(a) Examinations, which may differ for general dentistry, foreign school graduate and specialty examinations.

(b) Biennial dentist license, active.

(c) Biennial dentist license, inactive.

(d) Permits and certificates.

(e) Delinquency.

(2) Subject to prior approval of the Oregon Department of Administrative Services and a report to the Emergency Board prior to adopting the fees and charges, the fees and charges established under this section and ORS 680.075 shall not exceed the costs of administering the regulatory program of the board, as authorized by the Legislative Assembly within the board budget, as the budget may be modified by the Emergency Board.

(3)(a) The board may waive the payment of the license fee in the case of any licensee who furnishes satisfactory evidence that the licensee has discontinued the actual practice of dentistry because of retirement.

(b) Application to reinstate a license retired under paragraph (a) of this subsection or to convert an inactive status license to an active status license shall be made in accordance with the rules of the board and with the submission of the license fee prescribed for such license; provided, however, that if more than one year has expired since the license was retired or inactivated, satisfactory evidence of operative competence must be submitted to the board.

(4) Every dentist shall advise the board within 30 days of any change of address.

(5) Each dentist must renew the dentist's license every two years through submitting a renewal application and paying the license fee.

(6) Dentists licensed in even-numbered years must renew by March 31 of each even-numbered year. Dentists licensed in odd-numbered years must renew by March 31 of each odd-numbered year.

(7) A reasonable charge may be made in the event that the license fee or renewal application is more than 10 days delinquent.

(8) Fees paid are not refundable. [Amended by 1963 c.284 §7; 1967 c.19 §2; 1971 c.34 §2; 1973 c.390 §4; 1977 c.192 §3; 1977 c.444 §3a; 1981 c.232 §2; 1985 c.323 §5; 1989 c.338 §7; 1991 c.703 §25]

679.130 [Amended by 1973 c.390 §5; 1983 c.169 §10; 1991 c.67 §182; repealed by 1999 c.578 §6]

679.140 Discipline of licensee; grounds; procedure; sanctions. (1) The Oregon Board of Dentistry may discipline as provided in this section any person licensed to practice dentistry in this state for any of the following causes:

(a) Conviction of any violation of the law for which the court could impose a punishment if the board makes the finding required by ORS 670.280. The record of conviction or a certified copy thereof, certified by the clerk of the court or by the judge in whose court the conviction is entered, is conclusive evidence of the conviction.

(b) Renting or lending a license or diploma of the dentist to be used as the license or diploma of another person.

(c) Unprofessional conduct.

(d) Any violation of this chapter or ORS 680.010 to 680.205, of rules adopted pursuant to this chapter or ORS 680.010 to 680.205 or of an order issued by the board.

(e) Engaging in or permitting the performance of unacceptable patient care by the dentist or by any person working under the supervision of the dentist due to a deliberate or negligent act or failure to act by the dentist, regardless of whether actual injury to the patient is established.

(f) Incapacity to practice safely.

(2) “Unprofessional conduct” as used in this chapter includes but is not limited to the following:

(a) Obtaining any fee by fraud or misrepresentation.

(b) Willfully betraying confidences involved in the patient-dentist relationship.

(c) Employing, aiding, abetting or permitting any unlicensed personnel to practice dentistry, dental hygiene or dental therapy.

(d) Making use of any advertising statements of a character tending to deceive or mislead the public or that are untruthful.

(e) Impairment as defined in ORS 676.303.

(f) Obtaining or attempting to obtain a controlled substance in any manner proscribed by the rules of the board.

(g) Prescribing or dispensing drugs outside the scope of the practice of dentistry or in a manner that impairs the health and safety of an individual.

(h) Disciplinary action by a state licensing or regulatory agency of this or another state regarding a license to practice dentistry, dental hygiene, dental therapy or any other health care profession when, in the judgment of the board, the act or conduct resulting in the disciplinary action bears a demonstrable relationship to the ability of the licensee or applicant to practice dentistry, dental hygiene or dental therapy in accordance with the provisions of this chapter. A certified copy of the record of the disciplinary action is conclusive evidence of the disciplinary action.

(3) The proceedings under this section may be taken by the board from the matters within its knowledge or may be taken upon the information of another, but if the informant is a member of the board, the other members of the board shall constitute the board for the purpose of finding judgment of the accused.

(4) In determining what constitutes unacceptable patient care, the board may take into account all relevant factors and practices, including but not limited to the practices generally and currently followed and accepted by persons licensed to practice dentistry in this state, the current teachings at accredited dental schools, relevant technical reports published in recognized dental journals and the desirability of reasonable experimentation in the furtherance of the dental arts.

(5) In disciplining a person as authorized by subsection (1) of this section, the board may use any or all of the following methods:

(a) Suspend judgment.

(b) Place a licensee on probation.

(c) Suspend a license to practice dentistry in this state.

(d) Revoke a license to practice dentistry in this state.

(e) Place limitations on a license to practice dentistry in this state.

(f) Refuse to renew a license to practice dentistry in this state.

(g) Accept the resignation of a licensee to practice dentistry in this state.

(h) Assess a civil penalty.

(i) Reprimand a licensee.

(j) Impose any other disciplinary action the board in its discretion finds proper, including assessment of the costs of the disciplinary proceedings as a civil penalty.

(6) If the board places any person upon probation as set forth in subsection (5)(b) of this section, the board may determine and may at any time modify the conditions of the probation and may include among them any reasonable condition for the purpose of protection of the public and for the purpose of the rehabilitation of the probationer or both. Upon expiration of the

term of probation, further proceedings shall be abated by the board if the person holding the license furnishes the board with evidence that the person is competent to practice dentistry and has complied with the terms of probation. If the evidence fails to establish competence to the satisfaction of the board or if the evidence shows failure to comply with the terms of the probation, the board may revoke or suspend the license.

(7) If a license to practice dentistry in this state is suspended, the person holding the license may not practice during the term of suspension. Upon the expiration of the term of suspension, the license shall be reinstated by the board if the board finds, based upon evidence furnished by the person, that the person is competent to practice dentistry and has not practiced dentistry in this state during the term of suspension. If the evidence fails to establish to the satisfaction of the board that the person is competent or if any evidence shows the person has practiced dentistry in this state during the term of suspension, the board may revoke the license after notice and hearing.

(8) Upon receipt of a complaint under this chapter or ORS 680.010 to 680.205, the board shall conduct an investigation as described under ORS 676.165.

(9) Information that the board obtains as part of an investigation into licensee or applicant conduct or as part of a contested case proceeding, consent order or stipulated agreement involving licensee or applicant conduct is confidential as provided under ORS 676.175. Notwithstanding ORS 676.165 to 676.180, the board may disclose confidential information regarding a licensee or an applicant to persons who may evaluate or treat the licensee or applicant for drug abuse, alcohol abuse or any other health related conditions.

(10) The board may impose against any person who violates the provisions of this chapter or ORS 680.010 to 680.205 or rules of the board a civil penalty of up to $5,000 for each violation. Any civil penalty imposed under this section shall be imposed in the manner provided in ORS 183.745.

(11) Notwithstanding the expiration, suspension, revocation or surrender of the license, or the resignation or retirement of the licensee, the board may:

(a) Proceed with any investigation of, or any action or disciplinary proceedings against, the dentist, dental hygienist or dental therapist; or

(b) Revise or render void an order suspending or revoking the license.

(12)(a) The board may continue with any proceeding or investigation for a period not to exceed four years from the date of the expiration, suspension, revocation or surrender of the license, or the resignation or retirement of the licensee; or

(b) If the board receives a complaint or initiates an investigation within that four-year period, the board’s jurisdiction continues until the matter is concluded by a final order of the board following any appeal.

(13) Withdrawing the application for license does not close any investigation, action or proceeding against an applicant. [Amended by 1955 c.560 §2; 1961 c.311 §1; 1963 c.284 §8; 1965 c.122 §5; 1971 c.157 §1; 1973 c.554 §1; 1977 c.192 §3a; 1977 c.745 §51; 1979 c.142 §1; 1979 c.744 §53a; 1981 c.185 §2; 1983 c.169 §11; 1985 c.323 §6; 1991 c.734 §73; 1995 c.199 §2; 1997 c.791 §25; 1999 c.253 §1; 1999 c.578 §1; 2003 c.83 §5; 2009 c.756 §39; 2021 c.530 §14]

679.150 [Amended by 1961 c.311 §2; 1963 c.284 §9; 1965 c.122 §6; 1967 c.282 §2; 1983 c.169 §12; repealed by 1999 c.578 §6]

679.160 Appeal from board decision. (1) Any licensee who has been disciplined by the Oregon Board of Dentistry may obtain judicial review of the decision in the manner prescribed by ORS chapter 183.

(2) Notwithstanding ORS 676.210, enforcement of the board's disciplinary order pending appeal shall be determined pursuant to ORS 183.482 (3). [Amended by 1961 c.311 §3; 1967 c.282 §3; 1973 c.390 §6; 1977 c.192 §4; 1979 c.744 §54; 1983 c.169 §13; 1995 c.199 §3; 2003 c.83 §6]

679.165 Automatic suspension of license in case of mental disorder. The entry of a judgment by any court establishing the mental disorder of any person holding a license under this chapter operates as a suspension of such license. Such person may resume practice only upon a finding by the Oregon Board of Dentistry that the licensee has been declared restored to mental competence by an order of a court of competent jurisdiction. [1957 c.552 §3; 1999 c.59 §202; 2003 c.576 §542]

679.170 Prohibited practices. A person may not:

(1) Sell or barter, or offer to sell or barter, any diploma or document conferring or purporting to confer any dental degree, or any certificate or transcript made or purporting to be made, pursuant to the laws regulating the license and registration of dentists.

(2) Purchase or procure by barter, any diploma, certificate or transcript described in subsection (1) of this section, with intent that it be used as evidence of the holder's qualification to practice dentistry, or in fraud of the laws regulating the practice of dentistry.

(3) With fraudulent intent, alter in a material regard any diploma, certificate or transcript described in subsection (1) of this section.

(4) Use or attempt to use any diploma, certificate or transcript described in subsection (1) of this section, which has been purchased, fraudulently issued, counterfeited or materially altered, either as a license or color of license to practice dentistry, or in order to procure registration as a dentist.

(5) Willfully make a false written or recorded oral statement to the Oregon Board of Dentistry in a material regard.

(6) Within 10 days after demand made by the board, fail to respond to the board's written request for information or fail to furnish to the board the name and address of all persons practicing or assisting in the practice of dentistry in the office of such person at any time within 60 days prior to the notice, together with a sworn statement showing under and by what license or authority such person and employee are and have been practicing dentistry.

(7) Employ or use the services of any unlicensed person, to practice dentistry, dental hygiene or dental therapy, except as permitted by ORS 679.025, 679.176 and 680.010 to 680.205. [Amended by 1963 c.284 §10; 1977 c.192 §5; 1981 c.185 §3; 1983 c.169 §14; 1995 c.199 §4; 1999 c.578 §2; 2021 c.530 §15]

679.175 [1953 c.574 §3; repealed by 1957 c.552 §9]

679.176 Written work orders required for certain services. (1) No dentist may use the services of any person, not licensed to practice dentistry in this state, to construct, alter, repair, reline, reproduce or duplicate any prosthetic denture, bridge, appliance or any other structure to

be worn in the human mouth, unless the dentist first furnishes to such person a written work order, in substantially the following form:

(Date) _____, 2___

TO: (Name of dental technician or laboratory with address)

RE: (Name or number of patient)

(Description of the work to be done, including diagrams if necessary, together with specifications of the type of materials to be used.)

(Name of ordering dentist)

(Address) _____

(Current license number) ___

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(2) A duplicate copy of each such work order issued by the dentist shall be retained by each dentist for not less than two years. The Oregon Board of Dentistry or its agents shall be permitted to inspect, upon demand, the duplicate copies of all such work orders retained by each dentist.

(3) No work order shall permit or require the taking of impressions of any part of the human oral cavity by any person not a dentist licensed by the board. [1963 c.284 §15]

679.180 Enforcement; jurisdiction. (1) The district attorney of each county shall attend to the prosecution of all criminal complaints made under this chapter and may represent the Oregon Board of Dentistry in any proceeding brought pursuant to ORS 679.027 upon a complaint, information or indictment filed against any person under this chapter, or upon request of the board. However, nothing in this chapter shall be construed to prevent the prosecution of any person for violation of this chapter upon the information of the district attorney directly or, subject to the requirements of ORS 676.175, to prevent assistance being rendered to the district attorney by an employee of the board.

(2) Nothing contained in this chapter shall be construed to require the district attorney to prosecute any person who is licensed by the board and who is subject to disciplinary action directly by the board under any provision of this chapter or ORS 680.010 to 680.205. [Amended by 1963 c.284 §11; 1967 c.282 §4; 1977 c.192 §6; 1983 c.169 §15; 1997 c.791 §26]

OREGON BOARD OF DENTISTRY

679.230 Oregon Board of Dentistry; appointment; qualifications; confirmation; compensation and expenses. (1) The Oregon Board of Dentistry consists of 10 members appointed by the Governor and subject to confirmation by the Senate in the manner provided in ORS 171.562 and 171.565. All members of the board must be residents of this state. Of the members of the board:

(a) Six must be Oregon active licensed dentists, of which at least one must be a dentist practicing in a dental specialty recognized by the American Dental Association;

(b) Two must be Oregon active licensed dental hygienists; and

(c) Two must be members of the public who are not:

(A) Otherwise eligible for appointment to the board; or

(B) A spouse, domestic partner, child, parent or sibling of a dentist or dental hygienist.

(2)(a) Board members required to be Oregon active licensed dentists or dental hygienists may be selected by the Governor from a list of three to five nominees for each vacancy, submitted by:

(A) The Oregon Dental Association, if the vacancy is in a dentist position;

(B) The Oregon Dental Hygienists' Association, if the vacancy is in a dental hygienist position; or

(C) Any of the professional organizations representing a dental specialty, if the vacancy is in a dental specialty position.

(b) In selecting the members of the board, the Governor shall strive to balance the representation on the board according to:

(A) Geographic areas of this state; and

(B) Ethnic group.

(3)(a) The term of office of each member is four years, but a member serves at the pleasure of the Governor. The terms must be staggered so that no more than three terms end each year. Terms of office begin on the first Monday of April after the time of appointment. A member is eligible for reappointment. If there is a vacancy in the membership of the board for any reason, the Governor shall make an appointment to become immediately effective for the unexpired term.

(b) A board member shall be removed immediately from the board if, during the member's term, the member:

(A) Is not a resident of this state;

(B) Has been absent from three consecutive board meetings, unless at least one absence is excused;

(C) Is not a licensed dentist or a retired dentist whose license was in good standing at the time of retirement, if the board member was appointed to serve on the board as a dentist or a dental specialist; or

(D) Is not a licensed dental hygienist or a retired dental hygienist whose license was in good standing at the time of retirement, if the board member was appointed to serve on the board as a dental hygienist.

(4) Members of the board are entitled to compensation and expenses as provided in ORS 292.495. The board may provide by rule for compensation to board members for the performance of official duties at a rate that is greater than the rate provided in ORS 292.495. [Amended by 1963 c.284 §12; 1969 c.314 §82; 1971 c.650 §30; 1973 c.792 §36; 1977 c.747 §1; 1983 c.169 §16; 1991 c.955 §1; 2003 c.83 §7; 2009 c.535 §14]

679.240 [Repealed by 1983 c.169 §34]

679.250 Powers and duties of board; rules. The powers and duties of the Oregon Board of Dentistry are as follows:

(1) To, during the month of April of each year, organize and elect from its membership a president who shall hold office for one year, or until the election and qualification of a successor.

(2) To authorize all necessary disbursements to carry out the provisions of this chapter, including but not limited to, payment for necessary supplies, office equipment, books and

expenses for the conduct of examinations, payment for legal and investigative services rendered to the board, and such other expenditures as are provided for in this chapter.

(3) To employ such inspectors, examiners, special agents, investigators, clerical assistants, assistants and accountants as are necessary for the investigation and prosecution of alleged violations and the enforcement of this chapter and for such other purposes as the board may require. Nothing in this chapter shall be construed to prevent assistance being rendered by an employee of the board in any hearing called by it. However, all obligations for salaries and expenses incurred under this chapter shall be paid from the fees accruing to the board under this chapter and not otherwise.

(4)(a) To conduct examinations of applicants for license to practice dentistry, dental hygiene and dental therapy at least twice in each year.

(b) In conducting examinations for licensure, the board may enter into a compact with other states for conducting regional examinations with other board of dental examiners concerned, or by a testing service recognized by such boards.

(5) To meet for the transaction of other business at the call of the president. A majority of board members shall constitute a quorum. A majority vote of those present shall be a decision of the entire board. The board's proceedings shall be open to public inspection in all matters affecting public interest.

(6) To keep an accurate record of all proceedings of the board and of all its meetings, of all receipts and disbursements, of all prosecutions for violation of this chapter, of all examinations for license to practice dentistry, with the names and qualifications for examination of any person examined, together with the addresses of those licensed and the results of such examinations, a record of the names of all persons licensed to practice dentistry in Oregon together with the addresses of all such persons having paid the license fee prescribed in ORS 679.120 and the names of all persons whose license to practice has been revoked or suspended.

(7) To make and enforce rules necessary for the procedure of the board, for the conduct of examinations, for regulating the practice of dentistry, and for regulating the services of dental hygienists and dental auxiliary personnel not inconsistent with the provisions of this chapter. As part of such rules, the board may require the procurement of a permit or other certificate. Any permit issued may be subject to periodic renewal. In adopting rules, the board shall take into account all relevant factors germane to an orderly and fair administration of this chapter and of ORS 680.010 to 680.205, the practices and materials generally and currently used and accepted by persons licensed to practice dentistry in this state, dental techniques commonly in use, relevant technical reports published in recognized dental journals, the curriculum at accredited dental schools, the desirability of reasonable experimentation in the furtherance of the dental arts, and the desirability of providing the highest standard of dental care to the public consistent with the lowest economic cost.

(8) Upon its own motion or upon any complaint, to initiate and conduct investigations of and hearings on all matters relating to the practice of dentistry, the discipline of licensees, or pertaining to the enforcement of any provision of this chapter. In the conduct of investigations or upon the hearing of any matter of which the board may have jurisdiction, the board may take evidence, administer oaths, take the depositions of witnesses, including the person charged, in the manner provided by law in civil cases, and compel their appearance before it in person the same as in civil cases, by subpoena issued over the signature of an employee of the board and in the name of the people of the State of Oregon, require answers to interrogatories, and compel the production of books, papers, accounts, documents and testimony pertaining to the matter under

investigation or to the hearing. In all investigations and hearings, the board and any person affected thereby may have the benefit of counsel, and all hearings shall be held in compliance with ORS chapter 183. Notwithstanding ORS 676.165, 676.175 and 679.320, if a licensee who is the subject of an investigation or complaint is to appear before members of the board investigating the complaint, the board shall provide the licensee with a current summary of the complaint or the matter being investigated not less than five days prior to the date that the licensee is to appear. At the time the summary of the complaint or the matter being investigated is provided, the board shall provide to the licensee a current summary of documents or alleged facts that the board has acquired as a result of the investigation. The name of the complainant or other information that reasonably may be used to identify the complainant may be withheld from the licensee.

(9) To require evidence as determined by rule of continuing education or to require satisfactory evidence of operative competency before reissuing or renewing licenses for the practice of dentistry, dental hygiene or dental therapy.

(10) To adopt and enforce rules regulating administration of general anesthesia and conscious sedation by a dentist or under the supervision of a dentist in the office of the dentist. As part of such rules, the board may require the procurement of a permit which must be periodically renewed.

(11) To order an applicant or licensee to submit to a physical examination, mental examination or a competency examination when the board has evidence indicating the incapacity of the applicant or licensee to practice safely. [Amended by 1953 c.8 §2; 1957 c.552 §8; 1963 c.284 §13; 1965 c.122 §7; 1973 c.390 §7; 1973 c.829 §64; 1977 c.192 §7; 1983 c.169 §17; 1985 c.323 §7; 1989 c.338 §10; 1999 c.578 §3; 1999 c.751 §6; 2009 c.756 §41; 2021 c.530 §16]

679.253 Authority of board to require fingerprints. For the purpose of requesting a state or nationwide criminal records check under ORS 181A.195, the Oregon Board of Dentistry may require the fingerprints of a person who:

(1) Is employed or applying for employment by the board in a position in which the person has or will have access to information that is made confidential under state or federal laws, rules or regulations;

(2) Provides services or seeks to provide services to the board as a contractor, vendor or volunteer in a position in which the person has or will have access to information that is made confidential under state or federal laws, rules or regulations;

(3) Is applying for a license or permit that is issued by the board;

(4) Is applying for renewal of a license or permit that is issued by the board; or

(5) Is under investigation by the board. [2005 c.730 §54]

Note: 679.253 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 679 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

679.255 Board to adopt standards for sedation during dental procedures; rules. The Oregon Medical Board and the Oregon State Board of Nursing, in consultation with the Oregon Board of Dentistry, shall adopt rules establishing standards governing their respective licensees for general anesthesia and conscious sedation administered in conjunction with the professional services of a dentist or dental hygienist. [1985 c.323 §13]

679.260 Oregon Board of Dentistry Account; disbursement of receipts. (1) The Oregon Board of Dentistry Account is established in the State Treasury separate and distinct from the General Fund.

(2) All moneys received by the Oregon Board of Dentistry under this chapter shall be paid to the State Treasury and credited to the Oregon Board of Dentistry Account. Any interest or other income derived from moneys paid into the account shall be credited monthly to the account.

(3) Moneys in the Oregon Board of Dentistry Account are appropriated continuously and shall be used only for the administration and enforcement of ORS 676.850 and 680.010 to 680.205 and this chapter.

(4) Ten percent of the annual license fee to be paid by each licensee of the Oregon Board of Dentistry shall be used by the board to ensure the continued professional competence of licensees. Such activities shall include the development of performance standards and professional peer review. [Amended by 1957 c.552 §5; 1967 c.19 §3; 1967 c.282 §5; 1969 c.314 §103; 1973 c.427 §21; 1977 c.192 §8; 1977 c.747 §2; 2003 c.83 §8; 2011 c.597 §279; 2013 c.240 §10]

679.270 [Repealed by 1973 c.829 §71]

679.280 Dental committees or consultants for improving standards of practice; liability; confidentiality of proceedings. (1) The Oregon Board of Dentistry may appoint a consultant or a committee or committees, each consisting of one or more licensed dentists in this state, to study and report to the board the condition of and dental treatment rendered to any person or persons by any licensed dentist or dentists in this state or by any person purporting to practice dentistry in this state. Any person, hospital, sanatorium, professional grievance committee, nursing or rest home or other organization may, subject to the laws governing privileged or confidential communications, provide information, interviews, reports, statements, memoranda or other data relating to the condition and treatment of any person to the consultant or committee or to the board, to be used in the course of any study for the purpose of improving the standards of dental practice or to enable the board to assess the desirability of disciplinary action relating thereto; and no liability of any kind or character for damages or other relief shall arise or be enforced against the person or organization by reason of having provided the information or material, or arise or be enforced against any consultant or member of the committee by reason of having released or published the findings and conclusions of the consultants or committees to advance dental science and dental education, or by reason of having released or published generally a summary of those studies. When used by the board to assess the desirability of disciplinary action, the testimony given to and the proceedings, reports, statements, opinions, findings and conclusions of the consultants and committees and the board shall be confidential as provided under ORS 676.175, but this shall not preclude the use of the subpoena power with respect to the actual records of dentists, patients, hospitals, sanitaria, nursing or rest homes.

(2) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any consultant or member of a duly appointed committee for any act or proceeding undertaken or performed within the scope of the functions of that consultant or committee, if the consultant or committee member acts without malice, has made a reasonable effort to obtain the facts of the matter on which the consultant or committee member acts, and acts in a reasonable belief that the action taken is warranted by the facts known to the consultant

or committee member after that reasonable effort to obtain the facts. [1965 c.122 §2; 1977 c.192 §9; 1997 c.791 §27]

679.290 Failure to comply with subpoena issued by board. (1) If a person fails to comply with any subpoena issued under ORS 679.250 (8), a judge of the circuit court of any county, on application of the executive director of the Oregon Board of Dentistry, shall compel obedience by proceedings for contempt as in the case of disobedience of the requirements of a subpoena issued from the circuit court.

(2) In any proceeding under subsection (1) of this section and where the subpoena is addressed to a licensee of the board it shall not be a defense that:

(a) No witness or mileage fee was paid; or

(b) The material that is subject to the subpoena is protected under a patient and dentist privilege. [1983 c.169 §31; 2009 c.756 §42]

679.300 Privileged data; admissibility of data as evidence in judicial proceedings. (1) All data shall be privileged and shall not be admissible in evidence in any judicial proceeding, but this section shall not affect the admissibility in evidence of a party's records dealing with a party's care and treatment.

(2) A person serving on or communicating information to a committee described in subsection (4) of this section shall not be examined as to any communication to that committee or the findings thereof.

(3) A person serving on or communicating to a committee described in subsection (4) of this section shall not be subject to an action for civil damages for affirmative actions taken or statements made in good faith.

(4) As used in subsection (1) of this section, "data" means written reports, notes or records of peer review committees or other committees and similar committees of professional societies in connection with training, supervision or discipline of dentists. The term also includes written reports, notes or records of utilization review and professional standards review organization. [1983 c.169 §33]

Note: 679.300 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 679 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

679.310 Duty to report violations; exceptions; liability. (1)(a) Unless state or federal laws relating to confidentiality or the protection of health information prohibit disclosure, any dentist or dental hygienist, or any person licensed by the Oregon Board of Dentistry, shall report to the board any suspected violation of this chapter or ORS 680.010 to 680.205 or any rule adopted by the board.

(b) Unless state or federal laws relating to confidentiality or the protection of health information prohibit disclosure, a dentist or dental hygienist, or any person licensed by the board, shall report any prohibited conduct as defined in ORS 676.150 in the manner provided in ORS 676.150.

(c) Unless state or federal laws relating to confidentiality or the protection of health information prohibit disclosure, the Oregon Dental Association or any other organization

representing dentists or dental hygienists shall report to the board any suspected violation of this chapter or ORS 680.010 to 680.205 or any rule adopted by the board.

(d) Any person may report to the board any suspected violation of this chapter or ORS 680.010 to 680.205 or any rule adopted by the board, association or other organization representing dentists or dental hygienists.

(2) This section is not intended to require any person working on or with the Oregon Dental Association's Dentist Well Being Committee or Peer Review Committee or the Quality Assurance or Peer Review Committee of the Oregon Dental Hygienists' Association to report to the board any confidential information received within the scope of duties with that committee.

(3) No person who has made a complaint as to the conduct of a licensee of the board or who has given information or testimony relative to a proposed or pending proceeding for misconduct against the licensee of the board, shall be answerable for any such act in any proceeding except for perjury. [1985 c.323 §11; 1999 c.578 §4; 2009 c.536 §7]

679.320 Confidentiality of information provided to board; limitation of liability. (1) Any information provided to the Oregon Board of Dentistry as the basis of a complaint or in the investigation thereof shall not be subject to public disclosure during the period of investigation.

(2) Any person who reports or provides information to the board and who does so in good faith shall not be subject to an action for civil damages as a result thereof. [1985 c.323 §12]

679.323 Removal of individual disciplinary information; rules. (1) Upon the request of an individual who has been disciplined by the Oregon Board of Dentistry, the board shall remove from its website and other publicly accessible print and electronic publications under the board's control all information related to disciplining the individual under ORS 679.140 and any findings and conclusions made by the board during the disciplinary proceeding, if:

(a) The request is made 10 years or more after the date on which any disciplinary sanction ended;

(b) The individual was not disciplined for financially or physically harming a patient;

(c) The individual informed the board of the matter for which the individual was disciplined before the board received information about the matter or otherwise had knowledge of the matter;

(d) The individual making the request, if the individual is or was a licensee, has not been subjected to other disciplinary action by the board following the imposition of the disciplinary sanction; and

(e) The individual fully complied with all disciplinary sanctions imposed by the board.

(2) The board shall adopt by rule a process for making a request under this section. [2016 c.41 §2]

MISCELLANEOUS

679.500 Administration of local anesthesia for certain purposes; rules. (1) A dentist licensed to practice dentistry in this state may administer local anesthesia to a person for the purposes of receiving permanent lip color from a person licensed to perform tattooing under ORS 690.350 to 690.410 or having permanent hair removal in the lip area from a person licensed to perform electrolysis under ORS 690.350 to 690.410.

(2) Prior to administering local anesthesia for the purposes authorized under subsection (1) of this section, the dentist must:

(a) Receive a written order from a person licensed to perform tattooing or electrolysis under ORS 690.350 to 690.410;

(b) Obtain a current health history from and perform an oral examination of the person who will receive the anesthesia; and

(c) Establish and maintain a patient record in accordance with rules adopted by the Oregon Board of Dentistry.

(3) The Oregon Board of Dentistry shall adopt rules authorizing a dentist licensed to practice dentistry in Oregon to administer local anesthesia for the purposes of tattooing human lips or having permanent hair removal in the lip area by a person licensed to perform tattooing or electrolysis under ORS 690.350 to 690.410. [1999 c.578 §10; 2003 c.187 §1; 2011 c.346 §32]

679.510 Liability insurance for retired dentist; requirements; rules. (1) For the purposes of this section, "retired dentist" means a person who is retired from active practice except for the practice of dentistry without remuneration as a volunteer.

(2) Subject to availability of funding, the Oregon Department of Administrative Services shall establish a program to purchase and maintain liability insurance for retired dentists. Insurance provided under the program shall be acquired through contracts with liability insurers that are authorized to offer liability malpractice insurance in this state. Insurance shall be provided under the program only if:

(a) Dental services by the retired dentist will be provided through nonprofit corporations offering community services;

(b) Dental services provided by the retired dentist will be offered to low-income patients based on ability to pay; and

(c) The retired dentist will receive no compensation for the dental services provided, except for reimbursement for laboratory fees, testing services and other out-of-pocket expenses.

(3) This section does not impose any liability on the state, or on the officers, employees and agents of the state, for any civil or criminal action against a retired dentist insured under the program established under subsections (1) to (5) of this section.

(4) The department shall monitor the claims experience of retired dentists insured through the program established under subsections (1) to (5) of this section. The department may impose any risk management requirements that the department deems appropriate as a condition of providing liability insurance under the program.

(5) The department shall provide insurance under subsection (2) of this section only to the extent that funds are appropriated to the department for the purposes of funding the program established under subsections (1) to (5) of this section.

(6) The Oregon Department of Administrative Services may by rule establish any conditions considered necessary by the department before providing liability insurance for a retired dentist under the program established by subsections (1) to (5) of this section. [1999 c.1016 §§1,2; 2001 c.104 §261]

Note: 679.510 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 679 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

679.520 Treatment of dental waste materials containing mercury. (1) A dentist who places in or removes from the human oral cavity dental materials containing mercury shall:

(a) Implement and maintain best management practices of dental wastes as developed by the Oregon Dental Association to prevent amalgam waste and mercury from entering the air, sewage systems, waterways and garbage;

(b) Have an amalgam separator installed on a wastewater drain in a dental facility where the dentist practices if dental materials containing amalgam pass through the wastewater drain. The amalgam separator must be verified by the manufacturer to remove at least 95 percent of the amalgam that passes through the drain on which it is installed;

(c) Maintain an amalgam separator installed as required by this subsection in accordance with the manufacturer's recommendations; and

(d) Place all dental waste materials containing mercury in a vapor-proof container that is clearly labeled as containing mercury and dispose of the materials in accordance with best management practices of dental wastes recommended by the Oregon Dental Association. Disposal may not be by incineration that would result in the release of mercury into the air.

(2) Each dental office shall keep proof of installation of an amalgam separator and maintain an amalgam separator maintenance log that the office shall make available for inspection by the Oregon Board of Dentistry. The board may inspect maintenance logs from a period of up to three years prior to the date of inspection. [2007 c.517 §2]

679.525 Amalgam separators required in certain dental facilities. Each dental facility constructed on or after January 1, 2008, shall have amalgam separators that meet the requirements of ORS 679.520 (1)(b). [2007 c.517 §3]

Note: 679.525 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 679 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

679.530 Information about oral prosthetic devices. Dental technicians shall, upon request by a dentist or patient, provide the dentist or patient with information about the location where oral prosthetic devices that are inserted into the human oral cavity or that come in contact with its adjacent structures and tissues were manufactured. [2009 c.147 §2]

679.535 Requirement to test heat sterilization device; rules. (1) A person licensed by the Oregon Board of Dentistry who uses an autoclave or other heat sterilization device in the person's practice shall test the autoclave or other heat sterilization device at least once per week to ensure that the device is functioning properly.

(2) The Oregon Board of Dentistry shall adopt rules to implement this section. [2014 c.16 §2; 2017 c.362 §1]

679.540 Oral disease prevention services; reimbursement; rules. (1) As used in this section:

(a) "Dental provider" means a licensed dentist, dental hygienist or other dental practitioner or a dental care team or clinic that provides the following core services:

(A) Comprehensive dental care;

(B) Basic preventive dental services;

(C) Referral to dental specialists; and

(D) Family centered dental care.

(b) "Health worker" means "traditional health worker" as defined by the Oregon Health Authority by rule.

(2) The Oregon Health Authority, in consultation with coordinated care organizations and dental care organizations in this state, shall adopt rules and procedures for the training and certification of health workers to provide oral disease prevention services and for the reimbursement of oral disease prevention services provided by certified health workers.

(3) The rules adopted under subsection (2) of this section must prescribe the training required for certification, including instruction on:

(a) The performance of dental risk assessments; and

(b) The provision of oral disease prevention services.

(4) The authority shall adopt rules requiring that a certified health worker:

(a) Refer patients to dental providers; and

(b) Recommend to patients, or to the parent or legal guardian of a patient, that the patient visit a dental provider at least once annually. [2015 c.542 §1]

Note: 679.540 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 679 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

679.543 Use of telehealth by dental care provider. (1) As used in this section, "telehealth" means a variety of methods, through the use of electronic and telecommunications technologies, for the distance delivery of health care services, including dental care services, and clinical information designed to improve a patient's health status and to enhance delivery of the health care services and clinical information.

(2) A dental care provider authorized by the Oregon Board of Dentistry to practice dental care services may use telehealth if:

(a) In the professional judgment of the dental care provider, the use of telehealth is an appropriate manner in which to provide a dental care service; and

(b) The dental care provider is providing a dental care service that is within the scope of practice of the dental care provider.

(3) The use of telehealth as described in subsection (2) of this section is not an expansion of the scope of practice of a dental care provider.

(4) The board shall treat a dental care service that is delivered by a dental care provider through telehealth as described in subsection (2) of this section the same as the board treats the dental care service when delivered in person. The board shall apply identical quality and practice standards to a particular dental care service regardless of the method of delivery of the dental care service. [2017 c.348 §1]

Note: 679.543 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 679 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

679.546 Advertising as specialist; requirements; rules. (1) A dentist licensed by the Oregon Board of Dentistry may advertise that the dentist is a specialist in one or more areas of dentistry if the dentist:

(a) Has completed a post-doctoral residency program that is at least two years in length and is accredited by the Commission on Dental Accreditation, or its successor organization, and approved by the board by rule;

(b) Is a specialist as defined by the National Commission on Recognition of Dental Specialties and Certifying Boards, or its successor organization, and adopted by the board by rule; or

(c) Has completed an advanced dental education program that is at least two years in length and is recognized by the United States Department of Education, and approved by the board by rule.

(2) The board may adopt rules as necessary to carry out this section. [2019 c.379 §2]

679.549 Expression of regret or apology. (1) For the purposes of any civil action against a person licensed by the Oregon Board of Dentistry or against a dental office or clinic, health care institution, health care facility or other entity that employs or grants the person privileges, any expression of regret or apology made by or on behalf of the person, office, clinic, institution, facility or entity, including an expression of regret or apology that is made in writing or by conduct, does not constitute an admission of liability.

(2) A person licensed by the board, or any other person who makes an expression of regret or apology on behalf of a person licensed by the board, may not be examined by deposition or otherwise in any civil or administrative proceeding, including any arbitration or mediation proceeding, with respect to an expression of regret or apology made by or on behalf of the person, including expressions of regret or apology that are made in writing, orally or by conduct. [2019 c.182 §2]

679.552 Prescription and administration of vaccines; approved training course; rules. (1)(a) In accordance with rules adopted by the Oregon Board of Dentistry, a dentist may prescribe and administer vaccines to a person with whom the dentist has established a patient relationship.

(b) The board shall approve a training course on the prescription and administration of vaccines. The board may approve a training course offered by the Centers for Disease Control and Prevention, the American Dental Association or its successor organization or other similar federal agency or professional organization.

(c) The board may adopt other rules as necessary to carry out this section.

(2) The board shall adopt rules relating to the prescription and administration of vaccines by dentists, including rules requiring dentists to:

(a) Report the prescription and administration of vaccines to the immunization registry created by the Oregon Health Authority pursuant to ORS 433.094;

(b) Prior to administering a vaccine, review the patient's vaccination history in the immunization registry described in this subsection;

(c) Comply with protocols established by the authority for the prescription and administration of vaccines under subsection (1) of this section; and

(d) Comply with any applicable rules adopted by the authority related to vaccines.

(3) In consultation with the board, the authority may adopt rules related to vaccines prescribed and administered by dentists. [2019 c.58 §2]

Chapter 679 — Dentist Therapists

2021 EDITION

DENTAL THERAPY

679.600 Definitions for ORS 679.600 to 679.630. As used in ORS 679.600 to 679.630:

(1) "Collaborative agreement" means a written and signed agreement entered into between a dentist and a dental therapist under ORS 679.618.

(2) "Dental pilot project" means an Oregon Health Authority dental pilot project developed and operated by the authority.

(3) "Dentist" means a person licensed to practice dentistry under this chapter. [2021 c.530 §2]

679.603 Dental therapy license. (1) The Oregon Board of Dentistry shall issue a license to practice dental therapy to an applicant who:

(a) Is at least 18 years of age;

(b) Submits to the board a completed application form;

(c) Demonstrates the completion of a dental therapy education program;

(d) Passes an examination described in ORS 679.606; and

(e) Pays the application and licensure fees established by the board.

(2)(a) An individual who completed a dental therapy education program in another state or jurisdiction may apply for licensure under this section if the dental therapy education program is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization.

(b) The board shall determine whether the training and education of an applicant described in this subsection is sufficient to meet the requirements of subsection (1) of this section.

(3) If an applicant holds a current or expired authorization to practice dental therapy issued by another state, the federal government or a tribal authority, the applicant shall include with the application a copy of the authorization and an affidavit from the dental regulatory body of the other jurisdiction that demonstrates the applicant was authorized to practice dental therapy in that jurisdiction. [2021 c.530 §3]

Note: The amendments to 679.603 by section 3a, chapter 530, Oregon Laws 2021, become operative January 1, 2025. See section 18, chapter 530, Oregon Laws 2021. The text that is operative on and after January 1, 2025, is set forth for the user's convenience.

679.603. (1) The Oregon Board of Dentistry shall issue a license to practice dental therapy to an applicant who:

(a) Is at least 18 years of age;

(b) Submits to the board a completed application form;

(c) Demonstrates:

(A) The completion of a dental therapy education program that is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization, and approved by the board by rule; or

(B) That the applicant is or was a participant in a dental pilot project;

(d) Passes an examination described in ORS 679.606; and

(e) Pays the application and licensure fees established by the board.

(2)(a) An individual who completed a dental therapy education program in another state or jurisdiction may apply for licensure under this section if the dental therapy education program is accredited by the Commission on Dental Accreditation of the American Dental Association, or its successor organization.

(b) The board shall determine whether the training and education of an applicant described in this subsection is sufficient to meet the requirements of subsection (1) of this section.

(3) If an applicant holds a current or expired authorization to practice dental therapy issued by another state, the federal government or a tribal authority, the applicant shall include with the application a copy of the authorization and an affidavit from the dental regulatory body of the other jurisdiction that demonstrates the applicant was authorized to practice dental therapy in that jurisdiction.

679.606 Examinations, reexamination; acceptable results; rules. (1)(a) The Oregon Board of Dentistry may require an applicant for a license to practice dental therapy to pass written, laboratory or clinical examinations to test the professional knowledge and skills of the applicant.

(b) The examinations may not be affiliated with or administered by a dental pilot project or a dental therapy education program described in ORS 679.603.

(c) The examinations must:

(A) Be elementary and practical in character, and sufficiently thorough to test the fitness of the applicant to practice dental therapy;

(B) Be written in English; and

(C) Include questions on subjects pertaining to dental therapy.

(2) If a test or examination was taken within five years of the date of application and the applicant received a passing score on the test or examination, as established by the board by rule, the board:

(a) To satisfy the written examination authorized under this section, may accept the results of national standardized examinations.

(b) To satisfy the laboratory or clinical examination authorized under this section:

(A) Shall accept the results of regional and national testing agencies or clinical board examinations administered by other states; and

(B) May accept the results of board-recognized testing agencies.

(3) The board shall accept the results of regional and national testing agencies or of clinical board examinations administered by other states, and may accept results of board-recognized testing agencies, in satisfaction of the examinations authorized under this section for applicants who have engaged in the active practice of dental therapy in Oregon, another state, the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a period of at least 3,500 hours in the five years immediately preceding application and who meet all other requirements for licensure.

(4) The board shall establish rules related to reexamination for an applicant who fails an examination. [2021 c.530 §4]

679.609 Grounds for refusal to issue or renew license. The Oregon Board of Dentistry may refuse to issue or renew a license to practice dental therapy if the applicant or licensee:

(1) Subject to ORS 670.280, has been convicted of a violation of the law. A certified copy of the record of conviction is conclusive evidence of conviction.

(2) Has been disciplined by a state licensing or regulatory agency of this state or another state regarding a health care profession if, in the judgment of the board, the acts or conduct resulting in the disciplinary action bears a demonstrable relationship to the ability of the applicant or licensee to practice dental therapy in accordance with ORS 679.600 to 679.630. A certified copy of the disciplinary action is conclusive evidence of the disciplinary action.

(3) Has falsified an application for issuance or renewal of licensure.

(4) Has violated any provision of ORS 679.600 to 679.630 or a rule adopted under ORS 679.600 to 679.630. [2021 c.530 §5]

679.612 Prohibition on unauthorized practice, use of title; exceptions. (1) A person may not practice dental therapy or assume or use any title, words or abbreviations, including the title or designation "dental therapist," that indicate that the person is authorized to practice dental therapy unless the person is licensed under ORS 679.603.

(2) Subsection (1) of this section does not prohibit:

(a) The practice of dental therapy by a health care provider performing services within the health care provider's authorized scope of practice.

(b) The practice of dental therapy in the discharge of official duties on behalf of the United States government, including but not limited to the Armed Forces of the United States, the United States Coast Guard, the United States Public Health Service, the United States Bureau of Indian Affairs or the United States Department of Veterans Affairs.

(c) The practice of dental therapy pursuant to an educational program described in ORS 679.603.

(d) A dental therapist authorized to practice in another state or jurisdiction from making a clinical presentation sponsored by a bona fide dental or dental therapy association or society or an accredited dental or dental therapy education program approved by the Oregon Board of Dentistry.

(e) Bona fide students of dental therapy from engaging in clinical studies during the period of their enrollment and as a part of the course of study in a dental therapy education program described in ORS 679.603 (1). The clinical studies may be conducted on the premises of the program or in a clinical setting located off the premises. The facility, instructional staff and course of study at an off-premises location must meet minimum requirements established by the board by rule. The clinical studies at the off-premises location must be performed under the indirect supervision of a member of the program faculty.

(f) Bona fide full-time students of dental therapy, during the period of their enrollment and as a part of the course of study in a dental therapy education program located outside of Oregon that is accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency, from engaging 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 established by the board by rule and are performed under the indirect supervision of a member of the faculty of the Oregon Health and Science University School of Dentistry.

(g) The performance of duties by a federally certified dental health aide therapist or tribally authorized dental therapist in a clinic operated by the Indian Health Service, including, as described in 25 U.S.C. 1603, an Indian Health Service Direct Service Tribe clinic, a clinic

operated under an Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638) contract or a clinic operated under an urban Indian organization. [2021 c.530 §6]

679.615 Fees; waiver of fees; license renewal. (1) The Oregon Board of Dentistry may impose nonrefundable fees for the following:

(a) Application for licensure;

(b) Examinations;

(c) Biennial dental therapy licenses, both active and inactive;

(d) Licensure renewal fees;

(e) Permits; and

(f) Delinquency.

(2) Subject to prior approval of the Oregon Department of Administrative Services and a report to the Emergency Board prior to adopting fees and charges, the fees and charges established under ORS 679.600 to 679.630 may not exceed the cost of administering ORS 679.600 to 679.630 as authorized by the Legislative Assembly within the Oregon Board of Dentistry budget and as modified by the Emergency Board.

(3)(a) The Oregon Board of Dentistry may waive a license fee for a licensee who provides to the board satisfactory evidence that the licensee has discontinued the practice of dental therapy because of retirement.

(b) A licensee described in this subsection may apply to the board for reinstatement of the license pursuant to rules adopted by the board. An application under this paragraph must include a fee. If the licensee has been retired or inactive for more than one year from the date of application, the licensee shall include with the application satisfactory evidence of clinical competence, as determined by the board.

(4)(a) A license to practice dental therapy is valid for two years and may be renewed. A licensee shall submit to the board an application for renewal and payment of the fee.

(b) A dental therapist issued a license in an even-numbered year must apply for renewal by September 30 of each even-numbered year thereafter. A dental therapist issued a license in an odd-numbered year must apply for renewal by September 30 of each odd-numbered year thereafter.

(c) The board may charge a reasonable fee if the application for renewal or the fee is submitted more than 10 days delinquent.

(5) A dental therapist shall inform the board of a change of the dental therapist's address within 30 days of the change. [2021 c.530 §7]

679.618 Collaborative agreement required to practice dental therapy; required provisions; duties of dentist. (1) A dental therapist may practice dental therapy only under the supervision of a dentist and pursuant to a collaborative agreement with the dentist that outlines the supervision logistics and requirements for the dental therapist's practice. The collaborative agreement must include at least the following information:

(a) The level of supervision required for each procedure performed by the dental therapist;

(b) Circumstances under which the prior knowledge and consent of the dentist is required to allow the dental therapist to provide a certain service or perform a certain procedure;

(c) The practice settings in which the dental therapist may provide care;

(d) Any limitation on the care the dental therapist may provide;

(e) Patient age-specific and procedure-specific practice protocols, including case selection criteria, assessment guidelines and imaging frequency;

(f) Procedures for creating and maintaining dental records for patients treated by the dental therapist;

(g) Guidelines for the management of medical emergencies in each of the practice settings in which the dental therapist provides care;

(h) A quality assurance plan for monitoring care provided by the dental therapist, including chart review, patient care review and referral follow-up;

(i) Protocols for the dispensation and administration of drugs, as described in ORS 679.621, by the dental therapist, including circumstances under which the dental therapist may dispense and administer drugs;

(j) Criteria for the provision of care to patients with specific medical conditions or complex medical histories, including any requirements for consultation with the dentist prior to the provision of care; and

(k) Protocols for when a patient requires treatment outside the dental therapist's scope of practice, including for referral of the patient for evaluation and treatment by the dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390 or other licensed health care provider.

(2) In addition to the information described in subsection (1) of this section, a collaborative agreement must include a provision that requires the dental therapist to consult with a dentist if the dental therapist intends to perform an irreversible surgical procedure under general supervision on a patient who has a severe systemic disease.

(3) A dentist who enters into a collaborative agreement with a dental therapist shall:

(a) Directly provide care to a patient that is outside the scope of practice of the dental therapist or arrange for the provision of care by another dentist; and

(b) Ensure that the dentist, or another dentist, is available to the dental therapist for timely communication during the dental therapist's provision of care to a patient.

(4) A dental therapist may perform and provide only those procedures and services authorized by the dentist and set out in the collaborative agreement, and shall maintain with the dentist an appropriate level of contact, as determined by the dentist.

(5) A dental therapist and a dentist who enter into a collaborative agreement together shall each maintain a physical copy of the collaborative agreement.

(6)(a) A dental therapist may enter into collaborative agreements with more than one dentist if each collaborative agreement includes the same supervision requirements and scope of practice.

(b) A dentist may supervise and enter into collaborative agreements with up to three dental therapists at any one time.

(7)(a) A collaborative agreement must be signed by the dentist and dental therapist.

(b) A dental therapist shall annually submit a signed copy of the collaborative agreement to the Oregon Board of Dentistry. If the collaborative agreement is revised in between annual submissions, a signed copy of the revised collaborative agreement must be submitted to the board as soon as practicable after the revision is made. [2021 c.530 §8]

679.621 Dental therapist scope of practice; duties of dentist; authority of dental therapist to supervise. (1) A dental therapist may perform, pursuant to the dental therapist's collaborative agreement, the following procedures under the general supervision of the dentist:

(a) Identification of conditions requiring evaluation, diagnosis or treatment by a dentist, a physician licensed under ORS chapter 677, a nurse practitioner licensed under ORS 678.375 to 678.390 or other licensed health care provider;

(b) Comprehensive charting of the oral cavity;

(c) Oral health instruction and disease prevention education, including nutritional counseling and dietary analysis;

(d) Exposing and evaluation of radiographic images;

(e) Dental prophylaxis, including subgingival scaling and polishing procedures;

(f) Application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;

(g) Administering local anesthetic;

(h) Pulp vitality testing;

(i) Application of desensitizing medication or resin;

(j) Fabrication of athletic mouth guards;

(k) Changing of periodontal dressings;

(L) Simple extractions of erupted primary anterior teeth and coronal remnants of any primary teeth;

(m) Emergency palliative treatment of dental pain;

(n) Preparation and placement of direct restoration in primary and permanent teeth;

(o) Fabrication and placement of single-tooth temporary crowns;

(p) Preparation and placement of preformed crowns on primary teeth;

(q) Indirect pulp capping on permanent teeth;

(r) Indirect pulp capping on primary teeth;

(s) Suture removal;

(t) Minor adjustments and repairs of removable prosthetic devices;

(u) Atraumatic restorative therapy and interim restorative therapy;

(v) Oral examination, evaluation and diagnosis of conditions within the supervising dentist's authorization;

(w) Removal of space maintainers;

(x) The dispensation and oral or topical administration of:

(A) Nonnarcotic analgesics;

(B) Anti-inflammatories; and

(C) Antibiotics; and

(y) Other services as specified by the Oregon Board of Dentistry by rule.

(2) A dental therapist may perform, pursuant to the dental therapist's collaborative agreement, the following procedures under the indirect supervision of the dentist:

(a) Placement of temporary restorations;

(b) Fabrication of soft occlusal guards;

(c) Tissue reconditioning and soft reline;

(d) Tooth reimplantation and stabilization;

(e) Recementing of permanent crowns;

(f) Pulpotomies on primary teeth;

(g) Simple extractions of:

(A) Erupted posterior primary teeth; and

(B) Permanent teeth that have horizontal movement of greater than two millimeters or vertical movement and that have at least 50 percent periodontal bone loss;

(h) Brush biopsies; and

(i) Direct pulp capping on permanent teeth.

(3) The dentist described in subsection (2) of this section shall review a procedure described in subsection (2) of this section that is performed by the dental therapist and the patient chart that contains information regarding the procedure.

(4)(a) A dental therapist may supervise a dental assistant and an expanded function dental assistant, as defined by the board by rule, if the dental therapist is authorized to perform the services provided by the dental assistant or expanded function dental assistant.

(b) A dental therapist may supervise up to two individuals under this subsection. [2021 c.530 §9]

679.624 Dental therapist authority to perform specified procedures; liability insurance; patient population requirement. (1) A dental therapist may perform the procedures listed in ORS 679.621 so long as the procedures are included in an education program described in ORS 679.603 (1) or the dental therapist has received additional training in the procedure approved by the Oregon Board of Dentistry.

(2) A dental therapist shall purchase and maintain liability insurance as determined sufficient by the board.

(3) A dental therapist shall dedicate at least 51 percent of the dental therapist's practice to patients who represent underserved populations, as defined by the Oregon Health Authority by rule, or patients located in dental care health professional shortage areas, as determined by the authority. [2021 c.530 §10]

679.627 Discipline. A person licensed under ORS 679.603 is subject to the provisions of ORS 679.140. [2021 c.530 §11]

679.630 Rules. The Oregon Board of Dentistry shall adopt rules necessary to administer ORS 679.600 to 679.630. In adopting rules under this section, the board shall consult with dental therapists and organizations that represent dental therapists in this state. [2021 c.530 §12]

679.990 [Repealed by 1957 c.552 §6 (679.991 enacted in lieu of 679.990)]

PENALTIES

679.991 Penalties. (1) Violation of any provision of ORS 679.020 or 679.025 (1) is a Class C felony.

(2) Violation of ORS 679.170 or 679.176 is a Class B misdemeanor.

(3) In the event of a second or subsequent conviction under subsection (1) of this section, the court must impose a minimum sentence of 10 days of imprisonment.

(4) In any prosecution for violation of subsection (1) or (2) of this section, it is sufficient to sustain a conviction to show a single act of conduct in violation of any of the provisions of this chapter and it is not necessary to show a general course of such conduct. [1957 c.552 §7 (enacted in lieu of 679.990); 1963 c.284 §16; 1971 c.743 §407; 1973 c.390 §8; 1977 c.192 §10; 1985 c.323 §15; 2011 c.388 §1; 2011 c.597 §280]

CODA ACCREDITATION STANDARDS FOR A DENTAL THERAPY EDUCATION PROGRAM

Commission on Dental Accreditation

Accreditation Standards for Dental Therapy Education Programs

Accreditation Standards for Dental Therapy Education Programs

Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, Illinois 60611-2678
(312) 440-4653
www.ada.org/en/coda

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Document Revision History

Date	Item	Action
February 6, 2015	Accreditation Standards for Dental Therapy Education Programs	Adopted
August 7, 2015	Accreditation Standards for Dental Therapy Education Programs	Implemented
February 5, 2016	Revised Accreditation Status Definitions	Approved, Implemented
August 5, 2016	Revised Mission Statement	Adopted
January 1, 2017	Revised Mission Statement	Implemented
January 1, 2018	Areas of Oversight at Sites Where Educational Activity Occurs (new Standard 2-5, revisions to Standards 3-4, 3-5, and 3-7)	Adopted Implemented
February 8, 2019	Definition of Terms (Health Literacy) and Intent Statements for Standards 2-14, 2-15, 2-19 and 2-21	Adopted, Implemented
August 5, 2021	Definition of Terms (Should)	Adopted, Implemented

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Mission Statement of the Commission on Dental Accreditation

The Commission on Dental Accreditation serves the public and profession by developing and implementing accreditation standards that promote and monitor the continuous quality and improvement of dental education programs.

Commission on Dental Accreditation
Adopted: August 5, 2016

Accreditation Status Definitions

Programs Which Are Fully Operational

Approval *(without reporting requirements*): An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.

Approval (with reporting requirements): An accreditation classification granted to an educational program indicating that specific deficiencies or weaknesses exist in one or more areas of the program. Evidence of compliance with the cited standards must be demonstrated within eighteen (18) months if the program is between one and two years in length or two years if the program is at least two years in length. If the deficiencies are not corrected within the specified time period, accreditation will be withdrawn, unless the Commission extends the period for achieving compliance for good cause. Identification of new deficiencies during the reporting time period will not result in a modification of the specified deadline for compliance with prior deficiencies.

Circumstances under which an extension for good cause would be granted include, but are not limited to:

- sudden changes in institutional commitment;
- natural disaster which affects affiliated agreements between institutions; faculty support; or facilities;
- changes in institutional accreditation;
- interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program.

Programs Which Are Not Fully Operational

A program which has not enrolled and graduated at least one class of students/residents and does not have students/residents enrolled in each year of the program is defined by the Commission as not fully operational. The accreditation classification granted by the Commission on Dental Accreditation to programs which are not fully operational is "initial accreditation." When initial accreditation status is granted to a developing education program, it is in effect through the projected enrollment date. However, if enrollment of the first class is delayed for two consecutive years following the projected enrollment date, the program's accreditation will be discontinued, and the institution must reapply for initial accreditation and update pertinent information on program development. Following this, the Commission will reconsider granting initial accreditation status.

Initial Accreditation is the accreditation classification granted to any dental, advanced dental or allied dental education program which is not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification "initial accreditation" is granted based upon one or more site evaluation visit(s).

Introduction

Accreditation
Accreditation is a non-governmental, voluntary peer review process by which educational institutions or programs may be granted public recognition for compliance with accepted standards of quality and performance. Specialized accrediting agencies exist to assess and verify educational quality in particular professions or occupations to ensure that individuals will be qualified to enter those disciplines. A specialized accrediting agency recognizes the course of instruction which comprises a unique set of skills and knowledge, develops the accreditation standards by which such educational programs are evaluated, conducts evaluation of programs, and publishes a list of accredited programs that meet the national accreditation standards. Accreditation standards are developed in consultation with those affected by the standards who represent the broad communities of interest.

The Commission on Dental Accreditation
The Commission on Dental accreditation is the specialized accrediting agency recognized by the United States Department of Education to accredit programs that provide basic preparation for licensure or certification in dentistry and the related disciplines.

Dental Therapy Accreditation
The first dental therapy accreditation standards were developed by the Commission on Dental Accreditation in 2013. In an effort to provide the communities of interest with appropriate input into the latest revision of the standards, the Commission on Dental Accreditation used the following procedures: conducting surveys of communities of interest, holding open hearings and distributing widely a draft of the proposed revision of the standards for review and comment. Prior to approving the standards in February 2015, the Commission carefully considered comments received from all sources. The accreditation standards were implemented in August 2015.

Standards
Dental therapy education programs must meet the standards delineated in this document to achieve and maintain accreditation.

Standards 1 through 5 constitute *The Accreditation Standards for Dental Therapy Education Programs* by which the Commission on Dental Accreditation and its consultants evaluate Dental Therapy Education Programs for accreditation purposes. This entire document also serves as a program development guide for institutions that wish to establish new programs or improve existing programs. Many of the goals related to the educational environment and the corresponding standards were influenced by best practices in accreditation from other health professions.

The standards identify those aspects of program structure and operation that the Commission regards as essential to program quality and achievement of program goals. They specify the minimum acceptable requirements for programs and provide guidance regarding alternative and preferred methods of meeting standards.

Although the standards are comprehensive and applicable to all institutions that offer dental therapy education programs, the Commission recognizes that methods of achieving standards may vary according to the mission, size, type and resources of sponsoring institutions. Innovation and experimentation with alternative ways of providing required education and training are encouraged, assuming standards are met and compliance can be demonstrated. The Commission recognizes the importance of academic freedom, and an institution is allowed considerable flexibility in structuring its educational program so that it can meet the *Standards*. No curriculum has enduring value, and a program will not be judged by conformity to a given type. The Commission also recognizes that schools organize their faculties in a variety of ways. Instruction necessary to achieve the prescribed levels of knowledge and skill may be provided by the educational unit(s) deemed most appropriate by each institution.

The Commission has an obligation to the public, the profession and prospective students to assure that accredited Dental Therapy Education Programs provide an identifiable and characteristic core of required education, training and experience.

Format of the Standards

Each standard is numbered (e.g., 1-1, 1-2) and in bold print. Where appropriate, standards are accompanied by statements of intent that explain the rationale, meaning and significance of the standard. This format is intended to clarify the meaning and application of standards for both those responsible for educational programs and those who evaluate these programs for the Commission.

Statement of General Policy

Maintaining and improving the quality of dental therapy education is a primary aim of the Commission on Dental Accreditation. In meeting its responsibilities as a specialized accrediting agency recognized by the dental profession and by the United States Department of Education, the Commission on Dental Accreditation:

1. Evaluates dental therapy education programs on the basis of the extent to which program goals, institutional objectives and approved accreditation standards are met;

2. Supports continuing evaluation of and improvements in dental therapy education programs through institutional self-evaluation;

3. Encourages innovations in program design based on sound educational principles;

4. Provides consultation in initial and ongoing program development.

As a specialized accrediting agency, the Commission relies on an authorized institutional accrediting agency's evaluation of the institution's objectives, policies, administration, financial and educational resources and its total educational effort. The Commission's evaluation will be confined to those factors which are directly related to the quality of the dental therapy program. In evaluating the curriculum in institutions that are accredited by a U.S. Department of Education-recognized regional or national accrediting agency, the Commission will concentrate on those courses which have been developed specifically for the dental therapy program and core courses developed for related disciplines. When an institution has been granted "candidate for accreditation" status by a regional or national accrediting agency, the Commission will accept that status as evidence that the general education and biomedical science courses included in the dental therapy curriculum meet accepted standards, provided such courses are of appropriate level and content for the discipline.

The importance of institutional academic freedom is recognized by the Commission, and the Accreditation Standards allow institutions considerable flexibility in structuring their educational programs. The Commission encourages the achievement of excellence through curricular innovation and development of institutional individuality. Dependent upon its objectives, resources, and state practice act provisions, the institution may elect to extend the scope of the curriculum to include content and instruction in additional areas.

Programs and their sponsoring institutions are encouraged to provide for the educational mobility of students through articulation arrangements and career laddering (e.g., between dental therapy education programs and dental hygiene or dental assisting education programs).

Institutions and programs are also strongly encouraged to develop mechanisms to award advanced standing for students who have completed coursework at other educational programs accredited by the Commission on Dental Accreditation or by use of appropriate qualifying or proficiency examinations.

This entire document constitutes the Accreditation Standards for Dental Therapy Education Programs. Each standard is numbered (e.g., 1-1, 1-2) and in bold print. Where appropriate, standards are accompanied by statements of intent that explain the rationale, meaning and significance of the standard. Expanded guidance in the form of examples to assist programs in better understanding and interpreting the "must" statements within the standards follow. This format is intended to clarify the meaning and application of standards for both those responsible for educational programs and those who evaluate these programs for the Commission.

Goals

The assessment of quality in educational programs is the foundation for the *Standards*. In addition to the emphasis on quality education, the *Accreditation Standards for Dental Therapy Education Programs* are designed to meet the following goals:

1. to protect the public welfare;
2. to promote an educational environment that fosters innovation and continuous improvement;
3. to guide institutions in developing their academic programs;
4. to guide site visit teams in making judgments regarding the quality of the program and;
5. to provide students with reasonable assurance that the program is meeting its stated objectives.

Specific objectives of the current version of the Standards include:

- streamlining the accreditation process by including only standards critical to the evaluation of the quality of the educational program;
- increasing the focus on competency statements in curriculum-related standards; and
- emphasizing an educational environment and goals that foster critical thinking and prepare graduates to be life-long learners.

To sharpen its focus on the quality of dental therapy education, the Commission on Dental Accreditation includes standards related to institutional effectiveness. Standard 1, "Institutional Effectiveness," guides the self-study and preparation for the site visit away from a periodic approach by encouraging establishment of internal planning and assessment that is ongoing and continuous. Dental therapy education programs are expected to demonstrate that planning and assessment are implemented at all levels of the academic and administrative enterprise. The *Standards* focus, where necessary, on institutional resources and processes, but primarily on the results of those processes and the use of those results for institutional improvement.

The following steps comprise a recommended approach to an assessment process designed to measure the quality and effectiveness of programs and units with educational, patient care, research and service missions. The assessment process should include:

1. establishing a clearly defined purpose/mission appropriate to dental therapy education, patient care, research and service;
2. formulating goals consistent with the purpose/mission;
3. designing and implementing outcomes measures to determine the degree of achievement or progress toward stated goals;
4. acquiring feedback from internal and external groups to interpret the results and develop recommendations for improvement (viz., using a broad-based effort for program/unit assessment);
5. using the recommendations to improve the programs and units; and
6. re-evaluating the program or unit purpose and goals in light of the outcomes of this assessment process.

Implementation of this process will also enhance the credibility and accountability of educational programs.

It is anticipated that the *Accreditation Standards for Dental Therapy Education Programs* will strengthen the teaching, patient care, research and service missions of schools. These *Standards* are national in scope and represent the minimum requirements expected for a dental therapy education program. However, the Commission encourages institutions to extend the scope of the curriculum to include content and instruction beyond the scope of the minimum requirements, consistent with the institution's own goals and objectives.

The foundation of these *Standards* is a competency-based model of education through which students acquire the level of competence needed to begin the practice of dental therapy. Competency is a complex set of capacities including knowledge, experience, critical thinking, problem-solving, professionalism, personal integrity and procedural skills that are necessary to begin the practice of dental therapy. These components of competency become an integrated whole during the delivery of patient care. Professional competence is the habitual and judicious use of communication, knowledge, critical appraisal, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individuals and communities served. Accordingly, learning experiences help students blend the various dimensions of competency into an integrated performance for the benefit of the patient. The assessment process focuses on measuring the student's overall capacity to function as an entry-level, beginning dental therapist rather than measuring individual skills in isolation.

In these *Standards* the competencies for dental therapy are described broadly. The Commission expects each school to develop specific competency definitions and assessment methods in the context of the broad scope of dental therapy practice. These competencies must be reflective of an evidence-based definition of dental therapy. To assist schools in defining and implementing their competencies, the Commission strongly encourages the development of a formal liaison mechanism between the school and the practicing dental community.

The objectives of the Commission are based on the premise that an institution providing a dental therapy educational program will strive continually to enhance the standards and quality of both scholarship and teaching. The Commission expects an educational institution offering such a program to conduct that program at a level consistent with the purposes and methods of higher education and to have academic excellence as its primary goal.

Definition of Terms Used in Accreditation Standards for Dental Therapy Education Programs

The terms used in this document indicate the relative weight that the Commission attaches to each statement. Definitions of these terms are provided.

Standard: Offers a rule or basis of comparison established in measuring or judging capacity, quantity, quality, content and value; criterion used as a model or pattern.

Must: Indicates an imperative need or a duty; an essential or indispensable item; mandatory.

Should: Indicates a method to achieve the standard; highly desirable, but not mandatory.

Intent: Intent statements are presented to provide clarification to dental therapy education programs in the application of, and in connection with, compliance with the *Accreditation Standards for Dental Therapy Education Programs*. The statements of intent set forth some of the reasons and purposes for the particular Standards. As such, these statements are not exclusive or exhaustive. Other purposes may apply.

Examples of evidence to demonstrate compliance include: Desirable condition, practice or documentation indicating the freedom or liberty to follow a suggested alternative.

Understanding: Knowledge and recognition of the principles and procedures involved in a particular concept or activity.

In-depth: Characterized by a thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding (highest level of knowledge).

Competent: The levels of knowledge, skills and values required by the new graduates to begin dental therapy practice.

Competencies: Written statements describing the levels of knowledge, skills and values expected of graduates.

Instruction: Describes any teaching, lesson, rule or precept; details of procedure; directives.

Dental Therapy: Denotes education and training leading to dental therapy practice.

Community-based experience: Refers to educational opportunities for dental therapy students to provide patient care in community-based clinics or private practices under the supervision of faculty licensed to perform the treatment in accordance with the state dental practice act. Community-based experiences are not intended to be synonymous with community service

activities where dental therapy students might go to schools to teach preventive techniques or where dental therapy students help build homes for needy families.

Evidence-based dentistry (EBD): An approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the clinician's expertise and the patient's treatment needs and preferences.

Patients with special needs: Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly.

Quality assurance: A cycle of PLAN, DO, CHECK, ACT that involves setting goals, determining outcomes, and collecting data in an ongoing and systematic manner to measure attainment of goals and outcomes. The final step in quality assurance involves identification and implementation of corrective measures designed to strengthen the program.

Service learning: A structured experience with specific learning objectives that combines community service with academic preparation. Students engaged in service learning learn about their roles as dental therapists through provision of patient care and related services in response to community-based problems.

Advanced Standing: Programs and their sponsoring institutions are encouraged to provide for educational mobility of students through articulation arrangements and career laddering (e.g. between dental therapy education programs and dental hygiene or dental assisting education programs). Institutions and programs are also strongly encouraged to develop mechanisms to award advanced standing for students who have completed coursework at other educational programs accredited by the Commission on Dental Accreditation or by use of appropriate qualifying or proficiency examinations.

Advanced standing means the program has the authority to grant full or partial course credit for a specific course toward the completion of the dental therapy program. This may apply to one or more courses in the dental therapy program curriculum.

Humanistic Environment: Dental therapy programs are societies of learners, where graduates are prepared to join a learned and a scholarly society of oral health professionals. A humanistic pedagogy inculcates respect, tolerance, understanding, and concern for others and is fostered by mentoring, advising and small group interaction. A dental therapy program environment characterized by respectful professional relationships between and among faculty and students establishes a context for the development of interpersonal skills necessary for learning, for patient care, and for making meaningful contributions to the profession.

Health literacy: "The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."

(Institute of Medicine. 2004. *Health Literacy: A Prescription to End Confusion*. Washington, DC: The National Academies Press. https://doi.org/10.17226.10883.)

STANDARD 1-INSTITUTIONAL EFFECTIVENESS

1-1 The program **must** develop a clearly stated purpose/mission statement appropriate to dental therapy education, addressing teaching, patient care, research and service.

Intent: *A clearly defined purpose and a mission statement that is concise and communicated to faculty, staff, students, patients and other communities of interest is helpful in clarifying the purpose of the program.*

1-2 Ongoing planning for, assessment of and improvement of educational quality and program effectiveness **must** be broad-based, systematic, continuous, and designed to promote achievement of institutional goals related to institutional effectiveness, student achievement, patient care, research, and service.

Intent: *Assessment, planning, implementation and evaluation of the educational quality of a dental therapy education program that is broad-based, systematic, continuous and designed to promote achievement of program goals will maximize the academic success of the enrolled students. The Commission on Dental Accreditation expects each program to define its own goals and objectives for preparing individuals for the practice of dental therapy.*

Examples of evidence to demonstrate compliance may include:

- program completion rates
- employment rates
- success of graduates on licensing examinations
- surveys of alumni, students, employers, and clinical sites
- other benchmarks or measures of learning used to demonstrate effectiveness
- examples of program effectiveness in meeting its goals
- examples of how the program has been improved as a result of assessment
- ongoing documentation of change implementation
- mission, goals and strategic plan document
- assessment plan and timeline

1-3 The dental therapy education program **must** have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.

Intent: *The dental therapy education program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff, open communication, leadership, and scholarship.*

Examples of evidence to demonstrate compliance may include:

- Established policies regarding ethical behavior by faculty, staff and students that are regularly reviewed and readily available
- Student, faculty, and patient groups involved in promoting diversity, professionalism and/or leadership support for their activities
- Focus groups and/or surveys directed towards gathering information on student, faculty, patient, and alumni perceptions of the cultural environment

1-4 The program **must** have policies and practices to:

a. achieve appropriate levels of diversity among its students, faculty and staff;
b. engage in ongoing systematic and focused efforts to attract and retain students, faculty and staff from diverse backgrounds; and
c. systematically evaluate comprehensive strategies to improve the institutional climate for diversity.

Intent: *The program should develop strategies to address the dimensions of diversity including, structure, curriculum and institutional climate. The program should articulate its expectations regarding diversity across its academic community in the context of local and national responsibilities, and regularly assess how well such expectations are being achieved. Programs could incorporate elements of diversity in their planning that include, but are not limited to, gender, racial, ethnic, cultural and socioeconomic. Programs should establish focused, significant, and sustained programs to recruit and retain suitably diverse students, faculty, and staff.*

1-5 The financial resources **must** be sufficient to support the program's stated purpose/mission, goals and objectives.

Intent: *The institution should have the financial resources required to develop and sustain the program on a continuing basis. The program should have the ability to employ an adequate number of full-time faculty, purchase and maintain equipment; procure supplies, reference material and teaching aids as reflected in an annual operating budget. Financial resources should ensure that the program will be in a position to recruit and retain qualified faculty. Annual appropriations should provide for innovations and changes necessary to reflect current concepts of education in the discipline. The Commission will assess the adequacy of financial support on the basis of current appropriations and the stability of sources of funding for the program.*

Examples of evidence to demonstrate compliance may include:

- program's mission, goals, objectives and strategic plan
- institutional strategic plan
- revenue and expense statements for the program for the past three years
- revenue and expense projections for the program for the next three years

1-6 The program **must** be a recognized entity within the institution's administrative structure which supports the attainment of program goals.

Intent: *The position of the program in the institution's administrative structure should permit direct communication between the program administrator and institutional administrators who are responsible for decisions that directly affect the program. The administration of the program should include formal provisions for program planning, staffing, management, coordination and evaluation.*

Examples of evidence to demonstrate compliance may include:

- institutional organizational flow chart
- short and long-range strategic planning documents
- examples of program and institution interaction to meet program goals
- dental therapy representation on key college or university committees

1-7 Programs **must** be sponsored by institutions of higher education that are accredited by an institutional accrediting agency (i.e., a regional or appropriate* national accrediting agency) recognized by the United States Department of Education for offering college-level programs.

* Agencies whose mission includes the accreditation of institutions offering allied health education programs.

1-8 All arrangements with co-sponsoring or affiliated institutions **must** be formalized by means of written agreements which clearly define the roles and responsibilities of each institution involved.

Examples of evidence to demonstrate compliance may include:

- affiliation agreement(s)

1-9 The sponsoring institution **must** ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

Examples of evidence to demonstrate compliance may include:

- Written agreement(s)
- Contracts between the institution/ program and sponsor(s) (For example: contract(s)/agreement(s) related to facilities, funding, faculty allocations, etc.)

1-10 The authority and final responsibility for curriculum development and approval, student selection, faculty selection and administrative matters **must** rest within the sponsoring institution.

1-11 The program **must** show evidence of interaction with other components of the higher education, health care education and/or health care delivery systems.

Community Resources

1-12 There **must** be an active liaison mechanism between the program and the dental and allied dental professions in the community.

Intent: *The purpose of an active liaison mechanism is to provide a mutual exchange of information for improving the program, recruiting qualified students and meeting employment needs of the community. The responsibilities of the advisory body should be defined in writing and the program director, faculty, and appropriate institution personnel should participate in the meetings as non-voting members to receive advice and assistance*.

Examples of evidence to demonstrate compliance may include:

- policies and procedures regarding the liaison mechanism outlining responsibilities, appointments, terms and meetings
- membership list with equitable representation if the group represents more than one discipline
- criteria for the selection of advisory committee members
- an ongoing record of committee or group minutes, deliberations and activities

STANDARD 2-EDUCATIONAL PROGRAM

The dental therapist is a member of the oral healthcare team. The curriculum for dental therapy programs will support the overall education, training and assessment to a level of competency within the scope of dental therapy practice.

2-1 The curriculum **must** include at least three academic years of full-time instruction or its equivalent at the postsecondary college-level.

Intent: *The scope and depth of the curriculum should reflect the objectives and philosophy of higher education. The time necessary for psychomotor skill development and the number of required content areas require three academic years of study and is considered the minimum preparation for a dental therapist. This could include documentation of advanced standing. However, the curriculum may be structured to provide opportunity for students who require more time to extend the length of their instructional program.*

Examples of evidence to demonstrate compliance may include:

- copies of articulation agreements
- curriculum documents
- course evaluation forms and summaries
- records of competency examinations
- college catalog outlining course titles and descriptions
- documentation of advanced standing requirements

2-2 The stated goals of the program **must** be focused on educational outcomes and define the competencies needed for graduation, including the preparation of graduates who possess the knowledge, skills and values to begin the practice of dental therapy.

2-3 The program **must** have a curriculum management plan that ensures:

a. an ongoing curriculum review and evaluation process which includes input from faculty, students, administration and other appropriate sources;
b. evaluation of all courses with respect to the defined competencies of the school to include student evaluation of instruction;
c. elimination of unwarranted repetition, outdated material, and unnecessary material;
d. incorporation of emerging information and achievement of appropriate sequencing.

2-4 The dental therapy education program **must** employ student evaluation methods that measure its defined competencies and are written and communicated to the enrolled students.

Intent: *Assessment of student performance should measure not only retention of factual knowledge, but also the development of skills, behaviors, and attitudes needed for subsequent education and practice. The evaluation of competence is an ongoing process that requires a variety of assessments that can measure not only the acquisition of knowledge and skills but also assess the process and procedures which will be necessary for entry level practice.*

2-5 Students **must** receive comparable instruction and assessment at all sites where required educational activity occurs through calibration of all appropriate faculty.

Examples of Evidence to demonstrate compliance may include:

- On-going faculty training
- Calibration training manuals
- Periodic monitoring for compliance
- Documentation of faculty participation in calibration-related activities

2-6 In advance of each course or other unit of instruction, students **must** be provided written information about the goals and requirements of each course, the nature of the course content, the method(s) of evaluation to be used, and how grades and competency are determined.

Intent: *The program should identify the dental therapy fundamental knowledge and competencies that will be included in the curriculum based on the program goals, resources, current dental therapy practice responsibilities and other influencing factors. Individual course documentation needs to be periodically reviewed and revised to accurately reflect instruction being provided as well as new concepts and techniques taught in the program.*

2-7 Academic standards and institutional due process policies and procedures **must** be provided in written form to the students and followed for remediation or dismissal.

Intent: *If a student does not meet evaluation criteria, provision should be made for remediation or dismissal. On the basis of designated criteria, both students and faculty can periodically assess progress in relation to the stated goals and objectives of the program.*

Examples of evidence to demonstrate compliance may include:

- written remediation policy and procedures
- records of attrition/retention rates related to academic performance
- institutional due process policies and procedures

2-8 Graduates **must** demonstrate the ability to self-assess, including the development of professional competencies related to their scope of practice and the demonstration of professional values and capacities associated with self-directed, lifelong learning.

Intent: *Educational program should prepare students to assume responsibility for their own learning. The education program should teach students how to learn and apply evolving and new knowledge over a complete career as a health care professional. Lifelong learning skills include student assessment of learning needs.*

Examples of evidence to demonstrate compliance may include:

- Students routinely assess their own progress toward overall competency and individual competencies as they progress through the curriculum
- Students identify learning needs and create personal learning plans
- Students participate in the education of others, including fellow students, patients, and other health care professionals, that involves critique and feedback

2-9 Graduates **must** be competent in the use of critical thinking and problem-solving, related to the scope of dental therapy practice including their use in the care of patients and knowledge of when to consult a dentist or other members of the healthcare team.

Intent: *Throughout the curriculum, the educational program should use teaching and learning methods that support the development of critical thinking and problem solving skills.*

Examples of evidence to demonstrate compliance may include:

- Explicit discussion of the meaning, importance, and application of critical thinking
- Use of questions by instructors that require students to analyze problem etiology, compare and evaluate alternative approaches, provide rationale for plans of action, and predict outcomes
- Prospective simulations in which students perform decision-making
- Retrospective critiques of cases in which decisions are reviewed to identify errors, reasons for errors, and exemplary performance

- Writing assignments that require students to analyze problems and discuss alternative theories about etiology and solutions, as well as to defend decisions made
- Asking students to analyze and discuss work products to compare how outcomes correspond to best evidence or other professional standards

Curriculum

2-10 The curriculum **must** include content that is integrated with sufficient depth, scope, sequence of instruction, quality and emphasis to ensure achievement of the curriculum's defined competencies in the following three areas: general education, biomedical sciences, and dental sciences (didactic and clinical).

Intent: *Foundational knowledge should be established early in the dental therapy program and be of appropriate scope and depth to prepare the student to achieve competence in defined components of dental therapy practice. Content identified in each subject may not necessarily constitute a separate course, but the subject areas are included within the curriculum.*

Curriculum content and learning experiences should provide the foundation for continued formal education and professional growth with a minimal loss of time and duplication of learning experiences. General education, social science, and biomedical science courses included in the curriculum should be taught at the postsecondary level.

Programs and their sponsoring institutions are encouraged to provide for educational mobility of students through articulation arrangements and career laddering (e.g. between dental therapy education programs and dental hygiene or dental assisting education programs) that results in advanced standing permitted for dental hygienists or dental assistants.

2-11 General education content **must** include oral and written communications, psychology, and sociology.

Intent: *These subjects provide prerequisite background for components of the curriculum, which prepare the students to communicate effectively, assume responsibility for individual oral health counseling, and participate in community health programs.*

2-12 Biomedical science instruction in dental therapy education **must** ensure an understanding of basic biological principles, consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems in each of the following areas:

a. head and neck and oral anatomy
b. oral embryology and histology
c. physiology

d. chemistry
e. biochemistry
f. microbiology
g. immunology
h. general pathology and/or pathophysiology
i. nutrition
j. pharmacology

Intent: *These subjects provide background for both didactic and clinical dental sciences. The subjects are to be of the scope and depth comparable to college transferable liberal arts course work. The program should ensure that biomedical science instruction serves as a foundation for student analysis and synthesis of the interrelationships of the body systems when making decisions regarding oral health services within the context of total body health. The biomedical knowledge base emphasizes the orofacial complex as an important anatomical area existing in a complex biological interrelationship with the entire body.*

Dental therapists need to recognize abnormal conditions to understand the parameters of dental therapy care. The program should ensure that graduates have the level of understanding that assures that the health status of the patient will not be compromised by the dental therapy interventions.

2-13 Didactic dental sciences content **must** ensure an understanding of basic dental principles, consisting of a core of information in each of the following areas within the scope of dental therapy:

a. tooth morphology
b. oral pathology
c. oral medicine
d. radiology
e. periodontology
f. cariology
g. atraumatic restorative treatment (ART)
h. operative dentistry
i. pain management
j. dental materials
k. dental disease etiology and epidemiology
l. preventive counseling and health promotion
m. patient management
n. pediatric dentistry
o. geriatric dentistry
p. medical and dental emergencies
q. oral surgery
r. prosthodontics
s. infection and hazard control management, including provision of oral health care services to patients with bloodborne infectious diseases.

Intent: *These subjects provide the student with knowledge of oral health and disease as a basis for assuming responsibility for implementing preventive and therapeutic services. Teaching methodologies should be utilized to assure that the student can assume responsibility for the assimilation of knowledge requiring judgment, decision making skills and critical analysis.*

2-14 Graduates **must** be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.

Intent: *Students should learn about factors and practices associated with disparities in health status among populations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental therapy practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental therapy education in:*

- *basic principles of culturally competent health care;*
- *basic principles of health literacy and effective communication for all patient populations;*
- *recognition of health care disparities and the development of solutions;*
- *the importance of meeting the health care needs of dentally underserved populations, and;*
- *the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi-dimensionally diverse society.*

Dental therapists should be able to effectively communicate with individuals, groups and other health care providers. The ability to communicate verbally and in written form is basic to the safe and effective provision of oral health services for diverse populations. Dental therapists should recognize the cultural influences impacting the delivery of health services to individuals and communities (i.e. health status, health services and health beliefs).

Examples of evidence to demonstrate compliance may include:

- student projects demonstrating the ability to communicate effectively with a variety of individuals and groups.
- examples of individual and community-based oral health projects implemented by students during the previous academic year
- evaluation mechanisms designed to monitor knowledge and performance

2-15 Graduates **must** be competent in communicating and collaborating with other members of the health care team to facilitate the provision of health care.

Intent: *In attaining competence, students should understand the roles of members of the health care team and have educational experiences, particularly clinical experiences that involve working with other healthcare professional students and practitioners. Students should have educational experiences in which they participate in the coordination of patient care within the health care system relevant to dentistry.*

Ethics and Professionalism

2-16 Graduates **must** be competent in the application of the principles of ethical decision making and professional responsibility.

Intent: *Graduates should know how to draw on a range of resources, among which are professional codes, regulatory law, and ethical theories. These resources should pertain to the academic environment, patient care, practice management and research. They should guide judgment and action for issues that are complex, novel, ethically arguable, divisive, or of public concern.*

2-17 Graduates **must** be competent in applying legal and regulatory concepts to the provision and/or support of oral health care services.

Intent: *Dental therapists should understand the laws which govern the practice of the dental profession. Graduates should know how to access licensure requirements, rules and regulations, and state practice acts for guidance in judgment and action.*

Examples of evidence to demonstrate compliance may include:

- evaluation mechanisms designed to monitor knowledge and performance concerning legal and regulatory concepts
- outcomes assessment mechanisms

Clinical Sciences

2-18 Graduates **must** be able to access, critically appraise, apply, and communicate information as it relates to providing evidence-based patient care within the scope of dental therapy practice.

Intent: *The education program should introduce students to the basic principles of research and its application for patients.*

2-19 The program **must** ensure the availability of adequate patient experiences that afford all students the opportunity to achieve its stated competencies within a reasonable time.

Intent: *Sufficient practice time and learning experiences should be provided during preclinical and clinical courses to ensure that students attain clinical competence. Recognizing that there is a single standard of dental care, the care experiences provided for patients by students should be adequate to ensure competency in all components of dental therapy.*

Examples of evidence to demonstrate compliance may include:

- program clinical experiences
- patient tracking data for enrolled and past students
- policies regarding selection of patients and assignment of procedures
- monitoring or tracking system protocols
- clinical evaluation system policy and procedures demonstrating student competencies
- clinic schedules for each term

2-20 Graduates **must** be competent in providing oral health care within the scope of dental therapy to patients in all stages of life.

The dental therapist provides care with supervision at a level specified by the state dental practice act. The curriculum for dental therapy programs will support the following competencies within the scope of dental therapy practice.

2-21 At a minimum, graduates **must** be competent in providing oral health care within the scope of dental therapy practice with supervision as defined by the state practice acts, including:

a. identify oral and systemic conditions requiring evaluation and/or treatment by dentists, physicians or other healthcare providers, and manage referrals
b. comprehensive charting of the oral cavity
c. oral health instruction and disease prevention education, including nutritional counseling and dietary analysis
d. exposing radiographic images
e. dental prophylaxis including sub-gingival scaling and/or polishing procedures

f. dispensing and administering via the oral and/or topical route non-narcotic analgesics, anti-inflammatory, and antibiotic medications as prescribed by a licensed healthcare provider
g. applying topical preventive or prophylactic agents (i.e. fluoride) , including fluoride varnish, antimicrobial agents, and pit and fissure sealants
h. pulp vitality testing
i. applying desensitizing medication or resin
j. fabricating athletic mouthguards
k. changing periodontal dressings
l. administering local anesthetic
m. simple extraction of erupted primary teeth
n. emergency palliative treatment of dental pain limited to the procedures in this section
o. preparation and placement of direct restoration in primary and permanent teeth
p. fabrication and placement of single-tooth temporary crowns
q. preparation and placement of preformed crowns on primary teeth
r. indirect and direct pulp capping on permanent teeth
s. indirect pulp capping on primary teeth
t. suture removal
u. minor adjustments and repairs on removable prostheses
v. removal of space maintainers

Intent: *Graduates should be able to evaluate, assess, and apply current and emerging science and technology. Graduates should possess the basic knowledge, skills, and values to practice dental therapy at the time of graduation. The school identifies the competencies that will be included in the curriculum based on the school's goals, resources, accepted dental therapy responsibilities and other influencing factors. Programs should define overall competency, in order to measure the graduate's readiness to enter the practice of dental therapy.*

Additional Dental Therapy Functions

2-22 Where graduates of a CODA-accredited dental therapy program are authorized to perform additional functions defined by the program's state-specific dental board or regulatory agency, program curriculum **must** include content at the level, depth, and scope required by the state. Further, curriculum content **must** include didactic and laboratory/preclinical/clinical objectives for the additional dental therapy skills and functions. Students **must** demonstrate laboratory/preclinical/clinical competence in performing these skills.

Intent: *Functions allowed by the state dental board or regulatory agency for dental therapists are taught and evaluated at the depth and scope required by the state. The*

inclusion of additional functions cannot compromise the scope of the educational program or content required in the Accreditation Standards and may require extension of the program length.

2-23 Dental therapy program learning experiences **must** be defined by the program goals and objectives.

2-24 Dental therapy education programs **must** have students engage in service learning experiences and/or community-based learning experiences.

Intent: *Service learning experiences and/or community-based learning experiences are essential to the development of a culturally competent oral health care workforce. The interaction and treatment of diverse populations in a community-based clinical environment adds a special dimension to clinical learning experience and engenders a life-long appreciation for the value of community service.*

STANDARD 3- FACULTY AND STAFF

3-1 The program director **must** have a full-time administrative appointment as defined by the institution and have primary responsibility for operation, supervision, evaluation and revision of the Dental Therapy educational program.

Intent: *To allow sufficient time to fulfill administrative responsibilities, teaching contact hours should be limited for the program director and should not take precedent over administrative responsibilities.*

3-2 The program director **must** be a licensed dentist (DDS/DMD) or a licensed dental therapist possessing a master's or higher degree. The director **must** be a graduate of a program accredited by the Commission on Dental Accreditation and who has background in education and the professional experience necessary to understand and fulfill the program's mission and goals.

Intent: *The program director's background should include administrative experience, instructional experience, and professional experience in general dentistry. The term of interim/acting program director should not exceed a two year period.*

Examples of evidence to demonstrate compliance may include:

- bio sketch of program director.

3-3 The program director **must** have the authority and responsibility necessary to fulfill program goals including:

a) curriculum development, evaluation and revision;
b) faculty recruitment, assignments and supervision;
c) input into faculty evaluation;
d) initiation of program or department in-service and faculty development;
e) assessing, planning and operating program facilities;
f) input into budget preparation and fiscal administration;
g) coordination, evaluation and participation in determining admission criteria and procedures as well as student promotion and retention criteria.

Examples of evidence to demonstrate compliance may include:

- program director position description

3-4 The number and distribution of faculty and staff **must** be sufficient to meet the program's stated purpose/mission, goals and objectives, at all sites where required educational activity occurs.

Intent: *Student contact loads should allow the faculty sufficient time for class preparation, student evaluation and counseling, development of subject content and*

appropriate evaluation criteria and methods, program development and review, and professional development.

Examples of evidence to demonstrate compliance may include:
- faculty schedules including student contact loads and supplemental responsibilities

3-5 The faculty to student ratio for preclinical, clinical and radiographic clinical and laboratory sessions **must** not exceed one to six. The faculty to student ratio for laboratory sessions in the dental science courses **must** not exceed one to ten to ensure the development of clinical competence and maximum protection of the patient, faculty and students.

Intent: *The adequacy of numbers of faculty should be determined by faculty to student ratios during laboratory, radiography and supervised patient care clinics rather than by the total number of full-time equivalent positions for the program. The faculty to student ratios in clinical and radiographic practice should allow for individualized instruction and assessment of students' progression toward competency. Faculty are also responsible for ensuring that the patient care services delivered by students meet the program's standard of care.*

Examples of evidence to demonstrate compliance may include:
- faculty teaching commitments
- class schedules
- listing of ratios for clinical, radiographic and laboratory courses

3-6 All faculty of a dental therapy program **must** be educationally qualified for the specific subjects they are teaching.

Intent: *Faculty should have current background in education theory and practice, concepts relative to the specific subjects they are teaching, clinical practice experience and, if applicable, distance education techniques and delivery. Dentists, dental therapists, dental hygienists, and expanded function dental assistants who supervise students' clinical procedures should have qualifications which comply with the state dental practice act. Individuals who teach and supervise students in clinical experiences should have qualifications comparable to faculty who teach in the main program clinic and are familiar with the program's objectives, content, instructional methods and evaluation procedures.*

Examples of evidence to demonstrate compliance may include:
- faculty curriculum vitae

3-7 The program **must** show evidence of an ongoing faculty development process.

Intent: *Ongoing faculty development is a requirement to improve teaching and learning, to foster curricular change, to enhance retention and job satisfaction of faculty, and to maintain the vitality of academic dentistry as the wellspring of a learned profession. Effective teaching requires not only content knowledge, but an understanding of pedagogy, including knowledge of curriculum design and development, curriculum evaluation, and teaching methodologies.*

Examples of evidence to demonstrate compliance may include:

- evidence of participation in workshops, in-service training, self-study courses, on-line and credited courses
- attendance at regional and national meetings that address education
- mentored experiences for new faculty
- scholarly productivity
- maintenance of existing and development of new and/or emerging clinical skills
- records of calibration of faculty

3-8 The faculty, as appropriate to meet the program's purpose/mission, goals and objectives, **must** engage in scholarly activity.

3-9 Faculty **must** be ensured a form of governance that allows participation in the school's decision-making processes.

3-10 A defined faculty evaluation process **must** exist that ensures objective measurement of the performance of each faculty member.

Intent: *An objective evaluation system including student, administration and peer evaluation can identify strengths and weaknesses for each faculty member (to include those at distance sites) including the program administrator. The results of evaluations should be communicated to faculty members on a regular basis to ensure continued improvement.*

Examples of evidence to demonstrate compliance may include:

- sample evaluation mechanisms addressing teaching, patient care, research, scholarship and service
- faculty evaluation policy, procedures and mechanisms

3-11 The dental therapy program faculty **must** be granted privileges and responsibilities as afforded all other comparable institutional faculty.

Examples of evidence to demonstrate compliance may include:

- institution's promotion/tenure policy

- faculty senate handbook
- institutional policies and procedures governing faculty

3-12 Qualified institutional support personnel **must** be assigned to the program to support both the instructional program and the clinical facilities providing a safe environment for the provision of instruction and patient care.

Intent: *Maintenance and custodial staff should be sufficient to meet the unique needs of the academic and clinical program facilities. Faculty should have access to instructional specialists, such as those in the areas of curriculum, testing, counseling, computer usage, instructional resources and educational psychology. Secretarial and clerical staff should be assigned to assist the administrator and faculty in preparing course materials, correspondence, maintaining student records, and providing supportive services for student recruitment and admissions activities. Support staff should be assigned to assist with the operation of the clinic facility including the management of appointments, records, billing, insurance, inventory, hazardous waste, and infection control.*

Examples of evidence to demonstrate compliance may include:
- description of current program support/personnel staffing
- program staffing schedules
- staff job descriptions
- examples of how support staff are used to support students

STANDARD 4-EDUCATIONAL SUPPORT SERVICES

Admissions

4-1 Specific written criteria, policies and procedures **must** be followed when admitting students.

Intent: *The dental therapy education curriculum is a postsecondary scientifically-oriented program which is rigorous and intensive. Previous academic performance and/or performance on standardized national tests of scholastic aptitude or other predictors of scholastic aptitude and ability should be utilized as criteria in selecting students who have the potential for successfully completing the program. Applicants should be informed of the criteria and procedures for selection, goals of the program, curricular content, course transferability and the scope of practice of and employment opportunities for dental therapists.*

Because enrollment is limited by facility capacity, special program admissions criteria and procedures are necessary to ensure that students are selected who have the potential for successfully completing the program. The program administrator and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures which are non-discriminatory and ensure the quality of the program.

Examples of evidence to demonstrate compliance may include:

- admissions management policies and procedures
- copies of catalogs, program brochures or other written materials
- established ranking procedures or criteria for selection
- minutes from admissions committee
- periodic analysis supporting the validity of established admission criteria and procedures
- results from institutional research used in interpreting admissions data and criteria and/or correlating data with student performance
- advanced standing policies and procedures, if appropriate

4-2 Admission policies and procedures **must** be designed to include recruitment and admission of a diverse student population.

Intent: *Admissions criteria and procedures should ensure the selection of a diverse student body with the potential for successfully completing the program. The administration and faculty, in cooperation with appropriate institutional personnel, should establish admissions procedures that are non-discriminatory and ensure the quality of the program*.

4-3 Admission of students with advanced standing **must** be based on the same standards of achievement required by students regularly enrolled in the program. Advanced standing requirements for career laddering into a dental therapy program **must** meet advanced standing requirements of the college or university offering advanced standing for dental therapy.

Intent: *Advanced standing refers to applicants that may be considered for admission to a training program whose curriculum has been modified after taking into account the applicant's past experience. Examples include transfer from a similar program at another institution, completion of training at a non-CODA accredited program, or documented practice experience in the given discipline. Acceptance of advanced standing students/residents will not result in an increase of the program's approved number of enrollees. Applicants for advanced standing are expected to fulfill all of the admission requirements mandated for students/residents in the conventional program and be held to the same academic standards. Advanced standing students/residents, to be certified for completion, are expected to demonstrate the same standards of competence as those in the conventional program.*

4-4 Students with advanced standing **must** receive an individualized assessment and an appropriate curriculum plan that results in the same standards of competence for graduation required by students regularly enrolled in the program.

Examples of evidence to demonstrate compliance may include:

- Policies and procedures on advanced standing
- Results of appropriate qualifying examinations
- Course equivalency or other measures to demonstrate equal scope and level of knowledge

4-5 The number of students enrolled in the program **must** be proportionate to the resources available.

Intent: *In determining the number of dental therapy students enrolled in a program (inclusive of distance sites), careful consideration should be given to ensure that the number of students does not exceed the program's resources, including patient supply, financial support, scheduling options, facilities, equipment, technology and faculty.*

Examples of evidence to demonstrate compliance may include:

- sufficient number of clinical and laboratory stations based on enrollment
- clinical schedules demonstrating equitable and sufficient clinical unit assignments
- clinical schedules demonstrating equitable and sufficient radiology unit assignments

- faculty full-time equivalent (FTE) positions relative to enrollment
- budget resources and strategic plan
- equipment maintenance and replacement plan
- patient pool availability analysis
- course schedules for all terms

Facilities and Resources

4-6 The program **must** provide adequate and appropriately maintained facilities and learning resources to support the purpose/mission of the program and which are in conformance with applicable regulations.

Intent: *The classroom facilities should include an appropriate number of student stations with equipment and space for individual student performance in a safe environment.*

4-7 The clinical facilities **must** include the following:

a) sufficient clinical facility with clinical stations for students including conveniently located hand washing sinks and view boxes and/or computer monitors; functional, equipment; an area that accommodates a full range of operator movement and opportunity for proper instructor supervision;
b) a capacity of the clinic that accommodates individual student practice on a regularly scheduled basis throughout all phases of preclinical technique and clinical instruction;
c) a sterilizing area that includes sufficient space for preparing, sterilizing and storing instruments;
d) sterilizing equipment and personal protective equipment/supplies that follow current infection and hazard control protocol;
e) facilities and materials for students, faculty and staff that provide compliance with accepted infection and hazard control protocols;
f) patient records kept in an area assuring safety and confidentiality.

Intent: *The facilities should permit the attainment of program goals and objectives. To ensure health and safety for patients, students, faculty and staff, the physical facilities and equipment should effectively accommodate the clinic and/or laboratory schedule. This Standard applies to all sites where students receive clinical instruction.*

4-8 Radiography facilities **must** be sufficient for development of clinical competence and contain the following:

a) an appropriate number of radiography exposure rooms which include: dental radiography units; teaching manikin(s); and conveniently located hand-washing sinks;
b) processing and/or imaging equipment;
c) an area for viewing radiographs;
d) documentation of compliance with applicable local, state and federal regulations.

Intent: *The radiography facilities should allow the attainment of program goals and objectives. Radiography facilities and equipment should effectively accommodate the clinic and/or laboratory schedules, the number of students, faculty and staff, and comply with applicable regulations to ensure effective instruction in a safe environment. This Standard applies to all sites where students receive clinical instruction.*

4-9 A multipurpose laboratory facility **must** be provided for effective instruction and allow for required laboratory activities and contain the following:

a) placement and location of equipment that is conducive to efficient and safe utilization;
b) student stations that are designed and equipped for students to work while seated including sufficient ventilation and lighting, necessary utilities, storage space, and an adjustable chair;
c) documentation of compliance with applicable local, state and federal regulations.

Intent: *The laboratory facilities should include student stations with equipment and space for individual student performance of laboratory procedures with instructor supervision. This Standard applies to all sites where students receive clinical instruction.*

4-10 Office space which allows for privacy **must** be provided for the program administrator and faculty

Intent: *Office space for full- and part-time faculty should be allocated to allow for class preparation, student counseling and supportive academic activities. Student and program records should be stored to ensure confidentiality and safety.*

4-11 Instructional aids, equipment, and library holdings **must** be provided for student learning.

Intent: *The acquisition of knowledge, skills and values for students requires the use of current instructional methods and materials to support learning needs and development. All students, including those receiving education at distance sites, should be assured access to learning resources. Institutional library holdings should include or provide*

access to a diversified collection of current dental and medical literature and references necessary to support teaching, student learning needs, service, research and development. There should be a mechanism for program faculty to periodically review, acquire and select current titles and instructional aids.

Examples of evidence to demonstrate compliance may include:

- a list of references on education, medicine, dentistry, dental therapy, dental hygiene, dental assisting and the biomedical sciences
- policies and procedures related to learning resource access
- timely electronic access to a wide variety of professional scientific literature
- skeletal and anatomic models and replicas, sequential samples of laboratory procedures, slides, films, video, and other media which depict current techniques
- a wide range of printed materials and instructional aids and equipment available for utilization by students and faculty
- current and back issues of major scientific and professional journals related to medicine, dentistry, dental therapy, dental hygiene, dental assisting and the biomedical sciences

Student Services

4-12 Student services **must** include the following:

a. personal, academic and career counseling of students;
b. assuring student participation on appropriate committees;
c. providing appropriate information about the availability of financial aid and health services;
d. developing and reviewing specific written procedures to ensure due process and the protection of the rights of students;
e. student advocacy; and
f. maintenance of the integrity of student performance and evaluation records.

Intent: *All policies and procedures should protect the students and provide avenues for appeal and due process. Policies should ensure that student records accurately reflect the work accomplished and are maintained in a secure manner. Students should have available the necessary support to provide career information and guidance as to practice, post-graduate and research opportunities.*

Student Financial Aid

4-13 At the time of acceptance, students **must** be advised of the total expected cost of their education and opportunities for employment.

Intent: *Financial information should include estimates of living expenses and educational fees, an analysis of financial need, and the availability of financial aid.*

4-14 The institution **must** be in compliance with all federal and state regulations relating to student financial aid and student privacy.

Health Services

4-15 The dental therapy program **must** advise prospective students of mandatory health standards that will ensure that prospective students are qualified to undertake dental therapy studies.

4-16 There **must** be a mechanism for ready access to health care for students while they are enrolled in dental therapy school.

4-17 Students **must** be encouraged to be immunized against infectious diseases, such as mumps, measles, rubella, and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk of infection to patients, dental personnel, and themselves.

Intent: *All individuals who provide patient care or have contact with patients should follow all standards of risk management thus ensuring a safe and healthy environment.*

Examples of evidence to demonstrate compliance may include:

- policies and procedures regarding infectious disease immunizations
- immunization compliance records
- declinations forms

STANDARD 5 – HEALTH, SAFETY, AND PATIENT CARE PROVISIONS

5-1 Written policies and procedures **must** be in place to ensure the safe use of ionizing radiation, which include criteria for patient selection, frequency of exposing radiographs on patients, and retaking radiographs consistent with current standard of care.

Intent: *All radiographic exposure should be integrated with clinical patient care procedures.*

5-2 Written policies and procedures **must** establish and enforce a mechanism to ensure adequate preclinical/clinical/laboratory asepsis, infection and biohazard control, and disposal of hazardous waste.

Intent: *Policies and procedures should be in place to provide for a safe environment for students, patients, faculty and staff.*

5-3 The school's policies and procedures **must** ensure that the confidentiality of information pertaining to the health status of each individual patient is strictly maintained

5-4 All students, faculty and support staff involved in the direct provision of patient care **must** be continuously certified in basic life support (B.L.S.), including healthcare provider cardiopulmonary resuscitation with an Automated External Defibrillator (AED), and be able to manage common medical emergencies.

Examples of evidence to demonstrate compliance may include:

- accessible and functional emergency equipment, including oxygen
- instructional materials
- written protocol and procedures
- emergency kit(s)
- installed and functional safety devices and equipment
- first aid kit accessible for use in managing clinic and/or laboratory accidents

5-5 The program **must** conduct a formal system of continuous quality improvement for the patient care program that demonstrates evidence of:

a. standards of care that are patient-centered, focused on comprehensive care and written in a format that facilitates assessment with measurable criteria;
b. an ongoing review and analysis of compliance with the defined standards of care;
c. an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of the care provided;
d. mechanisms to determine the cause(s) of treatment deficiencies; and
e. implementation of corrective measures as appropriate.

Intent: *Programs should create and maintain databases for monitoring and improving patient care and serving as a resource for research and evidence-based practice.*

5-6 The program **must** have policies and mechanisms in place that inform patients, verbally and in writing, about their comprehensive treatment needs and the scope of dental therapy care available at the dental therapy facilities.

Intent: *All patients should receive appropriate care that assures their rights as a patient are protected. Patients should be advised of their treatment needs and the scope of care available at the training facility and appropriately referred for procedures that cannot be provided by the program. This Standard applies to all program sites where clinical education is provided.*

Examples of evidence to demonstrate compliance may include:

- documentation of an ongoing review of a representative sample of patients and patient records to assess the appropriateness, necessity and quality of care provided
- quality assurance policy and procedures
- patient bill of rights

5-7 The program **must** develop and distribute a written statement of patients' rights and commitment to patient-centered care to all patients, appropriate students, faculty, and staff.

Intent: *The primacy of care for the patient should be well established in the management of the program and clinical facility assuring that the rights of the patient are protected. A written statement of patient rights should include:*

a) considerate, respectful and confidential treatment;
b) continuity and completion of treatment;
c) access to complete and current information about his/her condition;
d) advance knowledge of the cost of treatment;

e) informed consent;
f) explanation of recommended treatment, treatment alternatives, the option to refuse treatment, the risk of no treatment, and expected outcomes of various treatments;
g) treatment that meets the standard of care in the profession.

5-8 The use of quantitative criteria for student advancement and graduation **must** not compromise the delivery of patient care.

Intent: *The need for students to satisfactorily complete specific clinical requirements prior to advancement and graduation should not adversely affect the health and care of patients.*

Examples of evidence to demonstrate compliance may include:
- patient bill of rights
- documentation that patients are informed of their rights
- continuing care (recall) referral policies and procedures

5-9 Patient care **must** be evidenced-based, integrating the best research evidence and patient values.

Intent: *The program should use evidence to evaluate new technology and products and to guide treatment decisions.*

5-10 The program **must** ensure that active patients have access to professional services at all times for the management of dental emergencies.

PUBLIC COMMENT