PUBLIC PACKET

OREGON BOARD OF DENTISTRY

BOARD MEETING
APRIL 22, 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: **BOARD OFFICE & VIRTUAL VIA ZOOM**
DATE: **April 22, 2022**
TIME: **8:00 a.m. – 2:30 p.m.**

Call to Order – Alicia Riedman, R.D.H., President **8:00 a.m.**

OPEN SESSION
https://us02web.zoom.us/j/86107455144?pwd=ZFA4eFZtMWFMT3VqaWVObWZJOUs4dz09
Dial-In Phone #: 1-253-215-8782 ● Meeting ID: 861 0745 5144 ● Passcode: 032952

Review Agenda
1. Approval of Minutes
   - March 30, 2022 Special Board Meeting Minutes

NEW BUSINESS
1. Association Reports
   - Oregon Dental Association
   - Oregon Dental Hygienists' Association
   - Oregon Dental Assistants Association

3. Committee and Liaison Reports
   - Yadira Martinez, RDH - Recommendation for Discussion - Add a dental therapist or a dental therapy representative to each of these OBD Standing Committees:
     - o Communication
     - o Rules Oversight
     - o Dental Hygiene
     - o Enforcement & Discipline
     - o Licensing & Standards and Competency
   - Call for a Public Member to serve on the JCNDE

4 Executive Director's Report
   - Board Member & Staff Updates
   - OBD Budget Status Report
   - OBD 2023-2025 Budget Revenue Memo
   - Customer Service Survey
   - 2022 Dental License Renewal
   - Board and Staff Speaking Engagements
   - AADA & AADB Mid-Year Meetings
   - OBD 2022 -2025 Strategic Plan
   - Newsletter

5. Unfinished Business and Rules
   Dental Therapy – Public Rulemaking Hearing scheduled at 9 am **9:00 a.m.**
     - o Pubic Rulemaking Hearing - Rules & Agreement
   - Dental Therapy Rulemaking Secretary of State Filing

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.

- Email to Dental Therapy Testing Agencies – Information Requested
    - CRDTS & CDCA-WREB Invited to review and discuss Board concerns with exams
    - DT Exam Information - CDCA-WREB
    - DT Exam Information - CRDTS
- HB 2359 – For discussion and review draft rule
- HB 4096 – For discussion and review draft rule
- SOS Filing – Rule Changes Effective 7.1.2022
- Dental Implant FAQ Guidance
- Dental Implant Proposed Rule Changes

6. Correspondence
    - PTIFA Standard for Facial Esthetic Therapies

7. Other
    - CODA Winter 2022 Accreditation Actions – Notice - Mt. Hood Community College
    - OBD Tribal Relationship & Cooperation Policy effective 2.25.2022
    - Invitation to the Tribes to address the Board
    - Open Public Comment Period - Anyone May Address the Board

8. Articles & Newsletters (No Action Necessary)
    - ADEA Trends in Dental Education
    - CRDTS Report
    - CRDTS Welcomes Idaho and Utah
    - February HPSP Newsletter
    - DANB and OSAP Launch Certified in Dental Infection Prevention and Control (CDIPC) Certification
    - DANB State of the States 2022 report

EXECUTIVE SESSION **11:30 a.m.**

The Board will meet in Executive Session pursuant to ORS 192.345(4); ORS 192.660(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 materials and investigatory information, and to consult with counsel. No final action will be taken in Executive Session.

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

LUNCH **12:30 p.m.**

OPEN SESSION **1:30 p.m.**

https://us02web.zoom.us/j/86107455144?pwd=ZFA4eFZtMWFMT3VqaWVObWZJOUs4dz09

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Enforcement Actions (vote on cases reviewed in Executive Session)

LICENSURE AND EXAMINATION

16. Ratification of Licenses Issued
17. License and Examination Issues

ADJOURN **2:30 p.m.**

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APPROVAL OF MINUTES

DRAFT 1

OREGON BOARD OF DENTISTRY
MINUTES
MARCH 30, 2022

MEMBERS PRESENT:	Alicia Riedman, R.D.H., President Reza Sharifi, D.M.D. Jennifer Brixey Sheena Kansal, D.D.S. Gary Underhill, D.M.D Amy B. Fine, D.M.D. Yadira Martinez, R.D.H. Chip Dunn Aarati Kalluri, D.D.S.
STAFF PRESENT:	Stephen Prisby, Executive Director Angela Smorra, D.M.D., Dental Investigator Haley Robinson, Office Manager Samantha VandeBerg, Examination and Licensing Manager Ingrid Nye, Investigator Kathleen McNeal, Office Specialist
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT
VIA TELECONFERENCE*: Jen Lewis-Goff - ODA; Bonnie Marshall, Barry Taylor, D.M.D. – ODA, Mark Schoenbaum, Karen Phillips, Kim Laudenslager – CRDTS Rep., Richael Cobler – CRDTS Rep., Mark Edwards – CRDTS Rep., Ron Sakaguchi, D.D.S. - OHSU, George Okulitch, Miranda Davis, D.D.S., Ginny Jorgensen, CDA, Lisa Rowley, R.D.H., Amy Coplen, R.D.H., Sarah Kowalski, R.D.H., Jill Mason, R.D.H., Hai Pham, D.M.D., Sabrina Riggs, Terrence Clark, D.M.D., Kimber Cobb, R.D.H., Karan Replogle, D.D.S., Gary Stafford, D.M.D., Alicia Michelson, Stuart Blumenthal – CDCA-WREB Rep.

*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 5:02 p.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

Dr. Sharifi moved and Dr. Fine seconded that the Board approve the minutes from the February 25, 2022 Board Meeting as presented. The motion passed unanimously.

COMMITTEE AND LIASON REPORTS

Anesthesia Committee

Dr. Sharifi reported on the March 18, 2022 Anesthesia Committee meeting.

Dr. Sharifi summarized two definitions that needed clarification in the rules. The addition of non-intramuscular in rule regarding minimal sedation. Definition of 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."

The Board discussed Dental Therapists performing procedures on patients under Nitrous Oxide Sedation and the proposed rules.

Dr. Fine moved and Dr. Underhill seconded that the Board support the recommendations from the March 18, 2022 Anesthesia Committee meeting as presented. The motion passed unanimously.

Dental Therapy Rules Oversight Committee

Ms. Martinez reported on the February 23, 2022 Dental Therapy Rules Oversight Committee meeting. The Board discussed the collaborative agreement document and concerns regarding those exempted from Oregon licensure pursuant to ORS 679.025.

Dr. Underhill moved and Dr. Sharifi seconded that the language in the Verification of Collaborative Agreement document be changed from "a licensed Dentist pursuant to ORS 679.020 and 679.025" to "a licensed Dentist pursuant to ORS 679.020 or exempt from licensure pursuant to ORS 679.025." The motion passed unanimously.

EXECUTIVE DIRECTOR'S REPORT

Memo – Work on Dental Therapy, Preparations, and possible path forward to licensure

Mr. Prisby discussed the memo and information for the Board. He briefly reviewed the work already taken and needed in future to make new dental therapy rules effective July 1, 2022. Mr. Prisby thanked Lori Lindley and OBD Staff for the work already done and yet to come. He also referenced the attached information in the meeting packet that the new dental therapy fees were submitted to DAS for approval. He asked the Board to approve his proposed plan and schedule for rulemaking.

Dr. Underhill moved and Mr. Dunn seconded that the proposed rulemaking plan and schedule be approved as proposed. The motion passed unanimously.

OBD Tribal Relationship & Cooperation Policy

The new policy was referenced.

RULES – DENTAL THERAPY

Recommendation from Dental Therapy Rules Oversight Committee – Master Rules Document

Ms. Martinez moved and Dr. Underhill seconded that the Board send OAR 818-021-0052 and OAR 818-021-0054 to a public rulemaking hearing as amended. The motion passed unanimously.

OAR 818-021-0052 – Application for License to Practice Dental Therapy

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 didactic and 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.

OAR 818-021-0054 – Application for License to Practice Dental Therapy Without Further Examination

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 didactic and 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.

Dr. Fine moved and Dr. Sharifi seconded that the Committee recommend the Board send OAR 818-038-0005 to a public rulemaking hearing as presented. The motion passed unanimously.

OAR 818-038-0005 – Dental Therapy Education Program

818-038-0005
Dental Therapy Education Program
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.

Ms. Martinez moved and Ms. Brixey seconded that the Committee recommend the Board send the final recommendations from the Dental Therapy Rules Oversight Committee to a public rulemaking hearing as amended. The motion passed unanimously.

OAR 818-001-0002 – Definitions

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.

OAR 818-001-0082 – Access to Public Records

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.

OAR 818-001-0087 – Fees

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

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

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.

OAR 818-021-0026 - **State and Nationwide Criminal Background Checks, Fitness Determinations**

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).

OAR 818-021-0076 – Continuing Education – Dental Therapists

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.

OAR 818-021-0080 – Renewal of License

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.

OAR 818-021-0085 – Renewal or Reinstatement of Expired License

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.

OAR 818-021-0088 – Volunteer License

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.

OAR 818-021-0090 – Retirement of License

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.

OAR 818-021-0095 – Resignation of License

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.

OAR 818-021-0110 – Reinstatement Following Revocation

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.

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

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.

OAR 818-038-0001 - Definitions

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.

OAR 818-038-0010 – Authorization to Practice

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.

OAR 818-038-0020 – Scope of Practice

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.

OAR 818-038-0025 – Prohibited Acts

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

OAR 818-038-0030 – Collaborative Agreements

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.

OAR 818-038-0035 – Record Keeping

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.

OAR 818-042-0010 - Definitions

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.

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

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.

OAR 818-042-0050 – Exposing Radiographic Images

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

OAR 818-042-0060 – Certification – Radiologic Proficiency

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.

OAR 818-042-0090 – Additional Functions of EFDAs

818-042-0090
Additional Functions of EFDAs
Upon successful completion of a course of instruction in a program accredited by the Co mmission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Dental Assist ant 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:
(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 authoriz ed 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.

OAR 818-042-0114 – Additional Functions of EFPDAs

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.

The OBD staff drafted Collaborative Agreement, Dental Therapy Application and instructions will be included in the public packet for discussion.

Testing Agency Information and Dental Therapy Clinical Examination Overview
The Board discussed the proposed dental therapy clinical examinations for licensure. Representatives from CRDTS and WREB-CDCA responded to questions from Board Members and informed the Board that more information regarding the components of the exams would be made available to the Board in the near future.

Sarah Kowalski, R.D.H. discussed a letter requesting an extension to the Dental Therapy Pilot Projects.

Mr. Prisby stated that he would compile and coordinate Board Member concerns and questions regarding the clinical examinations. He would transmit all of the information to CRDTS and WREB-CDCA so they could address any concerns in more detail at the April 22, 2022 Board meeting.

PUBLIC COMMENT

President Riedman invited Tribal Communities and members of the public to address the Board.

Amy Coplen, R.D.H. – Program Director for Pacific University stated that the Board was potentially encouraging dental therapists to take the OSCE type exam by requiring too many components in the hands-on clinical examinations.

The meeting was adjourned at 6:40 p.m. Ms. Riedman stated that the next Board Meeting would take place on April 22, 2022.

_____
Alicia Riedman, R.D.H.
President

ASSOCIATION REPORTS

COMMITTEE REPORTS

Oregon Board of Dentistry Committee and Liaison Assignments

Sept 2021 - April 2022

STANDING COMMITTEES

Dental Therapy Rules Oversight Committee

Purpose: To draft, refine and update dental therapy rules.

Committee:

Yadira Martinez, R.D.H., E.P.P., Chair
Sheena Kansal, D.D.S.
Jennifer Brixey
Kaz Rafia, D.D.S., OHA Rep
Miranda Davis, D.D.S., DT Rep
Brandon Schwindt, D.M.D., ODA Rep.
Amy Coplen, R.D.H., ODHA Rep.
Ginny Jorgensen, CDA, EFDA, ODAA Rep
Kari Douglass, DT Rep.
Jason Mecum, DT Rep

Communications

Purpose: To enhance communications to all constituencies

Committee:

Jose Javier, D.D.S., Chair
Yadira Martinez, R.D.H., E.P.P.
Jennifer Brixey
Aarati Kalluri, D.D.S.
Alayna Schoblaske, D.M.D., ODA Rep.
Lesley Harbison, R.D.H., ODHA Rep.
Linda Kihs, CDA, EFDA, OMSA, MADAA, ODAA Rep.

Subcommittees:

- Newsletter – Alicia Riedman, R.D.H., E.P.P., Editor

Dental Hygiene

Purpose: To review issues related to Dental Hygiene

Committee:

Yadira Martinez, R.D.H., E.P.P., Chair
Jose Javier, D.D.S.
Alicia Riedman, R.D.H., E.P.P.
Jennifer Brixey
David J. Dowsett, D.M.D., ODA Rep.
Lisa Rowley, R.D.H., ODHA Rep.
Bonnie Marshall, CDA, EFDA, EFODA, MADAA, ODAA Rep.

Enforcement and Discipline

Purpose: To improve the discipline process

Committee:

Gary Underhill, D.M.D., Chair
Alicia Riedman, R.D.H., E.P.P.
Sheena Kansal, D.D.S.
Chip Dunn
Jason Bajuscak, D.M.D., ODA Rep.
Jill Mason, R.D.H., ODHA Rep.
Mary Harrison, CDA, EFDA, EFODA, FADAA, ODAA Rep.

Subcommittees:

Evaluators

- Jose Javier, D.D.S., Senior Evaluator
- Reza Sharifi, D.M.D., Evaluator

Licensing, Standards and Competency

Purpose: To improve licensing programs and assure competency of licensees and applicants

Committee:

Amy B. Fine, D.M.D. Chair
Reza Sharifi, D.M.D.
Aarati Kalluri, D.D.S.
Jennifer Brixey
Daren L. Goin, D.M.D., ODA Rep.
Susan Kramer, R.D.H., ODHA Rep.
Ginny Jorgensen, CDA, EFDA, EFODA, AAS, ODAA Rep.

Rules Oversight

Purpose: To review and refine OBD rules

Committee:

Alicia Riedman, R.D.H., E.P.P., Chair
Jose Javier, D.D.S.
Yadira Martinez, R.D.H., E.P.P.
Chip Dunn
Philip Marucha, D.D.S., ODA Rep.
Sharity Ludwig, R.D.H., ODHA Rep.
Mary Harrison, CDA, EFDA, EFODA, FADAA, ODAA Rep.

Anesthesia

Purpose: To review and make recommendations on the Board's rules regulating the administration of sedation in dental offices.

Committee:

Reza Sharifi, D.M.D., Chair
Sheena Kansal, D.D.S.
Julie Ann Smith, D.D.S., M.D., M.C.R.
Brandon Schwindt, D.M.D.
Mark Mutschler, D.D.S.
Normund Auzins, D.M.D.
Ryan Allred, D.M.D.
Jay Wylam, D.M.D.
Michael Doherty, D.D.S.
Eric Downey, D.D.S.

LIAISONS

American Assoc. of Dental Administrators (AADA) — Stephen Prisby, Executive Director
American Assoc. of Dental Boards (AADB)

- Administrator Liaison – Stephen Prisby, Executive Director
- Board Attorneys' Roundtable – Lori Lindley, SAAG - Board Counsel
- Dental Liaison – Jose Javier, D.D.S.
- Hygiene Liaison – Alicia Riedman, R.D.H., E.P.P.

American Board of Dental Examiners (ADEX)

- House of Representatives – Amy B. Fine, D.M.D.
- Dental Exam Committee – Amy B. Fine, D.M.D.

Commission on Dental Competency Steering Committee (CDCA)

- Amy B. Fine, D.M.D.
- Yadira Martinez, R.D.H., E.P.P.

Oregon Dental Association – Sheena Kansal, D.D.S.
Oregon Dental Hygienists' Association Alicia Riedman, R.D.H., E.P.P.
Oregon Dental Assistants Association – Alicia Riedman, D.M.D.
Western Regional Exam Board (WREB)

- Dental Exam Review Committee – Amy B. Fine, D.M.D.
- Hygiene Exam Review Committee – Yadira Martinez, R.D.H., E.P.P.

Administrative Workgroup
Purpose: To update Board and agency policies and guidelines. Consult with Executive Director on administrative issues. Conduct evaluation of Executive Director. Also to work on and make strategic planning recommendations to the Board.
Committee:

- Alicia Riedman, R.D.H., E.P.P., Chair
- Gary Underhill, D.M.D.
- Aarati Kalluri, D.D.S.
- Chip Dunn

Subcommittee:
Budget/Legislative – *(President, Vice President, Immediate Past President)*

- Alicia Riedman, R.D.H., E.P.P
- Jose Javier, D.D.S.
- Yadira Martinez, R.D.H., E.P.P.

JCNDE
JOINT COMMISSION
ON NATIONAL
DENTAL EXAMINATIONS

Call for a Public Member to serve on the Joint Commission on National Dental Examinations (JCNDE)

Dear Board of Dentistry Directors, Members and Staff,

The Joint Commission on National Dental Examinations (JCNDE) seeks a member of the public to serve as a Commissioner, with a four-year term beginning October 18, 2022 and concluding in fall of 2026. Nominations are currently sought, with self-nominations also welcome.

The Joint Commission on National Dental Examinations (JCNDE) is responsible for the development and administration of the National Board Examinations (NBEs) - including the Integrated National Board Dental Examination (INBDE), the National Board Dental Hygiene Examination (NBDHE), and the Dental Licensure Objective Structured Clinical Examination (DLOSCE) - which are used by boards across the United States to understand the qualifications of candidates seeking licensure to practice dentistry and dental hygiene. The sixteen Commissioners of the JCNDE oversee the policies and procedures of the NBE programs, which have important implications for the public health. The individuals who serve on the JCNDE hold a variety of perspectives, having been appointed by associations composed of dental and/or dental hygiene board members, dental educators, dental practitioners, dental hygiene practitioners, and dental students. The JCNDE's mission is as follows:

Protecting public health through valid, reliable and fair assessments of knowledge, skills, and abilities, to inform decisions that help ensure safe and effective patient care by qualified oral healthcare team members.

Application materials and additional details are available on the JCNDE's Resources webpage, including the Qualifications for a Public Member PDF. Additional information about the JCNDE and its examination programs appears on the JCNDE website at jcnde.ada.org. We invite your board to share the linked information with individuals who meet the necessary qualifications and would be willing and able to serve in this capacity, and we ask that you encourage those individuals to apply. Your help in this regard is extremely important in helping the JCNDE to ultimately identify an individual who will be firmly committed to the JCNDE's mission and vision, which is firmly focused on the protection of the public health.

The deadline for submission is April 29, 2022. The Commission will review applications in May and June of 2022, with a decision announced in July of 2022. Any questions about this process can be directed to Dr. Kathleen Hinshaw, Director, DTS Operations.

Thanks again go to your board for its work in protecting the public. The JCNDE appreciates the opportunity to help serve your board's needs in understanding the qualifications of those seeking licensure.

Sincerely,

Dr. R. Michael Sanders
Chair, Joint Commission on National Dental Examinations

EXECUTIVE DIRECTOR'S REPORT

EXECUTIVE DIRECTOR'S REPORT
April 22, 2022

Board Member & Staff Updates

On behalf of the OBD, I would like to thank Dr. Amy B. Fine for her 8 years of service on the OBD from 2014 to 2022. As a resident of southern Oregon, the Dental Director at a FQHC and busy person, she brought an invaluable viewpoint, passion and scrutiny to Board actions and proceedings.

On behalf of the OBD, I would like to thank Dr. Gary Underhill for his 8 years of service on the OBD from 2014 to 2022. As a private practitioner from eastern Oregon, a volunteer at a FQHC and a well-travelled person, he brought an important viewpoint, experience and perspective to Board actions and proceedings.

On behalf of the OBD, I would like to thank Yadira Martinez for her 8 years of service on the OBD from 2014 to 2022. As a dental hygienist working at a FQHC in the Hillsboro community, and a person who is involved in many other aspects of her community, she brought an excellent perspective and lens to Board actions and proceedings.

All three of these Board Members' second terms of service are ending in April, but all have graciously agreed to stay on until their replacements are in place, which is expected to occur in May.

I sincerely appreciated their support and guidance when I transitioned into the Executive Director position in February 2015. Throughout the past eight years they all served as OBD President at one time and Chaired various OBD Committees. They committed their time and attention to 48 regular Board Meetings, other meetings, two Strategic Planning Sessions and helped steer the OBD through the 2020-2022 worldwide pandemic. I had the opportunity to co-present on Board updates and visit with these three Board Members in their communities throughout the years. They are well respected personally and professionally.

I hope the Board continues to attract members that can match their professional acumen, commitment to the profession, level of engagement and professional courtesy.

OBD Budget Status Report

Attached is the budget report for the 2021 - 2023 Biennium. This report, which is from July 1, 2021 through February 28, 2022, shows revenue of $1,276,214.50 and expenditures of $1,078,344.71. **Attachment #1**

OBD 2023-2025 Budget Revenue Memo

The budget development process for the 2023 - 2025 Biennium kicked off on March 16 with a statewide agency webinar. One of the first steps in the process is for agencies to forecast revenue, which I did with the attached memo. **Attachment #2**

Customer Service Survey

Attached are the most recent customer service survey results for the current Fiscal Year, from July 1, 2021 through March 31, 2022. The results of the survey show that the OBD continues to receive positive feedback from those that choose to submit a survey. **Attachment #3**

2022 Dental License Renewal

The 2022 Dental License Renewal period closed on March 31 and we report these results: 1709 renewed; 257 expired; 37 retired; 0 revoked; 2 resigned; and 4 deceased

Board and Staff Speaking Engagements

OBD Staff recorded a virtual presentation for the Oregon Dental Conference (ODC). Dr. Bernie Carter, Dr. Angela Smorra and Ingrid Nye recorded a presentation covering an overview of the Board, HPSP, enforcement issues and record keeping. The presentation would be made available to ODC participants.

Haley Robinson and I gave an in person presentation covering Board operations and updates at the ODC at the Oregon Convention Center in Portland on Thursday, April 7, 2022. We thank the Oregon Dental Association for inviting us to present again at their well respected conference.

I gave a "Board Updates" presentation to third year dental students at the OHSU School of Dentistry in Portland on Tuesday, April 12, 2022 and Dr. Bernie Carter was scheduled to present a "What you need to know & and how to stay out of trouble" presentation to the same students on April 18, 2022.

AADA & AADB Mid-Year Meetings

The American Association of Dental Administrators (AADA) Mid-Year Meeting was held on Thursday, April 7, 2022 as a virtual presentation. I led the meeting as President of the AADA.

The American Association of Dental Boards (AADB) Mid-Year Meeting was held April 8-9, 2022 as a virtual presentation. Lori Lindley participated and led the Board Attorneys' Roundtable and Alicia Riedman, RDH, and I attended the meeting. I was elected Chair of the Western Caucus and provided the AADB membership with updates and news from our caucus. **Attachment #4**

OBD 2022 - 2025 Strategic Plan

The Board is now operating under the new plan approved at the February 25, 2022 Board Meeting. Priorities identified in the plan are already being worked on and it will be more systematically addressed and reported on in future board meetings. **Attachment #5**

Newsletter

The OBD published a December 2021 Newsletter which can be accessed with past newsletters on the OBD website. We intend to publish a summer OBD Newsletter capturing relevant news and important updates for the first half of 2022.

Appn Year 2023

BOARD OF DENTISTRY
Fund 3400 BOARD OF DENTISTRY
For the Month of FEBRUARY 2022

REVENUES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
0205	OTHER BUSINESS LICENSES	774,754.00	223,117.00	997,871.00	3,100,001.00	2,102,130.00
0975	OTHER REVENUE	2,595.60	365.17	2,960.77	13,999.00	11,038.23
0210	OTHER NONBUSINESS LICENSES AND FEES	4,150.00	750.00	4,900.00	10,000.00	5,100.00
0605	INTEREST AND INVESTMENTS	4,765.05	533.98	5,299.03	60,000.00	54,700.97
0410	CHARGES FOR SERVICES	7,687.50	1,669.50	9,357.00	18,000.00	8,643.00
0505	FINES AND FORFEITS	255,826.70	0.00	255,826.70	250,000.00	-5,826.70
		1,049,778.85	**226,435.65**	**1,276,214.50**	**3,452,000.00**	**2,175,785.50**

TRANSFER OUT

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	2,070.00	0.00	2,070.00	226,800.00	224,730.00
		2,070.00	**0.00**	**2,070.00**	**226,800.00**	**224,730.00**

PERSONAL SERVICES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	59,134.93	11,525.88	70,660.81	220,730.00	150,069.19
3160	TEMPORARY APPOINTMENTS	0.00	0.00	0.00	4,400.00	4,400.00
3260	MASS TRANSIT	2,236.24	401.52	2,637.76	8,268.00	5,630.24
3110	CLASS/UNCLASS SALARY & PER DIEM	388,748.84	59,426.48	448,175.32	1,327,438.00	879,262.68
3170	OVERTIME PAYMENTS	103.13	55.70	158.83	6,400.00	6,241.17
3230	SOCIAL SECURITY TAX	29,503.96	5,223.60	34,727.56	104,164.00	69,436.44
3221	PENSION BOND CONTRIBUTION	18,061.01	3,546.26	21,607.27	79,458.00	57,850.73
3270	FLEXIBLE BENEFITS	66,506.19	10,369.61	76,875.80	305,856.00	228,980.20
3190	ALL OTHER DIFFERENTIAL	0.00	9,300.00	9,300.00	39,836.00	30,536.00
3210	ERB ASSESSMENT	108.00	16.80	124.80	464.00	339.20
3250	WORKERS' COMPENSATION ASSESSMENT	87.21	13.23	100.44	368.00	267.56
		564,489.51	**99,879.08**	**664,368.59**	**2,097,382.00**	**1,433,013.41**

SERVICES and SUPPLIES

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4425	LEASE PAYMENTS & TAXES	34,321.07	7,721.18	42,042.25	186,798.00	144,755.75
4225	STATE GOVERNMENT SERVICE CHARGES	33,542.71	1,812.68	35,355.39	73,273.00	37,917.61
4125	OUT-OF-STATE TRAVEL	0.00	0.00	0.00	7,888.00	7,888.00
4200	TELECOMM/TECH SVC AND SUPPLIES	7,348.54	1,294.48	8,643.02	25,997.00	17,353.98
4400	DUES AND SUBSCRIPTIONS	4,768.93	20.99	4,789.92	10,874.00	6,084.08

Budget Obj	Budget Obj Title	Prior Month	Current Month	Bien to Date	Financial Plan	Unoblig
4100	INSTATE TRAVEL	7,851.40	0.00	7,851.40	52,968.00	45,116.60
4715	IT EXPENDABLE PROPERTY	7,541.31	0.00	7,541.31	24,492.00	16,950.69
4575	AGENCY PROGRAM RELATED SVCS & SUPP	12,950.43	1,110.00	14,060.43	107,494.00	93,433.57
4650	OTHER SERVICES AND SUPPLIES	18,266.63	6,616.87	24,883.50	95,453.00	70,569.50
4175	OFFICE EXPENSES	19,081.14	1,560.00	20,641.14	95,153.00	74,511.86
4150	EMPLOYEE TRAINING	4,740.54	0.00	4,740.54	56,553.00	51,812.46
4700	EXPENDABLE PROPERTY $250-$5000	0.00	0.00	0.00	6,087.00	6,087.00
4250	DATA PROCESSING	27,965.00	2,204.54	30,169.54	186,234.00	156,064.46
4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	0.00	0.00	735.00	735.00
4275	PUBLICITY & PUBLICATIONS	683.63	67.34	750.97	15,494.00	14,743.03
4475	FACILITIES MAINTENANCE	0.00	0.00	0.00	608.00	608.00
4325	ATTORNEY GENERAL LEGAL FEES	81,678.25	6,229.80	87,908.05	306,725.00	218,816.95
4300	PROFESSIONAL SERVICES	114,128.26	10,470.40	124,598.66	270,498.00	145,899.34
4315	IT PROFESSIONAL SERVICES	0.00	0.00	0.00	148,013.00	148,013.00
		374,867.84	**39,108.28**	**413,976.12**	**1,671,337.00**	**1,257,360.88**

		3400		
		Monthly Activity	Biennium Activity	Financial Plan
TRANSFER OUT	TRANSFER OUT	0	2,070	226,800.00
	Total	0	2,070	226,800.00
PERSONAL SERVICES	PERSONAL SERVICES	99,879.08	664,368.59	2,097,382.00
	Total	99,879.08	664,368.59	2,097,382.00
REVENUES	REVENUE	226,435.65	1,276,214.5	3,452,000.00
	Total	226,435.65	1,276,214.5	3,452,000.00
EXPENDITURES	SERVICES AND SUPPLIES	39,108.28	413,976.12	1,671,337.00
	Total	39,108.28	413,976.12	1,671,337.00

Attachment #1

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 Analyst, LFO Analyst & OMB Budget Personnel

FROM: Stephen Prisby, OBD Executive Director

DATE: March 31, 2022

SUBJECT: OBD 2023 - 2025 Revenue Forecast

The Oregon Board of Dentistry (OBD) was created by an Act of the Legislature in 1887. The authority and responsibilities of the Board are contained in Oregon Revised Statutes Chapter 679 (Dentists and Dental Therapists), Chapter 680.010 to 680.205 (Dental Hygienists), and Oregon Administrative Rules, Chapter 818. These statutes charge the OBD with the responsibility to regulate the practice of dentistry, dental therapy, and dental hygiene by enforcing the standards of practice established in statute and rule. The statutes define the practice of dentistry, dental therapy, and dental hygiene and require that any person practicing any of those professions do so only while holding a license duly issued by the Board. The statutes require that the Board examine and license dentists, dental therapists, dental instructors and dental hygienists; establish and enforce regulations regarding sedation in dental offices; investigate complaints regarding the practice of dentistry, dental therapy, and dental hygiene; discipline Licensees found to have violated the provisions of the Dental Practice Act; regulate and monitor continuing education requirements for Licensees; and establish training, examination and certification standards for dental auxiliaries. The OBD has eight full-time staff members, one limited duration staff member for IT Project and 10 volunteer Board Members.

The Mission of the OBD is to promote quality oral health care and protect all communities in the state of Oregon by equitably and ethically regulating dental professionals.

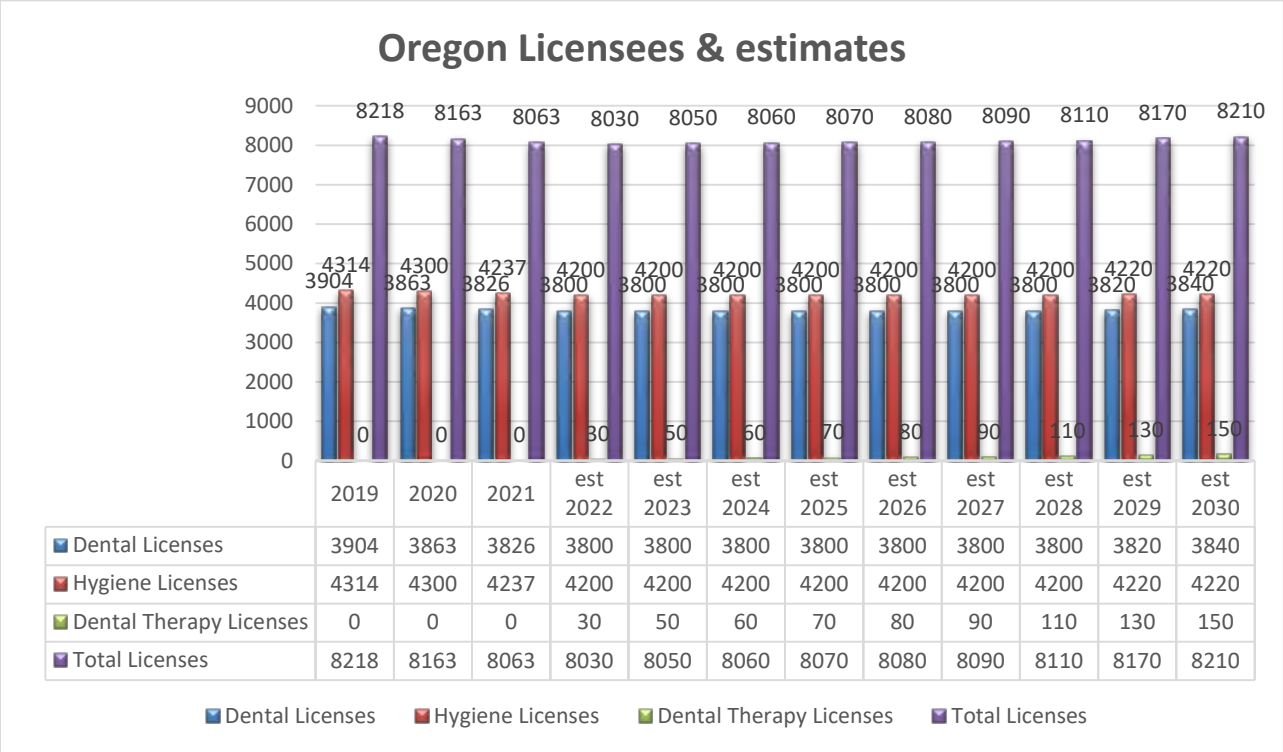
The Board of Dentistry's funding is 100% Other Funds generated primarily from fees paid by Licensees and applicants for new licenses, license renewals and various permits. A small portion (generally less than six percent) of the Board's revenue is from miscellaneous revenues generated from civil penalties, the sale of documents, late fees and interest.

Issues

1. The Board has historically required six months of beginning balance, for planning purposes for a new budget biennium

Licenses regulated by the Board are issued to expire and be renewed every year in two distinct timeframes. The result is that our biennial revenue is primarily received at different times during each biennium. Half of the dentists renew in the spring each year and half our dental hygienists and dental therapists renew in the fall each year. Thus, the agency requires a minimum beginning balance equal to six months of operating expenses at the beginning of every biennium.

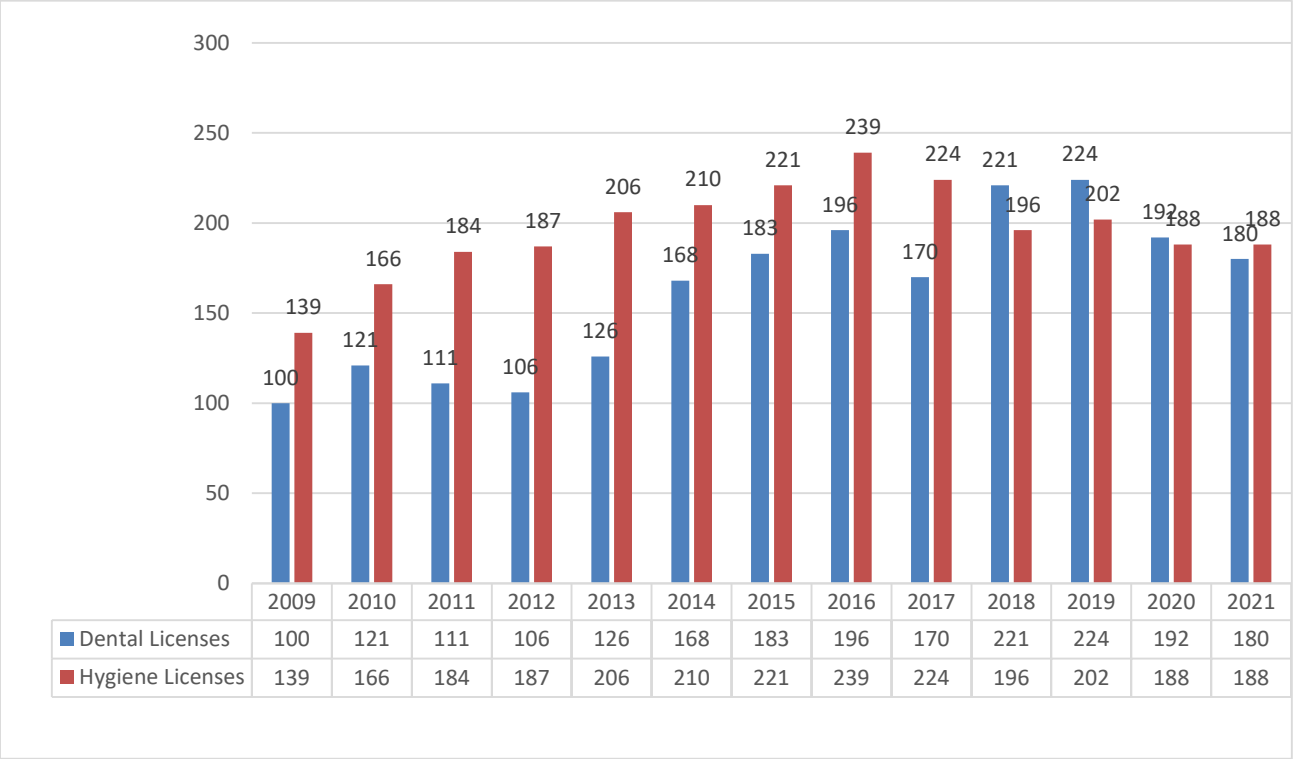
2. COVID-19 Pandemic Impact – A preliminary review shows that total Licensees dropped 1.2% year over year. A reduction of 100 Licensees from 2020 to 2021. The last few years of projections has been consistent and accurate, calling for almost no growth in total Licensees. Even accounting for a new Licensee in late 2022 (Dental Therapists), minor growth is projected out in the foreseeable future.



	2019	2020	2021	est 2022	est 2023	est 2024	est 2025	est 2026	est 2027	est 2028	est 2029	est 2030
Dental Licenses	3904	3863	3826	3800	3800	3800	3800	3800	3800	3800	3820	3840
Hygiene Licenses	4314	4300	4237	4200	4200	4200	4200	4200	4200	4200	4220	4220
Dental Therapy Licenses	0	0	0	30	50	60	70	80	90	110	130	150
Total Licenses	8218	8163	8063	8030	8050	8060	8070	8080	8090	8110	8170	8210

Dental Licenses Hygiene Licenses Dental Therapy Licenses Total Licenses

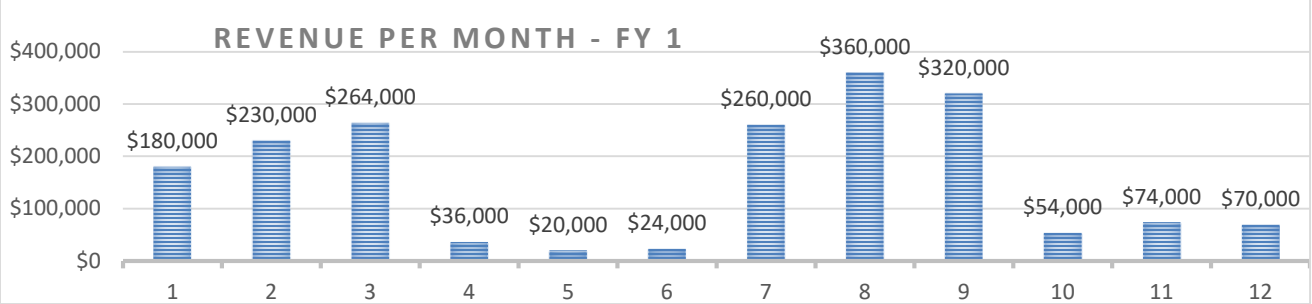
New Oregon Licenses issued per year

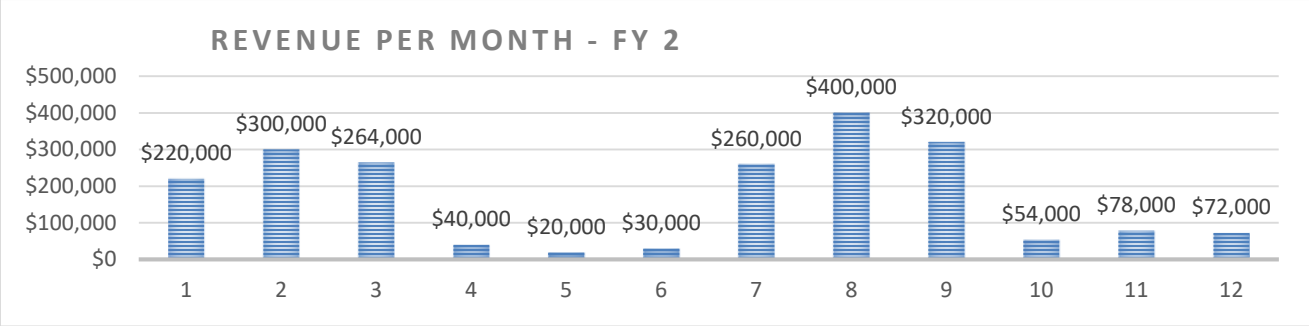


	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Dental Licenses	100	121	111	106	126	168	183	196	170	221	224	192	180
Hygiene Licenses	139	166	184	187	206	210	221	239	224	196	202	188	188

Revenue stream- uneven every year due to Licensees renewing in spring & fall

Every year one half of our dentists renew their 2-year license between Jan – March 31. Every year one half of our dental hygienists and dental therapists renew their 2-year license between July – Sept 30. Example of the uneven revenue typically received per Fiscal Year (FY) shown below. The OBD will begin licensing dental therapists later in 2022 and we forecast that it will have a minimal impact on revenue in the current biennium or in the 2023-2025 biennium.



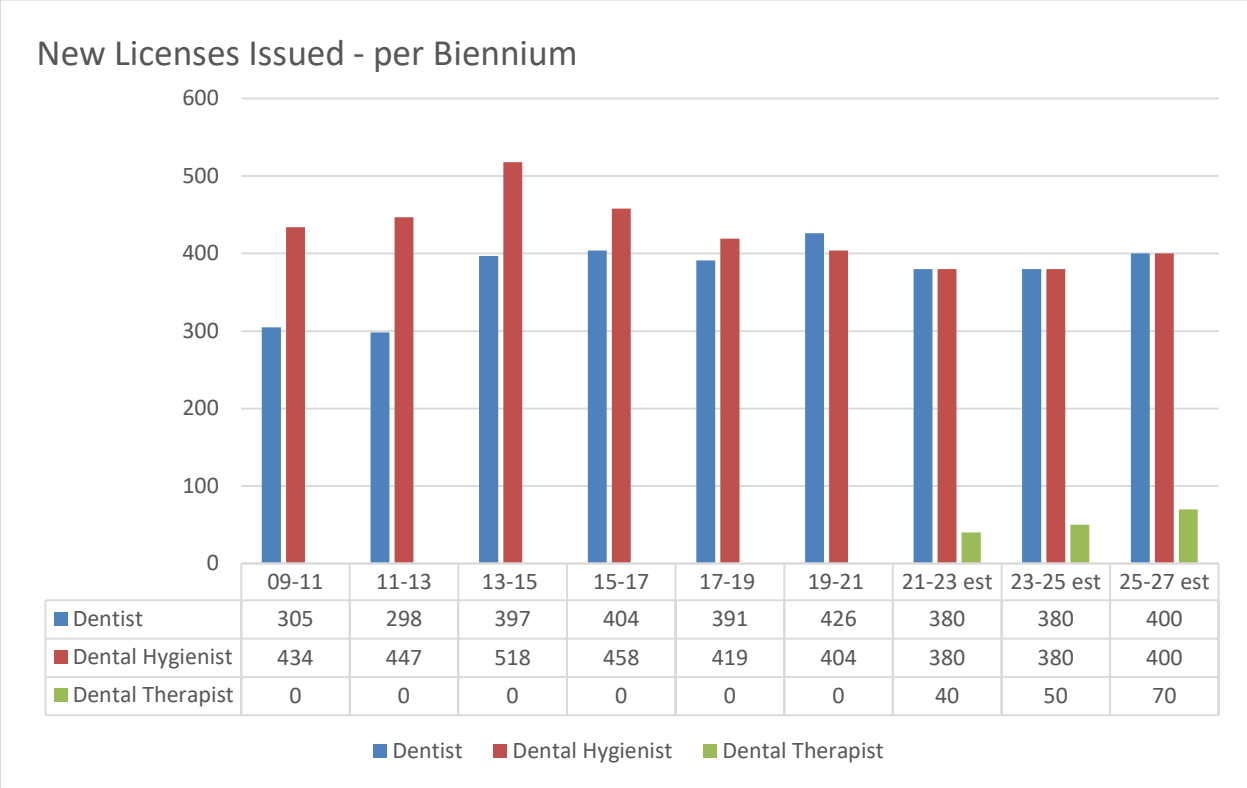


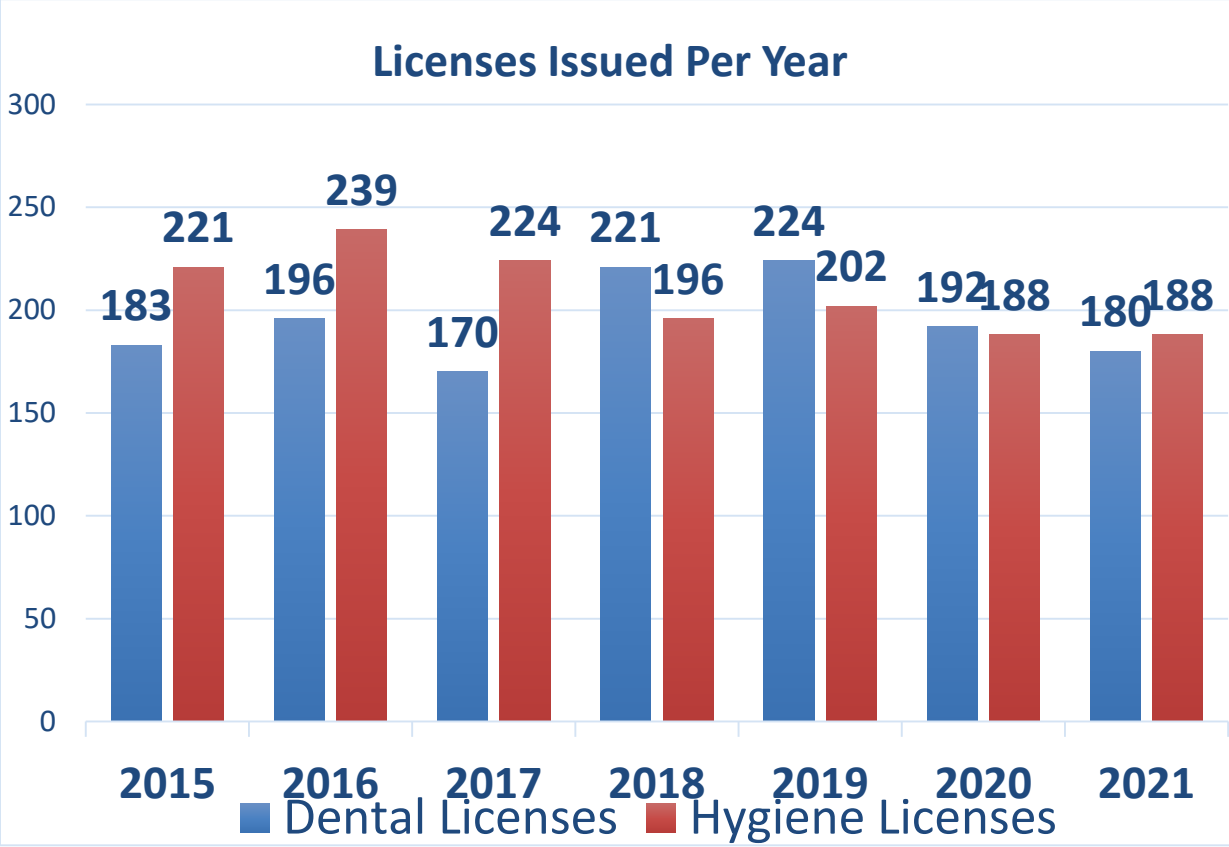
Revenue Estimates

At this point we are projecting revenue for 2023-2025 Biennium to be similar to the 2021-2023 budget biennium.

Revenue	FY 17-19 Actual	FY 19-21 Actual	FY 21-23 ESTIMATE	FY 23-25 ESTIMATE	FY 25-27 ESTIMATE
OTHER BUSINESS LICENSES	3,220,245	3,197,000	3,100,000	3,100,000	3,100,000
OTHER NONBUSINESS LIC & FEES	13,604	14,900	14,900	14,900	14,900
CHARGES FOR SERVICES	24,475	25,100	25,100	25,100	25,100
FINES AND FORFEITS	420,796	243,000	240,000	240,000	240,000
INTEREST AND INVESTMENTS	59,339	49,000	60,000	60,000	60,000
OTHER REVENUE	14,820	14,700	14,000	14,000	14,000
TOTAL	3,753,279	3,543,700	3,452,000	3,452,000	3,452,000

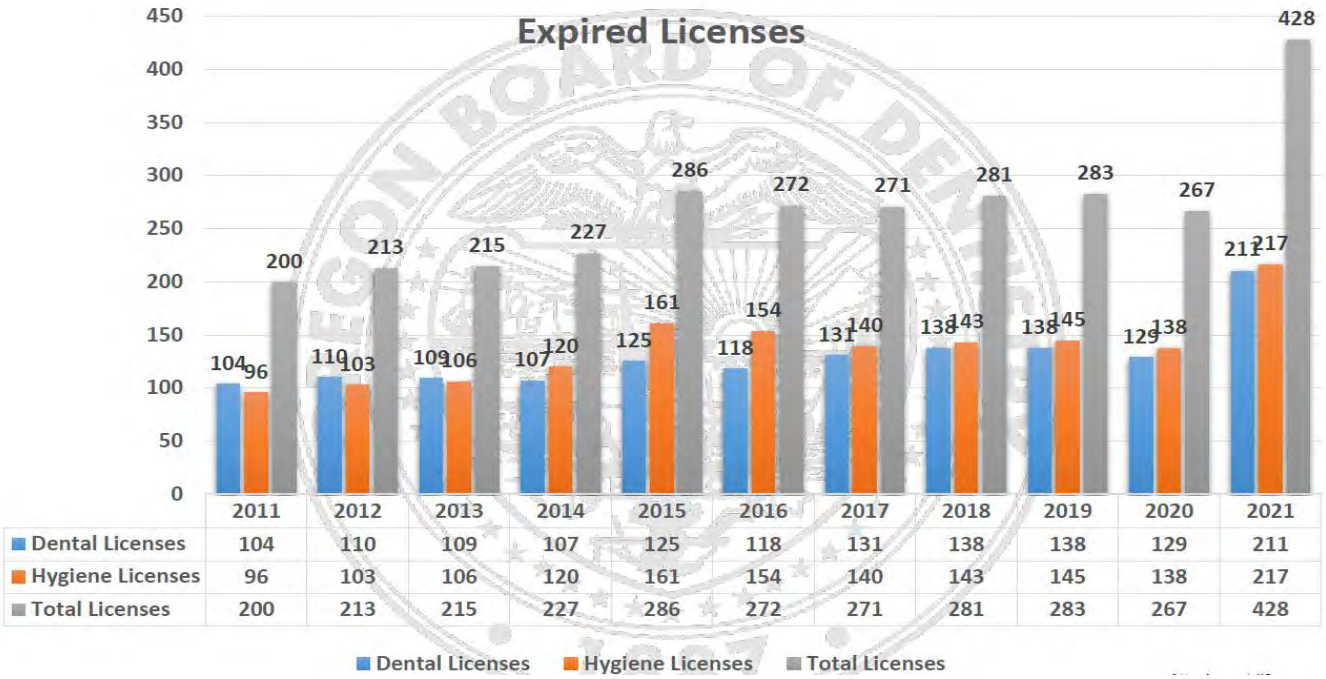
Data on Licensees



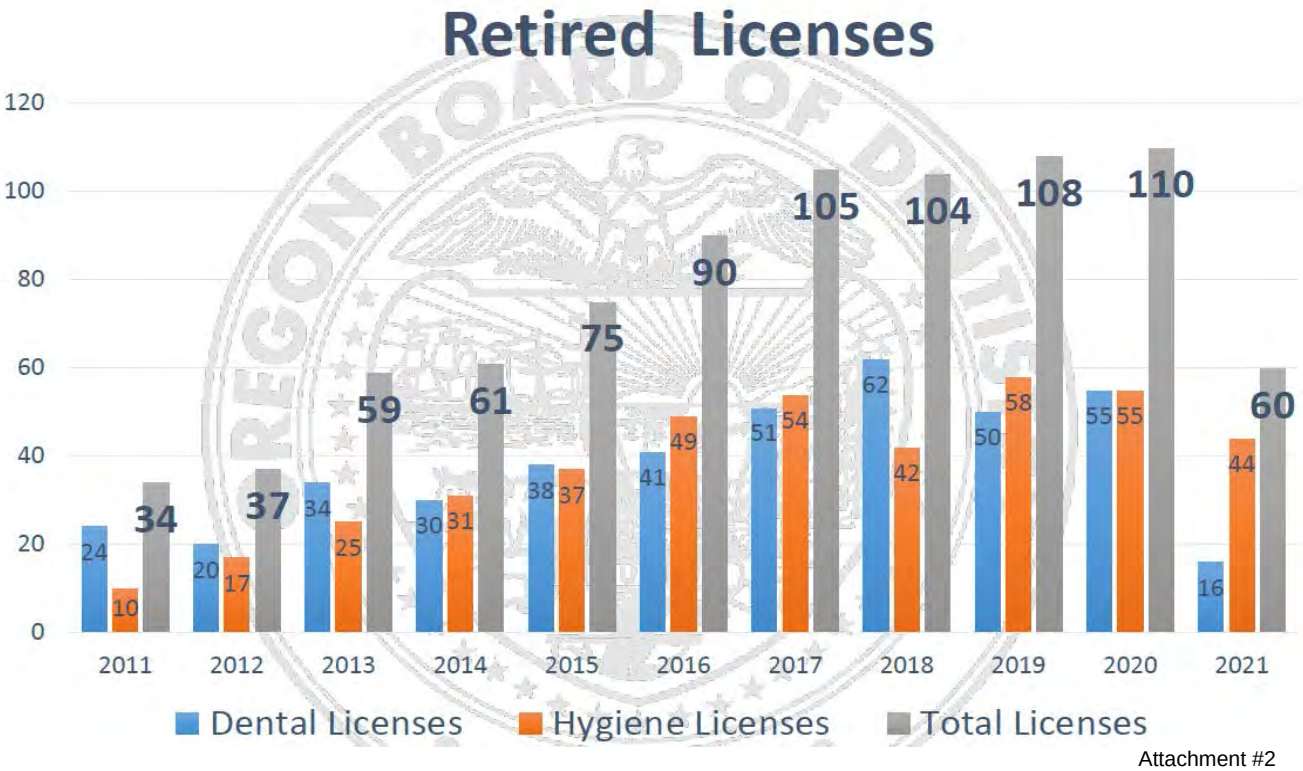


Expiration and Retirements of Licenses:

A spike in Licensees letting their licenses expire was not a surprise given the pandemic. When Licensees choose to stop practicing in Oregon they generally let their license expire instead of retiring it. When they retire, they are confirming that they are not practicing in any other state or jurisdiction in the U.S.



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Dental Licenses	104	110	109	107	125	118	131	138	138	129	211
Hygiene Licenses	96	103	106	120	161	154	140	143	145	138	217
Total Licenses	200	213	215	227	286	272	271	281	283	267	428



As noted in revenue projection memo two years ago:
"Projecting total licenses to slightly decline from 2021 – 2025, due to the impacts of Covid-19 Pandemic and the ability of new dental and dental hygiene graduates to take clinical licensing exams and then apply to get licensed. An aging population of our Licensees, should accelerate retirements and total licenses expiring every year over the next few years. Some older Licensees let their licenses expire, and do not retire them. We have seen the number of licenses issued per year stabilize for 2021-2023, but now expect that to decrease due to Covid-19 Pandemic. The total number of retired and expired licenses per year, almost matches new licenses issued per year."

The time frame between 2022 – 2026 should see total Licensees stabilized coming out of the pandemic. The regular turnover of Licensee's choosing to stop practicing in Oregon is offset with new graduates and individuals moving into Oregon, so that the total number of Licensees should be close to 8000 to 8100 from 2022 – 2026.

Estimated Starting Balance for 2023-2025 is anywhere between $900,000 to $1.3 million.
Our dental license period for ½ of our dentists concludes March 31. 2022. It is too soon to review the data and see if there will be a material impact on revenue, but we are conservatively estimating the renewals to be 1 - 3% lower than last year's renewal totals. We anticipated approximately 1800 dentists to renew their licenses.

Late July 2022 through Sept 2022 is the next license renewal period for ½ of our dental hygienists, which is approximately 2156 Licensees.

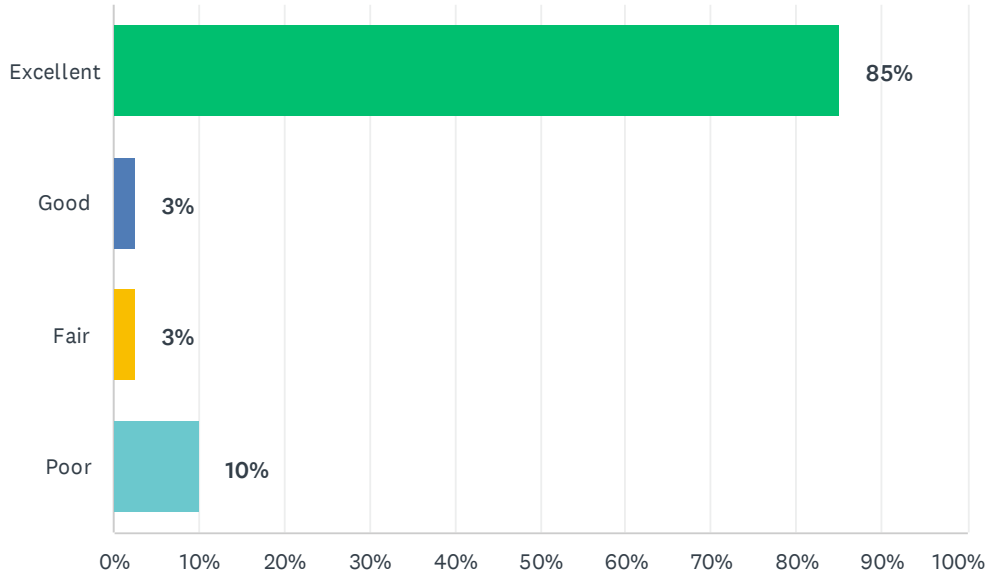
Estimated Ending Balance for 2023-2025 estimated to be $400,000 – $700,000.
Payroll adjustments higher, added inflation costs, technology support, additional transfers to the OHA for the PDMP, misc are driving up our operating expenses. This revenue forecast does not focus on expenses. That area will be addressed in more detail in the agency 2023-2025 budget request due later in the year.

Summary
The OBD like all state agencies is charged with being a good steward of its resources and also to plan for upcoming challenges. We should plan ahead with revenue expectations equal to the previous budget biennium in developing an accurate budget. I expect there to be revisions and changes as more information becomes available

Stephen Prisby
OBD Executive Director

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

Answered: 40 Skipped: 0

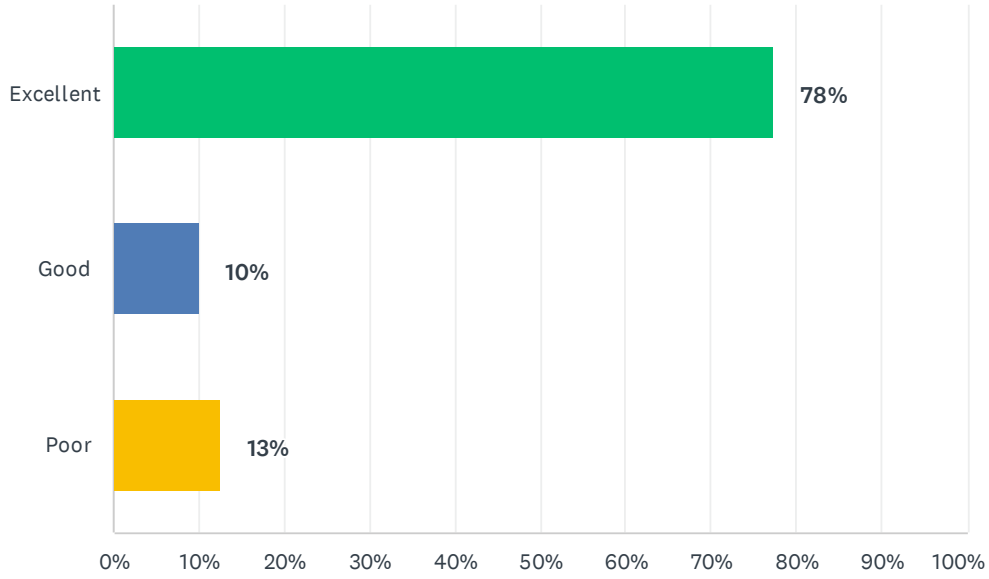


ANSWER CHOICES	RESPONSES	
Excellent	85%	34
Good	3%	1
Fair	3%	1
Poor	10%	4
TOTAL		40

Attachment #3

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

Answered: 40 Skipped: 0

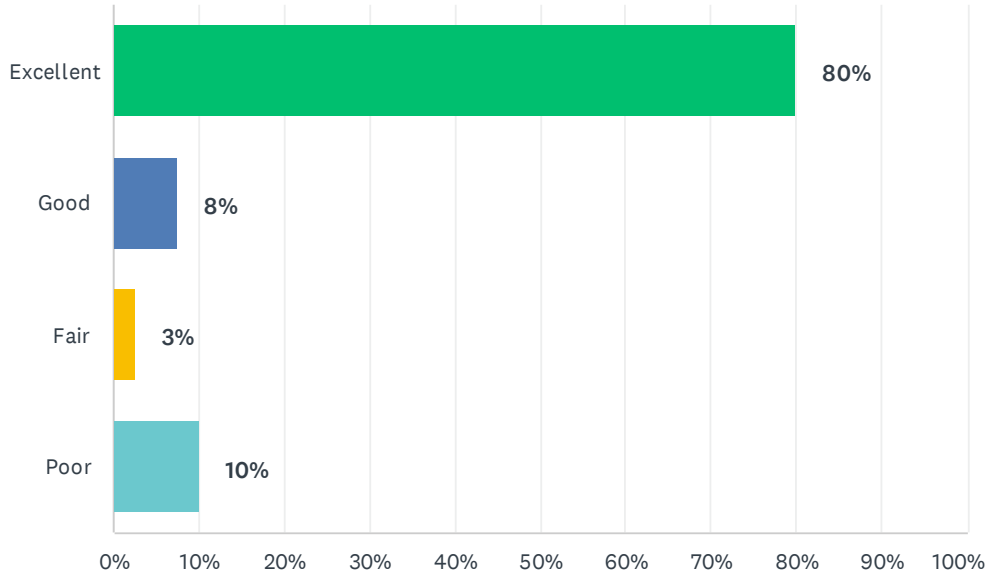


ANSWER CHOICES	RESPONSES	
Excellent	78%	31
Good	10%	4
Poor	13%	5
TOTAL		40

Attachment #3

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

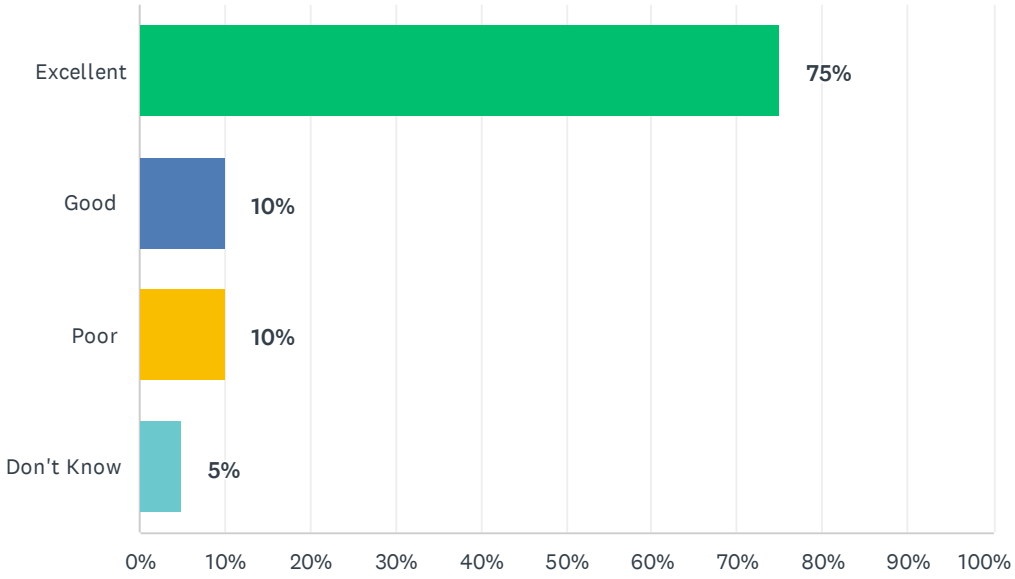
Answered: 40 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	80%	32
Good	8%	3
Fair	3%	1
Poor	10%	4
TOTAL		40

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

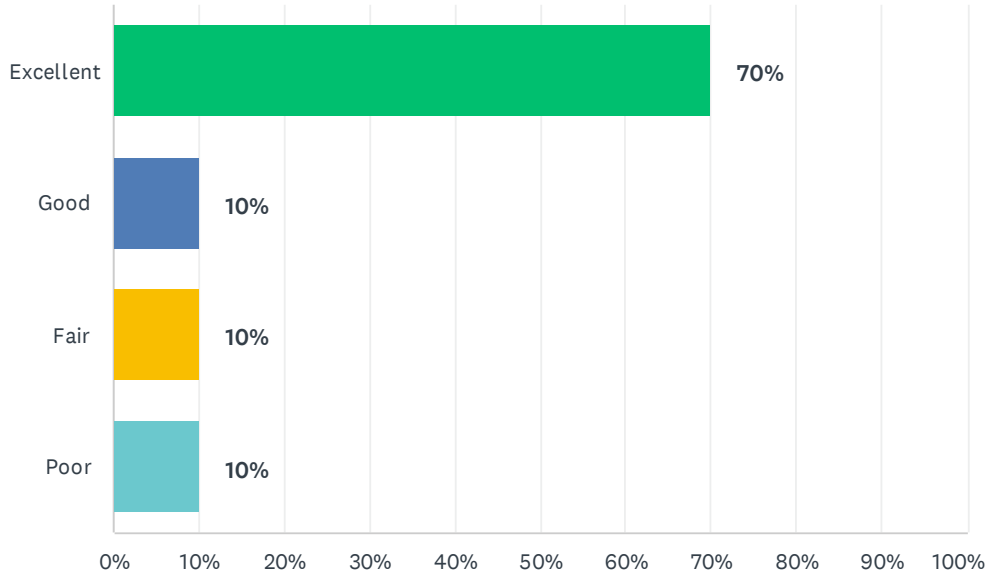
Answered: 40 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	75%	30
Good	10%	4
Poor	10%	4
Don't Know	5%	2
TOTAL		40

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

Answered: 40 Skipped: 0

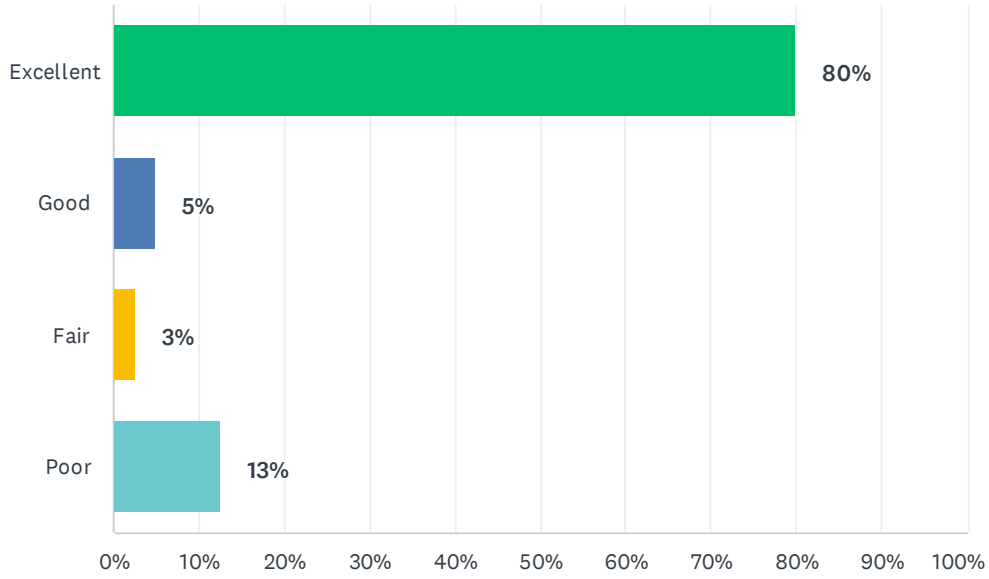


ANSWER CHOICES	RESPONSES	
Excellent	70%	28
Good	10%	4
Fair	10%	4
Poor	10%	4
TOTAL		40

Attachment #3

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

Answered: 40 Skipped: 0



ANSWER CHOICES	RESPONSES	
Excellent	80%	32
Good	5%	2
Fair	3%	1
Poor	13%	5
TOTAL		40

Attachment #3

OFFICERS AND EXECUTIVE COMMITTEE

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612-617-2250 (Main Number)
Cell: 612-600-5915
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Mississippi Board of Dentistry
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Licensing & Registration Prog Mngr
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Boise, ID 83714
Telephone 208-577-2639
E-Mail:Stephanie.lotridge@isbd.idaho.gov

TREASURER
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North Dakota Board of Dentistry
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Bismarck, ND 58507-7246
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Louisiana State Board of Dentistry
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Baton Rouge, LA 70821-5256
Telephone 225-219-7330
E-Mail: ahickham@lsbd.org

AADA
American Association of Dental Administrators

3/22/2022

Greetings,

The AADA Mid-Year Meeting is Thursday, April 7 from 5 pm – 6:30 pm (CST). We are asking you RSVP please, but there is no fee to register or attend this Zoom meeting.

The Agenda:

- **Welcome and introduction of AADA Officers.**

Springing Forward into 2022 as the pandemic and emergency recedes.

- **Introduction of new members/visitors** who have never attended/participated in an AADA Meeting. Please un mute, introduce yourself and share a 1-minute biography.

- **Update from AADA Committees**:

- Program Committee: Chair Bridgett Anderson - Tonia Socha-Mower, Bruce Bronoske, Ryan Edmonson and Stephen Prisby
- Membership Committee: Chair Chris Hutchinson - Ryan Edmonson, Casie Goode and Stephanie Lotridge
- Nominating Committee: Chair Rusty Hickham, Jr. - Brian Barnett
- Awards Committee: Chair Sandy Reen - Rita Sommers
- AADA Bylaws Committee: Chair Bobby White - Tiffany Allison and Alex Vandiver
- Strategic Planning Advisory Committee: Chair Stephen Prisby - Katherine Landsburg, Kimber Cobb and Rita Sommers

- **General Discussion and sharing on these topics:**
- **Dental & Dental Hygiene Licensing Compact**
- **License Portability- expedited licensure & reciprocity**
- **Dental Therapy Licensure**
- **AADA Website**
- **AADA Membership Fees & Annual Meeting in the Fall**
- **AADA Bylaws**
- **Treasurer's Report**

Zoom Meeting Information Attached.

Please RSVP to me regarding attendance at the April 7 Mid-Year Meeting.

Sincerely,
Stephen
Stephen.Prisby@OBD.oregon.gov

Attachment #4

2022
AADB
Mid-Year Meeting

President James A. Sparks, DDS

AADB Thanks Our Program Committee

Chair:
James A. Sparks, DDS (OK)

Vice Chair:
Dale Chamberlain, DMD (MT)

Yvonne Bach (KY)

Brian Barnett (MO)

Sherry Campbell, RDH, CDHC
(AL)

Bobby Carmen, DDS (OK)

Cliff Feingold, DDS (NC)

Arthur Chen-Shu Jee, DMD (MD)

Frank Maggio, DDS (IL)

D. Kevin Moore, DDS (NV)

Laura Richoux, RDH (MS)

Tonia Socha-Mower, MBA, EDd (AADB)

Robert Zena, DMD (KY)

American Association of Dental Boards

1701 Pennsylvania Ave NW, Suite 200
Washington, DC 20006

200 East Randolph Street, Suite 5100
Chicago, IL 60601

info@dentalboards.org

About AADB

The American Association of Dental Boards is a national association that encourages the highest standards of dental education. The AADB promotes higher and uniform standards of qualification for dental practitioners. Membership is composed of boards of dentistry, advanced education boards, present and past members of those boards, board administrators, board attorneys, educators, and oral health stakeholders.

Our Mission

To serve as a resource by providing a national forum for exchange, development, and dissemination of information to assist dental regulatory boards with their responsibility to protect the public.

About AADB's Mid-Year Meeting

The AADB Meeting provides an excellent forum for keeping up-to-date with state board concerns. Programs are designed to allow opportunities for interaction among all participants, including board members, dentists, dental hygienists, dental assistants, educators, board attorneys, and dental specialty associations. Panels and small discussion groups exchange ideas and information. Participants take away valuable information on current issues and all aspects of dental and dental hygiene regulation.

Meeting Agenda

Program Updated 4.06.22

Friday, April 08

*****Please note the times listed below are in Eastern Time*****

11:00 a.m.	**AADB Attorney Round Table Meeting** This closed session is for Attorneys who represent State/Territory Dental Boards.
12:00 - 12:15 p.m.	**President's Opening Remarks** James A. Sparks, DDS, AADB President
12:15 - 12:30 p.m.	**Chief Executive Officer's Welcome & Report** Tonia Socha-Mower, MBA, EdD, AADB Chief Executive Officer
12:30 - 1:10 p.m.	**Oral Health: An Evidence and Data-Driven Approach to Achieve Better Health, Equity, and Fiscal Responsibility** Natalia Chalmers, DDS, MHSc, PhD, Chief Dental Officer, CMS
1:10 - 1:30 p.m.	**Trends in Dental Education** Denice Stewart, DDS, MHSA, Senior Scholar in Residence, ADEA
1:30 - 1:40 p.m.	**Break**
1:40 - 3:40 p.m.	**Access to Care & Teledentistry** Steven C. Bilt, Chief Executive Officer, Smile Brands Scott Howell, DMD, MPH, Associate Professor and Director of Public Health Dentistry & Teledentistry, A.T. Still University-Arizona School of Dentistry & Oral Health Ifetayo B. Johnson, MA, Executive Director, Oral Health Progress and Equity Network, Inc. (OPEN) Jeffrey Sulitzer, DMD, Chief Clinical Officer, SmileDirectClub Robert B. Zena, DMD, AADB Immediate Past-President
3:40 - 4:00 p.m.	**Break**
4:00 - 4:30 p.m.	**Insights Garnered from Six Months with AADB's Remediate+ Program** MaryJane Hanlon, RDH, DMD, MBA, Project Manager
4:30 - 5:00 p.m.	**Regional Caucus Meetings**

5:00 - 5:30 p.m.	**Hygiene Caucus Meeting**

Saturday, April 09

*****Please note the times listed below are in Eastern Time*****

12:00 - 12:20 p.m.	**Sponsorship Recognition**
12:20 - 1:20 p.m.	**Attorney Round Table** Lori Lindley, Senior Assistant Attorney General, Oregon Board of Dentistry Susan Rogers, Executive Director and General Counsel, Oklahoma State Board of Dentistry
1:20 - 1:45 p.m.	**Break**
1:45 - 2:45 p.m.	**Future of Dentistry: The Oral Health in America Report & Multi-Directional Integration** Rear Admiral Timothy Ricks, DMD, MPH, FICD, Chief Dental Officer
2:45 - 3:15 p.m.	**AADB Accredited Continuing Education (ACE) Program** Robert B. Zena, DMD, AADB Immediate Past-President
3:15- 3:45 p.m.	**Break**
3:45 - 4:45 p.m.	**The History and Future of Fully Digital Workflows in Dentistry** Lee Coursey, Managing Partner, Russellville Dental Lab
4:45 - 5:00 p.m.	**Break**
5:00 – 6:00 p.m.	**AADB Forum: State/Territory Board Issues** This closed session is for individual voting members who have seats (or had seats) on their Board of Dentistry. Frank Maggio, DDS, AADB Member and Moderator
6:00 p.m.	**Adjournment**

The registration fee for the AADB 2022 Mid Year Meeting is **$600** for AADB members; **$825** for nonmembers and can be processed online at:

https://www.dentalboards.org/aadb-2022-mid-year-meeting

Refund Policy:
Notification of cancellation must be submitted in writing to srojas@dentalboards.org. Cancellations are subject to a $75 cancellation charge. No refunds will be given after March 15, 2022. Substitutions are allowed at any time but must be submitted in writing and must be of the same membership status.

Biographies

Steven C. Bilt, Chief Executive Officer, Smile Brands Inc.
Steve Bilt is the Chief Executive Officer at Smile Brands Inc. Steve co-founded Smile Brands and subsequently led the acquisitions of Monarch Dental Corporation [NASDAQ: MDDS], Castle Dental Centers Inc. [NASDAQ: CASL] and Midwest Dental. Steve is a Certified Public Accountant (inactive) and earned a Bachelor of Arts degree in business economics from the University of California, Santa Barbara and a Master of Business Administration degree from the Graziadio School of Business and Management at Pepperdine University

Natalia Chalmers, DDS, MHSc, PhD, CMS' Chief Dental Officer
Dr. Chalmers is a board-certified pediatric dentist, oral health policy expert, and public health advocate who brings more than 20 years of clinical, research, industry, and regulatory experience to CMS as Chief Dental Officer in the Office of the Administrator. Previously, Dr. Chalmers served as a Dental Officer at the US Food and Drug Administration.

Lee Coursey, Managing Partner, Russellville Dental Lab
Lee Coursey, MICOI is a third-generation owner and Managing Partner of Russellville Dental Lab, a progressive, full-service, removables-focused lab that is currently converting to fully digital design and manufacturing. He is a lifetime lover of technology and brings that passion for technology and innovation to the dental lab. Lee spoke for several years after the launch of All-On-4 to clinicians all over North America about how to get the best results prosthetically from those surgeries.

MaryJane "MJ" Hanlon, RDH, DMD, MBA, AADB Project Manager
Dr. Mary Jane Hanlon has a long and varied background in the field of dentistry including dental receptionist, dental assistant and dental hygienist. She started a practice from scratch in Lexington, MA where she would work for fifteen years. Having had some challenges along the way with her dental practice, she realized she wanted a more formal education in the principles of business. This led her to pursue an MBA from Suffolk University in 2012.

Scott Howell, DMD, MPH, Associate Professor and Director of Public Health Dentistry & Teledentistry
Dr. Scott Howell is an associate professor and Director of Public Health Dentistry & Teledentistry at A.T. Still University, Arizona School of Dentistry & Oral Health (ATSU-ASDOH), clinical advisor for MouthWatch, and an Atlantic Fellow for Health Equity. Prior to dental school, Dr. Howell worked in portable dentistry as a dental assistant in Michigan going to long term care facilities, detention centers, and inner-city schools. He graduated from the ATSU-ASDOH DMD/MPH program in 2014. He spent one year at the Swedish Medical Center GPR in Seattle treating patients with complex medical conditions and special needs.

Ifetayo B. Johnson, MA, Executive Director, OPEN

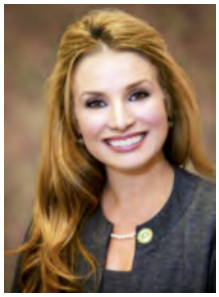
Ms. Johnson is the first Executive Director of the Oral Health Progress and Equity Network, Inc. (OPEN), a position she has held since January 2020. OPEN is a national network of over 2,500 members across all 50 states who are dedicated to oral health, health equity, and social justice. From 1999 to 2020, Ms. Johnson served as the Executive Director of United Health Organization (UHO) and Project Healthy Living in Detroit, Michigan. Her work and interests have always focused on health and equity. Ms. Johnson is a native of Detroit and is married to a retired army officer and the mother of two adult sons and an adult foster daughter.

Lori H. Lindley, Senior Assistant Attorney General, Oregon Board of Dentistry

Lori is a Senior AAG Business Activities Section. Assigned to Workers' Compensation Board general advice; assigned as attorney for Oregon Dental Board, Oregon Board of Chiropractic Examiners, Oregon Board of Licensed Massage Therapists, attorney for the Oregon Board of Nursing contested cases and assigned counsel for the Oregon Optometry Board. Lori s has represented most medical boards in her section.

Frank Maggio, DDS, AADB Member and Moderator

Dr. Maggio was born in Chicago and raised in a dental family. From a young age he was involved with dentistry and it continues to be his passion. Upon completion of dental school he served his country in the United States Army. It was at that time that he was able to obtain a California dental license. He returned to Illinois and he completed his residency in Periodontics. In 1975 he established his practice of Periodontics and Implantology in Elgin, Illinois.



Laura Richoux, RDH, Dental Hygiene Member

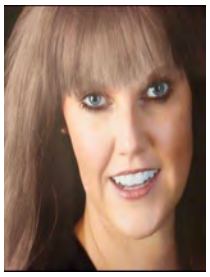
Laura Richoux is a dental hygienist on the Mississippi Gulf Coast. After graduating from the University of Mississippi Medical Center's Dental Hygiene program, she practiced her first four years in South Louisiana and has spent the last fifteen years practicing in Mississippi. Laura served as the Dental Hygienist at Large on the Mississippi State Board of Dental Examiners for six years and is currently serving as the Dental Hygienist member of the American Association of Dental Boards.

Rear Admiral Timothy Ricks, DMD, MPH, FICD

Rear Admiral Timothy L. Ricks, DMD, MPH, FICD currently serves as the 20th Chief Dental Officer of the U.S. Public Health Service as well as Assistant Surgeon General, a four-year term appointment he has held since September 2018. He serves as the Surgeon General's spokesperson on oral health and interacts with chief dental officers from other countries, with military chief dental officers, with leaders in organized dentistry and public health, with state oral health programs, and much more.

Susan Rogers, Executive Director and General Counsel

Susan Rogers is the Executive Director and General Counsel for the State of Oklahoma Board of Dentistry. She previously served as the General Counsel for the Oklahoma Bureau of Narcotics and Dangerous Drugs for approximately 5 years.. She graduated from the University of Oklahoma with Bachelor's Degrees in Political Science with a major in Law Enforcement Administration and a Bachelor's degree in Journalism with a major in Public Relations.



Tonia Socha-Mower, MBA, EdD, AADB Chief Executive Officer

A pioneer in the public health arena, Dr. Socha-Mower is the CEO of the American Association of Dental Boards (AADB). She first gained national attention when she started the first dental clinic in the United States that was embedded in a medical and mental health clinic in a student health center on a college campus in eastern Kentucky. She ultimately was promoted to be the Director of Counseling, Medical and Dental Services at Morehead State University.

James A. Sparks, DDS, AADB President

Dr. James A. Sparks is a dentist in private practice in Oklahoma City, Oklahoma. A graduate of Oklahoma University College of Dentistry, class of 1986, where he is and has been part time faculty in Oral Diagnosis and Radiology ever since, and is currently a Clinical Associate Professor. He was elected to six terms (18 years) on the Oklahoma Board of Dentistry and served as President for 8 years. Currently Dr. Sparks is serving as President of the American Association of Dental Boards.

Denice Stewart, DDS, MHSA, Senior Scholar in Residence

Dr. Denice Stewart is a Senior Scholar in Residence at the American Dental Education Association (ADEA). She received her D.D.S. at the University of North Carolina at Chapel Hill School of Dentistry, completed a General Practice Residency at Wilmington Medical Center (now Christiana Medical Center) in Delaware, and obtained a Master's in Health Services Administration from the University of Michigan School of Public Health.

Jeffrey Sulitzer, DMD, Chief Clinical Officer, SmileDirectClub

Jeffrey Sulitzer, DMD, is the Chief Clinical Officer at SmileDirectClub, where he is responsible for the clinical leadership of the direct to consumer market leader in remote clear aligner therapy. SmileDirectClub operates in 4 countries, including all 50 states and Puerto Rico where it supports an affiliated doctor network of more than 240 state-licensed dentists and orthodontists. After graduating from the Temple University School of Dentistry in 1985, Dr. Sulitzer spent more than a decade serving as Vice President of US Healthcare's dental division.

Robert B. Zena, DMD, AADB Immediate Past-President

Dr. Robert Zena has a very diversified background from his four decades of devotion to the dental profession. He has assumed the roles of clinician, educator, consultant, researcher, author, lecturer, editor, inventor, and most of all leader. As a graduate from the University of Kentucky's College of Dentistry, he practiced for seven years as a general dentist. He then gained more education by a residency in the Postgraduate Prosthodontics Program at the University of Louisville's School of Dentistry.

The ACE Program is a service of the AADB to assist dental boards in identifying quality continuing education courses to help protect the public. ACE accreditation may not be accepted by particular boards of dentistry. Questions or comments can be directed to the AADB at info@dentalboards.org.

The American Association of Dental Boards is an ADA CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry. The American Association of Dental Boards designates this activity for 8.25 continuing education credits. Concerns or complaints about a CE provider may be directed to the provider or to ADA CERP at www.ada.org/cerp.

Caucuses by State

East	West	North	South
Connecticut	Alaska	Illinois	Alabama
Delaware	Arizona	Indiana	Arkansas
District of Columbia	California	Iowa	Florida
Maine	Colorado	Kansas	Georgia
Maryland	Hawaii	Michigan	Kentucky
Massachusetts	Idaho	Minnesota	Louisiana
New Hampshire	Montana	Missouri	Mississippi
New Jersey	Nevada	Nebraska	North Carolina
New York	New Mexico	North Dakota	Puerto Rico
Pennsylvania	Oregon	Ohio	South Carolina
Rhode Island	Utah	Oklahoma	Tennessee
Vermont	Washington	South Dakota	Texas
West Virginia	Wyoming	Wisconsin	Virginia
			Virgin Islands

AADB Board of Directors

James A. Sparks, DDS, President
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Warr Acres, OK 73132

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Helena, MT 59602

Arthur Chen-Shu Jee, DMD, Vice President
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Laurel, Maryland 20707

Clifford Feingold, DDS, Treasurer
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Asheville, NC 2880

Bobby J. Carmen, DDS, MAGD, Secretary
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Norman, OK 73072

Yvonne Bach, Public Member
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Brian Barnett, Administrator Member
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Jefferson City, MO 65102

Laura Richoux, RDH, Dental Hygiene Member
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Oregon Board of Dentistry

Strategic Plan 2022-2025

Adopted February 25, 2022

Attachment #5

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Oregon Board of Dentistry

2022-2025 Strategic Plan

Board members and staff of the Oregon Board of Dentistry who participated in the development of this strategic plan at the October 22-23, 2021 Planning Session:

Alicia Riedman, RDH - President
Jose Javier, DDS - Vice President
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Gary Underhill, DMD
Reza J. Sharifi, DMD
Charles "Chip" Dunn
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Jennifer Coyne - CEO, The PEAK Fleet
Theresa Trelstad - Contractor Consultant, The PEAK Fleet

Oregon Board of Dentistry
Strategic Plan Overview

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

At the end of the previous 2017-2020 planning cycle and after hardships of the COVID 19 pandemic (which has persisted from 2020 into 2022), OBD had established transformative ways of addressing critical issues. Strong relationships with the Governor's office, Oregon Legislature, Oregon Health Authority, peer professional organizations, and national associations gave context and direction, and kept a finger on the pulse of rapid changes in the dental profession, business practices, and operating models.

In mid-2021 the Board and staff of OBD agreed to secure professional, external strategy and facilitation services in the creation of their next multi-year strategic plan, building upon the efforts of the 2017-2020 Plan.

During the planning process, the OBD Board and Staff agreed to update the mission statement to reflect a focus on access to care as well as on integrity. The OBD will implement the strategic plan, adaptively to rapidly changing circumstances, in support of its Mission: *to promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals.*

Through external market research, initial discussions with the Board and Staff, and tabulation of the licensee surveys, a set of priorities emerged. Through the facilitated process between August and October 2021, five key strategic priorities were defined and goals established. Actions needed to meet the strategic goals were drafted and prioritized.

Covered in more detail in the subsequent pages, focus for the next 3-5 years will be on Licensure Evolution (including Dental Therapy legislation implementation),

Dental Practice Accountability, Workplace Environment, Technology & Processes, and Community Interaction & Equity.

This multi-year strategic plan outlines OBD's path and efforts to engage constituents on many levels to upscale practices and processes reflecting the changing environment and statutory responsibilities.

The new strategic plan is built upon a foundation of strength in Staff and Board expertise and experience, as well as positive Licensee sentiment, expressed as 78% positive, following a very tough year with the pandemic and other social impacts (especially on the healthcare industry). In addition, the Board and Staff defined and approved organizational core values of ***integrity***, ***fairness***, ***responsibility***, and ***community.*** Combined with a focus on mission, the newly defined core values are a visible lens through which to make decisions and set direction.

Oregon Board of Dentistry
Mission Statement & Core Values

Mission of the Oregon Board of Dentistry:

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

Oregon Board of Dentistry Core Values:

- Integrity
- Fairness
- Responsibility
- Community

Oregon Board of Dentistry

Organizational & External Influences Analysis

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

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

STRENGTHS	WEAKNESSES
• Foundation of known, common values: Integrity, Fairness, Responsibility, Community and commitment to the mission • Skilled, experienced, and dedicated staff • Successful migration and knowledge transfer as new Board and Staff onboarded during previous strategic period • Foresight and proactive succession and onboarding planning • Board composition provides a breadth of perspectives • Member survey shows support in OBD remains high at 78% after problematic pandemic year	• Lack of clear understanding for OBD scope and jurisdiction by public, patients and Licensees • Limited control over budget/funding impact ability to adjust staffing plans to meet overall strategic plan needs • Legislature changes can create significant increases in staff work that are not in alignment with staffing capacity • Low levels of Licensee participation in inputs/surveys. 2020 strategic priorities member survey had 265 responses • Board member turnover creates loss of continuity and historical knowledge
OPPORTUNITIES	**THREATS**
• Ability to implement Dental Therapy licensure process • Migration of technology to improve licensee experience, overall processes & efficiency, and provide workplace flexibility • Collaboration with Oregon Health Authority (OHA) to manage public engagement and expectations for language, cultural diversity, equity, and inclusion across OHA partners. (With guidance from the State Racial Justice Council.)	• Continued lagging technology infrastructure • Shifts in business operations and managed care pose challenges to dentistry practices and regulation • Insurance maximums dating to the 1960's influence patient care recommendations

In addition to the SWOT items called out above it is important to note that ability to address Opportunities, Threats, and Weaknesses will come from the areas of Strength. For instance, the Engaged Board and Staff expertise coupled with the learnings from the migration and knowledge transfer of the previous period is the key to implementing needed technology infrastructure which in turn drives the hybrid work environment. In a similar fashion, collaboration with OHA and the State Racial Justice Council recommendations will set standards for community engagement, helping clarify OBD scope and public expectations for interaction with the OBD.

STRATEGIC PRIORITY A

Licensure Evolution

In support of providing quality oral care equitably to all, the dental profession must address the issue of communities having access to dental care services. This access may be limited by lack of dental care professionals in certain community areas such as rural areas, lower socio-economic areas, or tribal communities. Solving this problem requires creativity and the evolution of types of licenses granted. As new legislation is created, the OBD must implement rules and standards to govern dental professionals in Oregon.

Goals

⇒ Develop and implement rules based on legislation changes

⇒ Successfully implement Dental Therapy license

Action Items

- Develop and implement rules in support of HB 2528 (2021) for newly created Dental Therapist license
- Develop and implement communication strategies with communities most impacted by Dental Therapy license implementation
- Engage interested parties to learn more and gather feedback about implementing Dental Therapy practice in Oregon

STRATEGIC PRIORITY B

Dental Practice Accountability

The landscape of dental practices continues to evolve further toward group dentistry practice including ownership by national corporate entities. This in turn, creates challenges and complexity in ensuring the public safety and high standards of practice are upheld. In addition, when complaints are made, establishing appropriate accountability and encouraging improvements to happen is more challenging than in the past.

Goals

⇒ Ensure Licensees dictate clinical care provided to patients (in contrast to corporate non-Licensees driving care decisions)

⇒ Increase OBD visibility into practice ownership models

⇒ OBD jurisdiction over Dental practices in Oregon, regardless of ownership and business operating model

⇒ Correlate patient care to level of competency required by practitioners (DT, DMD, DDS, DH); hold entities accountable to the level of licenses within their practice

Action Items

- Implement changes to Licensee Renewal form to capture multiple office/group affiliation
- Gather dental practice ownership and training information
- Analyze complaints by ownership types
- Receive OHSU updated curriculum and include in Board Book
- Evaluate options for strengthening statute related to accountability, ownership, and standards of care

STRATEGIC PRIORITY C

Community Interaction and Equity

The Oregon Board of Dentistry recognizes that systemic inequities exist in our society which have resulted in practices that have not always provided equitable access to dental care across our community.

Protecting the Community has always been at the center of the Oregon Board of Dentistry Mission. Fairness and equity are imbedded in the OBD Values. The OBD believes it can do more to address the systemic inequities that have existed and ensure more fully that our mission and values apply to everyone.

Goals

⇒ Communicate and market to reach the diverse communities within Oregon

⇒ Increase ease of access to OBD services

⇒ Ensure equity exists in Investigation outcomes

⇒ Increase OBD Licensee, patient, and community understanding of OBD roles, responsibilities, and services

Action Items

- Align Diversity, Equity, and Inclusion plans to guidance provided by the State of Oregon Racial Justice Council
- Include diversity analysis when developing Marketing or Communications materials; consider diversity in visual representations
- Enable OBD to take complaints in complainant's first language
- Create analysis of prior investigations, findings, and actions across Licensee demographics to frame equity-related data

STRATEGIC PRIORITY D

Workplace Environment

The COVID-19 pandemic, technology advances, talent supply/demand issues as well as numerous factors affecting employee expectations of the work environment are driving the need for changes to work environments worldwide. OBD has previously been limited in ability to offer more flexible work location options due to technological limitations. Those limitations are easing, allowing for secure and effective ways to access needed information while employees work from home or other remote locations. Offering this flexibility will likely increase employee satisfaction while at the same time enabling increased efficiency.

In addition to flexible work arrangements, employees also desire clear expectations and recognition for their work as well as fair and equitable processes for advancing their careers. OBD investments in these areas should result in increased employee retention.

Board succession planning is also critical. Several Board members have terms ending in this next plan horizon. The strategic resource plans extend to the Board as well as employees.

Goals

⟹ Establish succession plan for Board members, continuing to represent many viewpoints and experiences in Board composition

⟹ Increase workplace flexibility through a hybrid workplace guideline

⟹ Increase workplace satisfaction and career development conversations

Action Items

- Define and implement hybrid workplace guidelines
- Evaluate overall workload and staff workload balance, consider adjustments for upcoming fiscal cycles
- Develop succession plans for Board positions coming open and establish effective process for ongoing timely replacement

STRATEGIC PRIORITY E

Technology & Processes

All organizations are affected by technology developments, and Oregon Board of Dentistry and the dental profession is no exception. The OBD has the strategic opportunity to implement processes and tools that will improve efficiency, employee and Board member experience as well as improve the effectiveness of processes for dental professional engaged with OBD. In addition, growing advances in data collection and analysis will enable the ability to continue to ensure fair and equitable outcomes for applicants and Licensees.

Goals

⇒ Improve efficiency and resource utilization through online record keeping

⇒ Increase ability to complete analytics related to licensees and investigations

⇒ Improve investigation case management with archived files

Action Items

- Complete digitization and modernization process for Board Books
- Complete implementation of InLumon system
- Build working digital database of Licensee records
- Create digital archive of investigation files
- Pilot data analysis capabilities

Oregon Board of Dentistry Strategic Plan 2022-2025

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

MISSION-CRITICAL PRIORITIES				
A. Licensure Evolution	B. Dental Practice Accountability	C. Community Interaction & Equity	D. Workplace Environment	E. Technology and Processes
GOALS				
• Develop and implement rules based on legislation changes	• Ensure licensees dictate clinical care provided to patients (in contrast to corporate non-licensees driving care decisions)	• Communicate and market to reach the all communities within Oregon	• Establish succession plan for Board members, continuing to represent many viewpoints and experiences in Board composition	• Improve efficiency and resource utilization through on-line records keeping
• Successfully implement Dental Therapy license	• Increase OBD visibility into practice ownership models	• Increase ease of access to OBD services	• Increase workplace flexibility through a hybrid workplace guideline	• Increase ability to complete analytics related to licensees and investigations
	• OBD jurisdiction over Dental practices in Oregon, regardless of ownership and business operating model	• Ensure equity exists in investigation outcomes	• Increase workplace satisfaction and career development conversations	• Improve investigation case management with archived files
	• Correlate patient care to level of competency required by practitioners (DT, DMD, DDS, DH); hold entities accountable to the level of licenses within their practice	• Increase OBD licensee, patient, and community understanding of OBD roles, responsibilities, and services		
ACTION ITEMS				
• Develop and implement rules in support of HB 2528 (2021) for newly created Dental Therapist license	• Implement changes to Licensee Renewal form to capture multiple office/group affiliation	• Align Diversity, Equity, and Inclusion plans to guidance provided by the State of Oregon Racial Justice Council	• Develop succession plans for Board positions coming open and establish effective process for ongoing timely replacement	• Complete digitization and modernization process for Board Books
• Develop and implement communication strategies with communities impacted by Dental Therapy license implementation	• Gather dental practice ownership and training information	• Enable OBD to take complaints in complaintant's first language	• Define and implement hybrid workplace guidelines	• Complete implementation of InLumon system
• Engage interested parties to learn more and gather feedback about implementing Dental Therapy Practice in Oregon	• Receive OHSU updated curriculum and include in Board Book	• Include diversity analysis when developing Marketing or Communications materials; consider diversity in visual representations	• Evaluate overall workload and staff workload balance, consider adjustment for upcoming fiscal cycles	• Build working digital database of Licensee records
	• Analyze complaints by ownership types	• Create analysis of prior investigations, findings, and actions across licensee demographics to frame equity-related data		• Pilot data analysis capabilities
	• Evaluate options for strengthening statute related to accountability, ownership, and standards of care	• Additional prioritized actions taken from recomendations and resources proivided by State Racial Justice Council		• Create digital archive of investigation files
	• Potential for proposed legislative changes			

Oregon Board of Dentistry 2022-2025 Strategic Plan

Roadmap and Goals

Strategic Priorities	2022-2023	2023 - 2024	2024-2025	Goals
Licensure Evolution	• Develop and implement rules in support of HB 2528 (2021) for newly created Dental Therapist license	• Engage interested parties to learn more and gather feedback about implementing Dental Therapy Practice in Oregon		• Develop and implement rules based on legislation changes
	• Develop and implement communication strategies with communities impacted by Dental Therapy license implementation			• Successfully implement Dental Therapy license
Dental Practice Accountability	• Implement changes to Licensee Renewal form to capture multiple office/group affiliation • Gather dental practice ownership and training information • Receive OHSU updated curriculum and include in Board Book	• Analyze complaints by ownership types • Evaluate options for strengthening statute related to accountability, ownership, and standards of care	• Potential for proposed legislative changes	• Ensure licensees dictate clinical care provided to patients (in contrast to corporate non-licensees driving care decisions) • Increase OBD visibility into practice ownership models • OBD jurisdiction over Dental practices in Oregon, regardless of ownership and business operating model • Correlate patient care to level of competency required by practitioners (DT, DMD, DDS, DH); hold entities accountable to the level of licenses within their practice
Community Interaction and Equity	• Align Diversity, Equity, and Inclusion plans to guidance provided by the State of Oregon Racial Justice Council	• Include diversity analysis when developing Marketing or Communications materials; consider diversity in visual representations	• Additional prioritized actions taken from recomendations and resources proivided by State Racial Justice Council	• Communicate and market to reach the all communities within Oregon
	• Enable OBD to take complaints in complaintant's first language	• Create analysis of prior investigations, findings, and actions across licensee demographics to frame equity-related data		• Increase ease of access to OBD services
				• Ensure equity exists in investigation outcomes
				• Increase OBD licensee, patient, and community understanding of OBD roles, responsibilities, and services
Workplace Environment	• Develop succession plans for Board positions coming open and establish effective process for ongoing timely replacement • Develop and implement hybrid workplace guidelines	• Evaluate overall workload and staff workload balance, consider adjustment for upcoming fiscal cycles		• Establish succession plan for Board members, continuing to represent many viewpoints and experiences in Board composition • Increase workplace flexibility through a hybrid workplace guideline • Increase workplace satisfaction and career development conversations
Technology and Processes	• Complete digitization and modernization process for Board Books	• Build working digital database of Licensee records	• Create digital archive of investigation files	• Improve efficiency and resource utilization through on-line records keeping
	• Complete implementation of InLumon system	• Pilot data analysis capabilities		• Increase ability to complete analytics related to licensees and investigations
				• Improve investigation case management with archived files

UNFINISHED BUSINESS & RULES

OREGON BOARD OF DENTISTRY
PUBLIC RULEMAKING HEARINGS
April 22, 2022 from 9 am – 10 am
May 18, 2022 from 12 pm – 12:30 pm
(Both Hearings will end early if no one is signed up or indicate they have public testimony to give)
Written public comment is welcome & open from April 1, 2022 – June 3, 2022 and may be submitted to information@obd.oregon.gov
1500 SW 1st Ave., Suite 770 Portland OR 97201

818-001-0002	**Definitions**
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818-042-0114	**Additional Functions of EFPDAs**
Collaborative Agreement	**Feedback also sought on the Draft - Collaborative Agreement**

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;
(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 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 didactic and 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.

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 didactic and 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.

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.

818-038-0005
Dental Therapy Education Program
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.

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 or exempt from licensure pursuant to ORS 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.

OFFICE OF THE SECRETARY OF STATE
SHEMIA FAGAN
SECRETARY OF STATE

CHERYL MYERS
DEPUTY SECRETARY OF STATE

ARCHIVES DIVISION
STEPHANIE CLARK
DIRECTOR

800 SUMMER STREET NE
SALEM, OR 97310
503-373-0701

NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 818
OREGON BOARD OF DENTISTRY

FILED
03/31/2022 2:59 PM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: The OBD is proposing 10 new rules and amending 19 others for Dental Therapy.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 06/03/2022 4:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

CONTACT: Stephen Prisby
971-673-3200
stephen.prisby@state.or.us

1500 SW 1st Ave
Suite 770
Portland,OR 97201

Filed By:
Stephen Prisby
Rules Coordinator

HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 04/22/2022
TIME: 9:00 AM - 10:00 AM
OFFICER: OBD President
ADDRESS: Oregon Board of Dentistry
1500 SW 1st Ave.
Suite 770
Portland, OR 97201-5837
SPECIAL INSTRUCTIONS:
In person & Teleconference Option Call 971-673-3200 for details closer to meeting date.

DATE: 05/18/2022
TIME: 12:00 PM - 12:30 PM
OFFICER: Stephen Prisby
ADDRESS: Oregon Board of Dentistry
1500 SW 1st Ave.
Suite 770
Portland, OR 97201-5837
SPECIAL INSTRUCTIONS:
Only Teleconference Call 971-673-3200 for details closer to meeting date.

NEED FOR THE RULE(S)

Due to the passage of HB 2528 (2021) the OBD must create rules for dental therapy and issue dental therapist licenses.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

HB 2528(2021) and current Dental Practice Act (DPA)

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

The OBD utilized a dedicated new committee to address rulemaking issues that included participants from the dental therapy community as directed by HB 2528.

FISCAL AND ECONOMIC IMPACT:

There is no or limited material financially impact identified.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

There is no way to identify impact as this is a new Licensee and there will only be a limited number of licenses issued in 2022.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

The OBD's Committees are comprised of small business owners and professional association representatives.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

818-001-0002, 818-001-0082, 818-001-0087, 818-012-0020, 818-012-0030, 818-021-0026, 818-021-0052, 818-021-0054, 818-021-0076, 818-021-0080, 818-021-0085, 818-021-0088, 818-021-0090, 818-021-0095, 818-021-0110, 818-026-0055, 818-038-0001, 818-038-0005, 818-038-0010, 818-038-0020, 818-038-0025, 818-038-0030, 818-038-0035, 818-042-0010, 818-042-0020, 818-042-0050, 818-042-0060, 818-042-0090, 818-042-0114

AMEND: 818-001-0002

RULE SUMMARY: Dental therapy and dental therapist references are being added to the rule.

CHANGES TO RULE:

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.¶
(~~6~~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.¶
(~~7~~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.¶
(~~8~~)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.¶
(~~9~~11) "Licensee" means a dentist ~~or,~~ hygienist or dental therapist.¶
(1~~0~~2) "Volunteer Licensee" is a dentist, hygienist or dental ~~hygien~~therapist licensed according to rule to provide dental health care without receiving or expecting to receive compensation.¶
(1~~1~~3) "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.¶
(1~~2~~)4) "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.¶
(13~~3~~5) "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 ~~or,~~ dental hygiene or dental therapy.¶
(14~~)~~6) 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).¶
(15~~7~~7) "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.¶
(16~~8~~8) "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.¶
(17~~9~~9) "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.¶
(~~18~~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.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.010, 680.010

AMEND: 818-001-0082

RULE SUMMARY: Dental therapist reference is being added to the rule

CHANGES TO RULE:

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.
Statutory/Other Authority: ORS 183, 192, 670, 679
Statutes/Other Implemented: ORS 192.420, 192.430, 192.440

AMEND: 818-001-0087

RULE SUMMARY: Dental therapist fees are being added to the rule.

CHANGES TO RULE:

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 and, Dental Hygiene and¶
Dental Therapy - $790.¶
(d) Examinations:¶
(Ae) Jurisprudence - $0;¶
(ef) 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.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 293.445, 679.060, 679.115, 679.120, 679.250, 680.050, 680.075, 680.200, 680.205, 679.615

AMEND: 818-012-0020

RULE SUMMARY: Dental therapy reference is being added to the rule.

CHANGES TO RULE:

818-012-0020
Additional Methods of Discipline for Unacceptable Patient Care ¶

~~[Reserved]~~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.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.140(5)(h), 680.100

AMEND: 818-012-0030

RULE SUMMARY: Dental therapy reference is being added to the rule.

CHANGES TO RULE:

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 ~~or,~~ dental hygiene~~.~~ or dental therapy. ¶
(16) Practice dentistry ~~or,~~ 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 ~~or,~~ 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 D~~EA registration. ¶~~
~~[Publications: Publications referenced are available from the agency.]~~rug Enforcement Administration (DEA) registration
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.140(1)(c), 679.140(2), 679.170(6), 680.100

AMEND: 818-021-0026

RULE SUMMARY: Dental therapy reference is being added to the rule.

CHANGES TO RULE:

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).
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 181, 183, 670.280, 679.060, 679.115, 679.140, 679.160, 680.050, 680.082, 680.100

ADOPT: 818-021-0052

RULE SUMMARY: A new dental therapy license rule is being added to the DPA.

CHANGES TO RULE:

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 didactic and 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.
Statutory/Other Authority: ORS 679, ORS 679.603, ORS 679.609
Statutes/Other Implemented: ORS 679.603, ORS 679.609

ADOPT: 818-021-0054

RULE SUMMARY: A new dental therapy licensure rule is being added to the DPA.

CHANGES TO RULE:

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 didactic and 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.
Statutory/Other Authority: ORS 679, ORS 679.603, ORS 679.609
Statutes/Other Implemented: ORS 679.603, ORS 679.609

ADOPT: 818-021-0076

RULE SUMMARY: A new dental therapist continuing education rule is being added to the DPA.

CHANGES TO RULE:

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.
Statutory/Other Authority: ORS 679, ORS 679.603, ORS 679.609
Statutes/Other Implemented: ORS 679.603, ORS 679.609

AMEND: 818-021-0080

RULE SUMMARY: Dental therapy reference is being added to the rule.

CHANGES TO RULE:

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.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.090, 679.120, 680.072, 680.075

AMEND: 818-021-0085

RULE SUMMARY: Dental therapy reference is being added to the rule.

CHANGES TO RULE:

818-021-0085
Renewal or Reinstatement of Expired License ¶

Any person whose license to practice as a dentist ~~or,~~ 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 ~~dentist or dental hygienist~~Licensee fails to renew or reinstate ~~his or he~~their license within four years from expiration, the ~~dentist or dental hygienist~~Licensee must apply for licensure under the current statute and rules of the Board.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.090, 679.120, 680.072, 680.075

AMEND: 818-021-0088

RULE SUMMARY: Dental therapy reference is being added to the rule.

CHANGES TO RULE:

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.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 676.345, 679.010, 679.020, 679.025, 679.090, 680.010, 680.020, 680.050, 680.072

AMEND: 818-021-0090

RULE SUMMARY: Dental therapy reference is being added to the rule.

CHANGES TO RULE:

818-021-0090
Retirement of License ¶

(1) A ~~dentist or dental hygienist~~Licensee who no longer practices in any jurisdiction may retire their ~~or his~~ 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 ~~dentist or dental hygienist~~Licensee fails to reinstate their ~~or his~~ license within four years from retiring the license, the ~~dentist or dental hygienist~~Licensee must apply for licensure under the current statute and rules of the Board.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.090, 679.120, 680.072, 680.075

AMEND: 818-021-0095

RULE SUMMARY: Dental therapy reference is being added to the rule.

CHANGES TO RULE:

818-021-0095
Resignation of License ¶

(1) The Board may allow a dentist ~~or,~~ dental hygienist or dental therapist who no longer practices in Oregon to resign their ~~or his~~ license, unless the Board determines the license should be revoked.¶
(2) Licenses that are resigned under this rule may not be reinstated.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.090, 679.120, 680.072, 680.075

AMEND: 818-021-0110

RULE SUMMARY: Dental therapy reference is being added to the rule.

CHANGES TO RULE:

818-021-0110
Reinstatement Following Revocation ¶

~~[Reserved]~~(1) Any person whose license has been revoked for a reason other than failure to pay the 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.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.140, ORS 679.600

AMEND: 818-026-0055

RULE SUMMARY: Dental Therapy reference is being added to the rule.

CHANGES TO RULE:

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
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.250(7), 679.250(10), ORS 679.600

ADOPT: 818-038-0001

RULE SUMMARY: A new rule referencing dental therapy is being added to the DPA.

CHANGES TO RULE:

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.
Statutory/Other Authority: ORS 679, ORS 679.600
Statutes/Other Implemented: ORS 679.600, ORS 679.603, ORS 679.618, ORS 679.621

ADOPT: 818-038-0005

RULE SUMMARY: A new dental therapy education program definition rule is being added to the DPA.

CHANGES TO RULE:

818-038-0005
Dental Therapy Education Program
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.
Statutory/Other Authority: ORS 679, ORS 679.600
Statutes/Other Implemented: ORS 679.621, ORS 679.600, ORS 679.603

ADOPT: 818-038-0010

RULE SUMMARY: A new rule referencing dental therapy is being added to the DPA.

CHANGES TO RULE:

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.
Statutory/Other Authority: ORS 679, ORS 679.621
Statutes/Other Implemented: ORS 679.621, ORS 679.600

ADOPT: 818-038-0020

RULE SUMMARY: A new rule referencing dental therapy is being added to the DPA.

CHANGES TO RULE:

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.
Statutory/Other Authority: ORS 679, ORS 679.600
Statutes/Other Implemented: ORS 679.600, ORS 679.603, ORS 679.618

ADOPT: 818-038-0025

RULE SUMMARY: A new dental therapy rule is being added to the DPA.

CHANGES TO RULE:

818-038-0025
Prohibited Acts
A dental therapist may not:¶
(1) Place or Restore Dental Implants or any other soft tissue surgery except as described in 818-038-0020 ¶
(2) Prescribe any drugs, unless permitted by ORS 679.010¶
(3) Use the behavior management techniques of Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.¶
(4) Perform any dental therapy procedure unless it is documented in the collaborative agreement and rendered under appropriate Oregon Licensed Dentist supervision.¶
(5) Operate a hard or soft tissue Laser.¶
(6) Treat a patient under moderate, deep or general anesthesia. ¶
(7)) Order a computerized tomography scan
Statutory/Other Authority: ORS 679, ORS 679.603, ORS 679.010
Statutes/Other Implemented: ORS 679.603, ORS 679.010

ADOPT: 818-038-0030

RULE SUMMARY: A new rule referencing dental therapy is being added to the DPA.

CHANGES TO RULE:

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. ¶
(4) 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.
Statutory/Other Authority: ORS 679, ORS 679.618
Statutes/Other Implemented: ORS 679.618, ORS 679.621

ADOPT: 818-038-0035

RULE SUMMARY: A new dental therapy rule is being added to the DPA.

CHANGES TO RULE:

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.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.618, ORS 679.624

AMEND: 818-042-0010

RULE SUMMARY: Dental therapy reference is being added to the rule.

CHANGES TO RULE:

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 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.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.025(2)(j), 679.250(7), ORS 679.600

AMEND: 818-042-0020

RULE SUMMARY: Dental therapy reference and clarification changes made to the rule.

CHANGES TO RULE:

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. ¶
(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.¶
(45) Dental assistants who are in compliance with written training and screening protocols adopted by the Board may perform oral health screenings under general supervision.
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.025(2)(j), 679.250(7), ORS 679.600

AMEND: 818-042-0050

RULE SUMMARY: Dental therapy reference being added to the rule.

CHANGES TO RULE:

818-042-0050
Taking of X-Rays - Exposing of 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
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.025(2)(j), 679.250(7), ORS 679.603

AMEND: 818-042-0060

RULE SUMMARY: Dental therapy reference being added to the rule.

CHANGES TO RULE:

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.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.020, 679.025, 679.250, ORS 679.600

AMEND: 818-042-0090

RULE SUMMARY: Dental therapy reference is being added to the rule.

CHANGES TO RULE:

818-042-0090
Additional Functions of EFDAs ¶

Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Dental Assistant may perform the following functions under the indirect supervision of a dentist, 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 cord retraction material subgingivally.~~
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.025(2)(j), 679.250(7), ORS 679.600

AMEND: 818-042-0114

RULE SUMMARY: Dental therapy reference is being added to the rule.

CHANGES TO RULE:

818-042-0114
Additional Functions of Expanded Function Preventive Dental Assistants (EFPDA)
(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.
Statutory/Other Authority: ORS 676
Statutes/Other Implemented: ORS 676, ORS 679.600

OBD - Feedback for DT Testing Agencies

PRISBY Stephen * OBD <Stephen.PRISBY@obd.oregon.gov>
Mon 4/4/2022 4:16 PM
To: Richael Cobler <richael@crdts.org>;Kimber Cobb <kcobb@cdcawreb.org>

Happy Monday!

I am sharing this now, and will send over any additional feedback from our Board Members so you can prepare accordingly. I realize your exam may not be able to address all the concerns referenced. We welcome you at our April 22 Board Meeting and any material you want in the public meeting packet needs to be emailed to me no later than Monday, April 11.

Following are some areas that need addressing on the DT exam.
Mechanism of action of fluoride varnish
Diagnosing presents of caries prior to placement of PFS
Area of coverage for athletic mouth guards
Tooth reimplantation

- **a. Permanent tooth bud damage by reimplantation of primary teeth**
- **b. Clots in the socket of avulsed permanent teeth**

Local anesthetic

- **a. needle choice for mandibular blocks**

Patient/Case selection:
Post Covid Patients - Even pre-pandemic trips to the dentist or dental hygienist were not a twice a year occurrence for most Oregonians. In the not too distant future underserved populations will begin visiting dental therapists in Oregon. Have they been prepared adequately to assess patients with challenging health conditions? Add in the legal and illegal drugs being ingested by many and this may create a patient with unknown conditions being treated by our dental therapists who have limited education and training. Have the DPPs been adequately training the dental therapists on this topic?

- **a. Nitrous Oxide**
  1. **Risk factors with obese patients**
  2. **Risk factors of polypharm patients**
  3. **RIsk factors with those who have high blood pressure**
- **b. Extractions**
  1. **Primary second molars**
  2. **Root fractures of periodontally involved permanent teeth**
  3. **Medical history**
- **c. Brush biopsies**

A potential threat to public safety presented by the DT is that they don't know what they don't know. Just because it is in their scope of practice, does not mean they should do it. Will their collaborating dentist know enough too, as they sign off on the collaborative agreement?

Thank you,
Stephen

Stephen Prisby
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"The Mission of the OBD is to promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals."

CDCA WREB

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April 11, 2022

Mr. Stephen Prisby
Executive Director
Oregon Board of Dentistry

Hi Stephen,

Thank you for sharing questions and concerns from the last Board meeting and for allowing us the opportunity to respond.

The CDCA-WREB Dental Therapy Licensure Exam was developed in response to a request from the Minnesota Board of Dentistry and was designed to be a universal exam that could be utilized in any state initiating Dental Therapy licensure. With this in mind, the examination was developed to be consistent with the curriculum defined by the "CODA Accreditation Standards for a Dental Therapy Education Program" and the state's defined scope of practice. Recognizing that each state has minor differences in its scope of practice, these examinations evaluate the skills and knowledge necessary to demonstrate the competency of an entry-level candidate to practice as a dental therapist.

Please note that for all sections of the CDCA-WREB Dental Therapy Examination, the DT candidates are held to the same standards and examination protocols as the dental candidates taking the ADEX Dental Examination. Further, the Restorative Examination is given in concert with the Dental Restorative Examination, assuring the anonymity of dental therapy students within the cohort being evaluated. The CDCA-WREB Dental Therapy Examination currently administered has been updated based on an Occupational Analysis conducted by the Minnesota Board of Dentistry. These Occupational Analyses are based on the predominant procedures and standards of care that are applied by active practitioners within the current practice of Dental Therapy.

The general skill set areas for the specific functions referenced in your recent communication are addressed by the OSCE portion of the examination. The blueprint for the Dental Therapy OSCE is attached for your review.

While no singular examination can evaluate all aspects of practice, as evidenced by currently accepted dental and dental hygiene exams, the CDCA-WREB Dental Therapy Licensure Examination does evaluate competency in those key skill sets identified by the Occupational Analysis, essential for an entry-level dental therapy provider.

Please don't hesitate to reach out with any questions or requests for additional information. We thank you again for this opportunity to support you and the Board.

Best,

Kimber Cobb
Director, Dental Hygiene Examinations
National Director, Licensure Acceptance and Portability
443.270.4626|kcobb@cdcawreb.org

Enclosures

DENTAL THERAPY OSCE BLUEPRINT

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 exam, 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 and Administration of agents	
Concepts and Management of Pain and Anxiety	
Pre and Post-Op Management of the Patient	
Pharmacology of agents	
Prevention, recognition and management of complications	

8. Infection Control	3%
Understand and apply the CDC recommendations and OSHA standards relevant to 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	

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.

Hello Stephen. Please see attached for CRDTS responses to the questions posed by the board relating to the DT exams. Also attached is a paper from our psychometrician, Brett Foley, Ph.D. with Alpine Testing Solutions, that summarizes the strengths, limitations, and reasons that CRDTS should and does continue to offer both patient-based and simulated-patient examinations, for the board's reference.

If there are any follow-up questions prior to the April 22 meeting, please let us know.

Thank you.

Richael "Sheli" Cobler
Executive Director
Central Regional Dental Testing Service, Inc.
1725 SW Gage Blvd. | Topeka, KS | 66604
785.273.0380 | richael@crdts.org
www.crdts.org

Dear Mr. Prisby and Oregon Board of Dentistry members,

Thank you for sharing the concerns of the board relative to the dental therapy license rules and their addition to the Oregon Dental Practice Act. We appreciate the concerns that you have regarding patient safety and protection of the public and are here to assist you via implementation of exam components that either currently exist and are ready for use, or by creating elements specific to your concerns that could be ready for use soon.

The following concern areas are either current content or could be created in a written OSCE-like exam part:

1) Mechanism of action of fluoride varnish
2) Diagnosing of caries prior to placement of sealants
3) Area of coverage for athletic mouth guards
4) Tooth reimplantation
5) Local anesthesia (Currently covered in CRDTS Dental Hygiene written and clinical examination)
6) Health history and treatment of patients with complex medical histories
7) Nitrous Oxide
8) Extractions
9) Brush biopsies

While there are many solutions to the concerns the board has presented, such as specifically requiring educational course content to include subject matter that concerns the board or modifying the level of supervision necessary for the concern areas, CRDTS is here to assist you with the licensure by examination side, by tailoring the clinical procedures included to fit the requirements of the Oregon Board of Dentistry, as we have done in other states.

We look forward to being present again at the April 22 Meeting!

Sincerely,

Mark Edwards D.D.S.
Director of Dental Examinations
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Comparing the CRDTS Patient-Based and Simulated Patient Periodontal and Restorative Examinations for Licensure

Brett P. Foley, Ph.D.
Psychometric Service & Industry Practice Lead
Alpine Testing Solutions
3/31/2022

Performance exams are important supplements to written/multiple choice (MC) exams in that they allow assessment of certain skills that are difficult to measure in other ways. Actions performed for performance exams often are more closely related to what candidates do on the job than can be re-created with MC questions. Therefore, there is a more clear-cut, logical argument for the job-relatedness of the exam.

As useful as they are, performance exams can have limitations when used with large groups of candidates for high-stakes decisions. One challenge all assessment programs must grapple with when designing performance exams is the balance between authenticity and standardization. An exam becomes more authentic the closer it becomes to what happens on the job. An exam is more standardized when it is consistent and content and difficulty across all candidates. Both features are desirable. However, in practice, increasing one tends to decrease the other. Therefore, it is up to policymakers to select an assessment strategy that strikes an appropriate balance to serve the needs of their jurisdictions.

This brief document summarizes the reasons for CRDTS to continue offering both **Patient-Based (PB)** and **Simulated Patient (SIM)** periodontal and restorative examinations for licensure. It examines the relative strengths and limitations of each with respect to authenticity and standardization and discusses that comparability of the resulting pass/fail decisions from both exam modes from a psychometric perspective.

Relative Strengths and Limitations of Modes

Each mode has different strengths and limitations, as summarized in the table below. On the spectrum of authenticity/standardization, PB exams place more emphasis on authenticity while SIM exams place more emphasis on standardization. One is not inherently better than the other. Instead, it relies on the judgement of policymakers to determine which version better serves the needs of their candidates and other stakeholders (e.g., the public). By offering both versions of the exams, CRDTS offers policymakers flexibility when it comes to making these decisions.

Patient-Based Examination	**Simulated Patient Examination**
Strengths • Very authentic – Real patients, teeth, treatment needs • More closely resembles actual practice *Limitations* • Need to submit the patient for treatment selection • Candidate could lose points if the patient does not qualify (e.g., insufficient surfaces of calculus) • Patient management variables (e.g., veneered, difficult to remove calculus) • Candidate ability to pre-screen/ examine patient (potentially with assistance) • Potential timing constraints (e.g., in practice, a difficult patient would require additional treatment time, which may not be available in the examination) • Can lack authenticity if patient substantially deviates from “typical patient”	*Strengths* • Case is standardized and ready for treatment • Minimized variability in experience for candidates • Potential for testing for additional skills • No risk of patient harm *Limitations* • Less authentic – simulated patent does not necessarily reflect live patients with respect to physiology/psychology • May become a rote task or remove elements of professional judgement if there is no variability in simulations.

Comparability of Modes

There are multiple ways exam comparability can be assessed. Three important factors to consider are (1) comparability of content, (2) comparability of scoring, and (3) comparability of outcomes. Each of these areas are described in more detail below

Comparability of Content

One criterion for establishing the comparability of exams is verifying that they assess the same content. The table below shows that the PB and SIM examinations closely mirror each other in content for both the periodontal and restorative examinations.

Patient-Based Examination	**Simulated Patient Examination**
Periodontal 1. Periodontal measurements 2. Supra-gingival scaling and polish 3. Extra-Intra Oral Examination 4. Scaling and root planning 5. Tissue management (Penalty points) *Restorative* 1. One Class II preparation and restoration of the same tooth 2. One Class III preparation and restoration of the same tooth	*Periodontal* 1. Periodontal measurements 2. Calculus detection 3. Extra-Intra Oral Examination 4. Scaling and root planning 5. Tissue management (Penalty points) *Restorative* 1. One Class II preparation of a posterior tooth 2. One Class III preparation of an anterior tooth 3. One Class II restoration of a posterior tooth 4. One Class III restoration of an anterior tooth

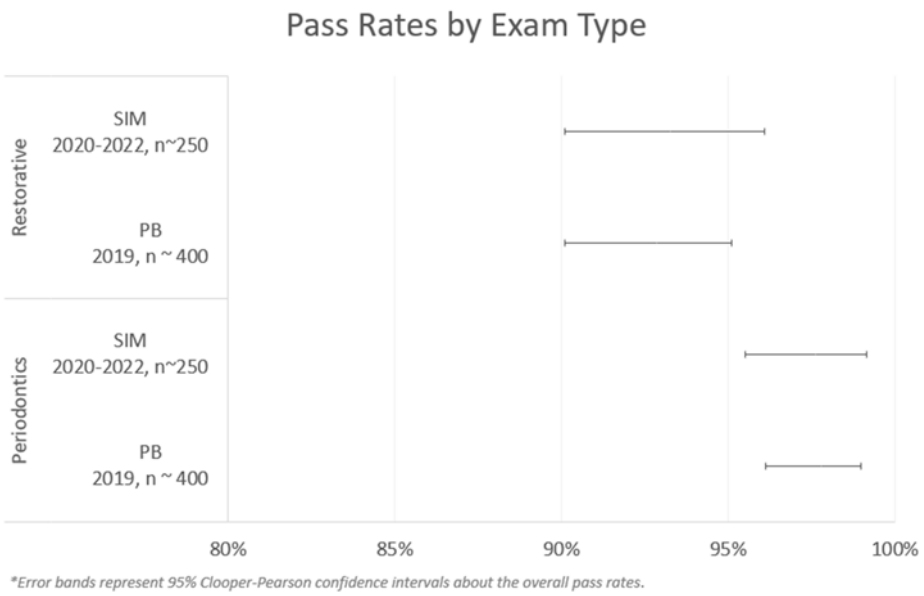
Comparability of Scoring

The PD and SIM examinations mirror each other in criteria and scoring. That is, individual scoring elements in the content areas listed above are substantially similar[1]. Additionally, examiners receive the same level of training, and the same scoring rubrics and rules are applied to candidates. Candidates are evaluated by multiple examiners for both types of exams. CRDTS regularly monitors examiners for consistency and provides similar formative feedback to examiners across both assessment types to ensure continuous improvement and scoring accuracy.

[1] One minor exception being that CRDTS does not give a deficient score for occlusion on the posterior Class II finished restoration on the simulated patient exam.

Comparability of Outcomes

Because different jurisdictions may require different types of examinations, and in some cases candidates can self-select their exam type (PD or SIM), comparisons of exam results based on patient type are confounded with potential differences in cohort ability. In other words, candidates are not randomly assigned to PD/SIM exams, so we do not expect identical pass rates across types. However, it would be reasonable to expect that the pass rates be substantially similar when looking across longer time frames. This the case for the CRDTS examinations and can be seen in the graphic below:



Conclusions

PB and SIM examinations are both widely accepted methods for conducting performance exams. The choice between the two often comes down to policy preferences with respect to the relative importance given to authenticity and standardization. CRDTS produces both types of exams to give policymakers the flexibility to select the most appropriate option to fit their needs. The similarity with respect to content, scoring, and outcomes shown here should give policymakers additional confidence that the PB and SIM exam formats share many similarities and provide comparable results when assessing candidates.

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:

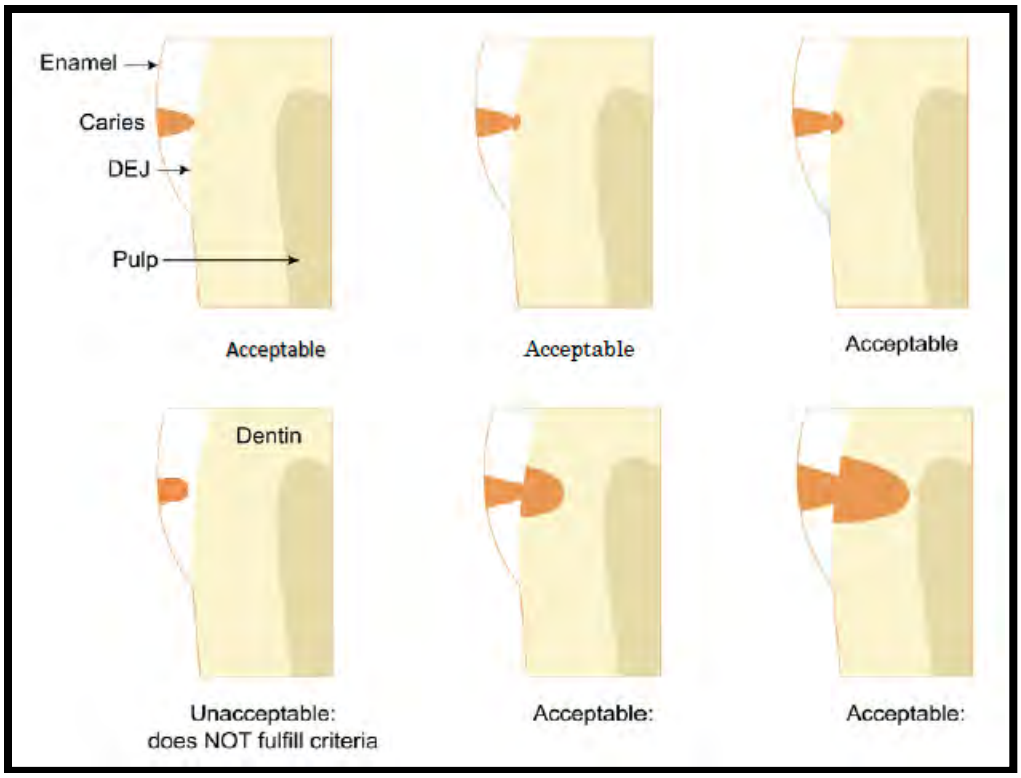
A. completed Medical History
B. mirror, sharp explorer, cotton pliers, periodontal probe
C. articulating paper and holder
D. tooth # and type of restoration circled on the Progress Form, outline existing restoration(s)
    1. A CFE will note the size of the lesion
E. radiographs (bitewing and periapical 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.

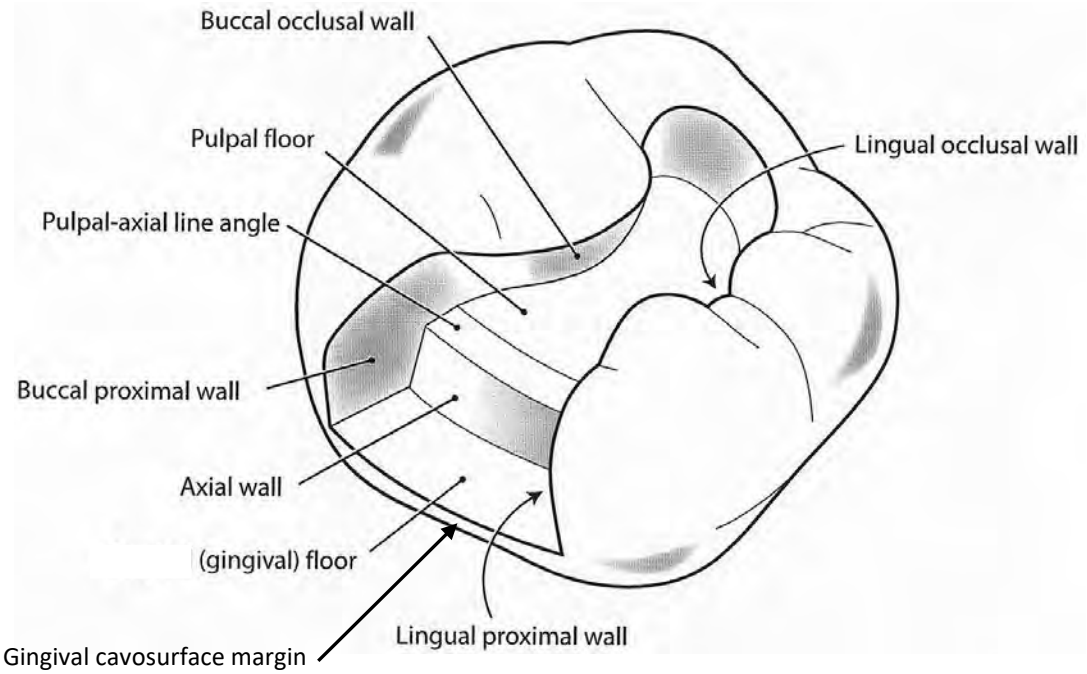
Instruct the assistant to notify the evaluation area that the patient is there for the Express Chair for a modification request and not for evaluation of the preparation. The examiners will record on the Modification Request Form whether the request is accepted or denied and forward notification to the 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.

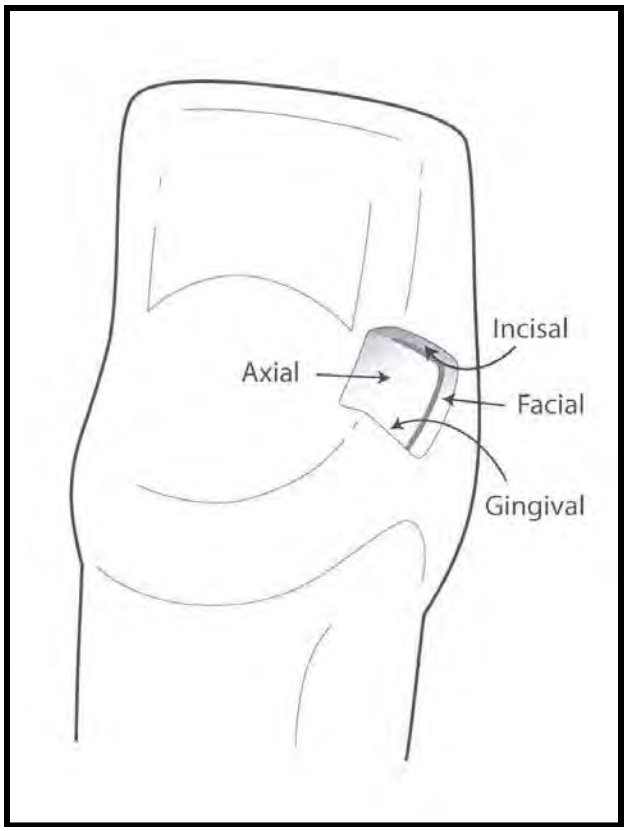
If more than one modification is anticipated at any time, it is to the candidate's advantage to submit them on the same form as no additional time is provided for evaluation of modification requests and multiple submissions may significantly decrease treatment time. Candidates will submit their copy 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:

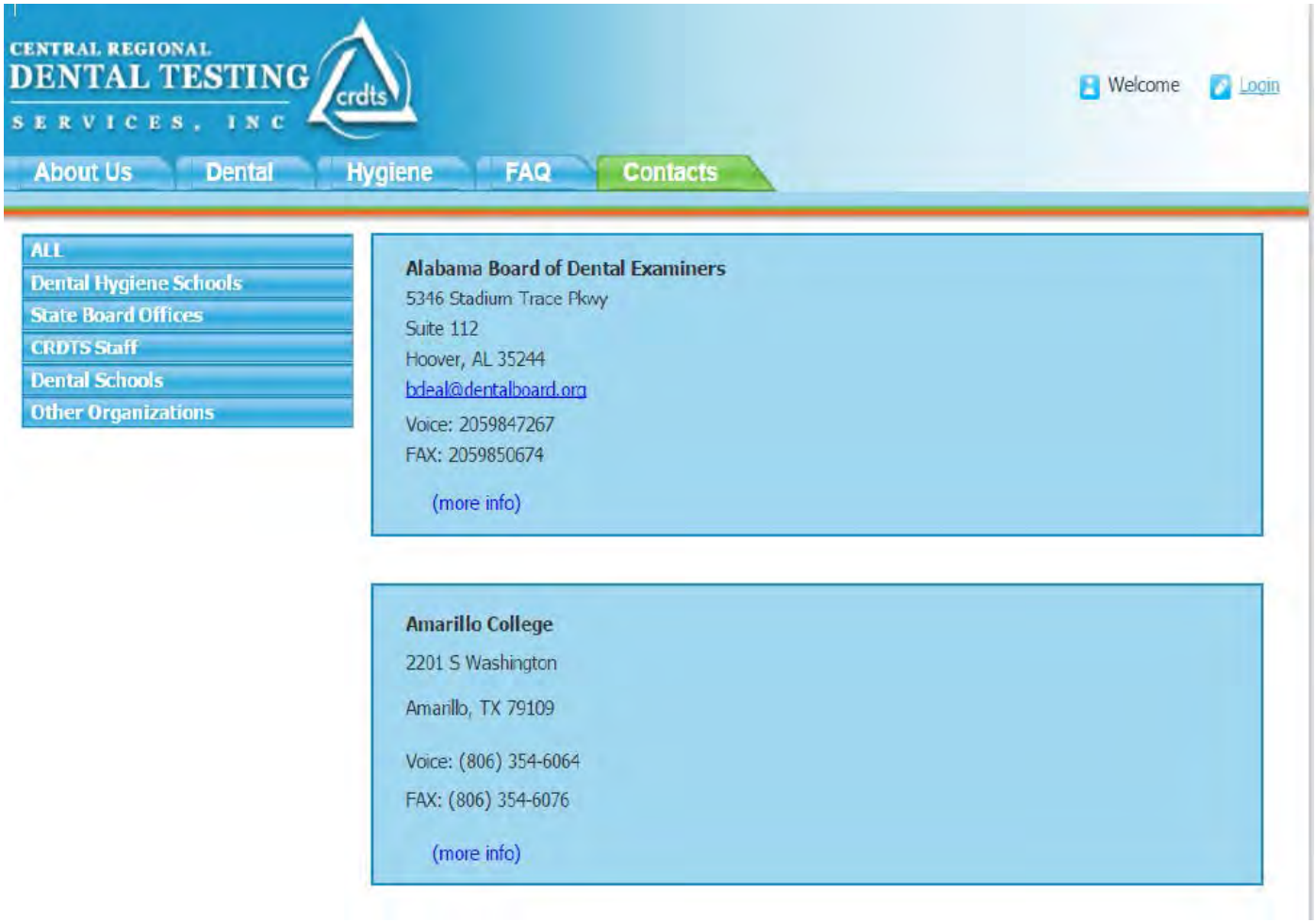
- Timing of request: Submit, in writing together with the application, a request and all documentation for the auxiliary aid or modification. Requests received after the application date or retroactive requests will not be considered.
- Documentation verifying disability: Provide documentation of the 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**

Enrolled
House Bill 2359

Sponsored by Representatives SALINAS, RUIZ, Senator FREDERICK; Representatives ALONSO LEON, BYNUM, CAMPOS, DEXTER, GRAYBER, LEIF, NOSSE, PHAM, REYNOLDS, SANCHEZ, SCHOUTEN, SOLLMAN, VALDERRAMA (Presession filed.)

CHAPTER .....

AN ACT

Relating to health care interpreters; creating new provisions; amending ORS 413.550, 413.552, 413.556, 413.558, 414.572, 656.027 and 657.046; repealing ORS 657.048; and declaring an emergency.

Whereas current law contains a loophole for health care providers and interpretation service companies to justify working with untrained health care interpreters despite the availability of health care interpreters who are qualified or certified by the Oregon Health Authority; and

Whereas current law does not hold accountable health care providers and interpretation service companies for failing to work with qualified or certified interpreters or for failing to work with best practices in providing health care interpretation services; and

Whereas there is currently no complaint process for health care interpreters who experience wage or other labor violations; and

Whereas there is a growing demand for health care interpreters in rural communities in this state, especially for interpreters capable of interpreting languages of limited diffusion in those areas; and

Whereas health care interpreters suffer from the inequitable business practices of interpretation service companies; and

Whereas due to the low payment rates and the rising cost of training and testing, current and potential health care interpreters are reluctant to invest in training, testing, qualification or certification because of the low return on their investment; and

Whereas there is a lack of uniformity statewide in the quality of health care interpretation services; and

Whereas there is a lack of a uniform training curriculum statewide; now, therefore,

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

SECTION 1. Section 2 of this 2021 Act is added to and made a part of ORS 413.550 to 413.558.

SECTION 2. (1) Except as provided in subsection (2) of this section, a health care provider shall work with a health care interpreter from the health care interpreter registry administered by the Oregon Health Authority under ORS 413.558 when communicating with a patient who prefers to communicate in a language other than English, unless the health care provider is a doctor or clinician who is proficient in the patient's preferred language.

(2) A health care provider who is otherwise required to work with a health care interpreter from the health care interpreter registry may work with a health care interpreter who is not listed on the health care interpreter registry only if the provider:

(a) Verifies, in the manner prescribed by rule by a board or agency described in section 3 of this 2021 Act, that the provider has taken appropriate steps needed to obtain a health care interpreter from the health care interpreter registry in accordance with rules adopted by the authority under ORS 413.558; or

(b) Has offered the patient the services of a health care interpreter from the health care interpreter registry and the patient declined the offer and chose a different interpreter.

(3) A health care provider shall give personal protective equipment, consistent with established national standards, to health care interpreters providing services on-site at no cost to the health care interpreter and may not suggest to the health care interpreter that the health care interpreter should procure the health care interpreter's own personal protective equipment as a condition of working with the health care provider.

(4) A health care provider shall maintain records of each patient encounter in which the provider worked with a health care interpreter from the health care interpreter registry. The records must include:

(a) The name of the health care interpreter;

(b) The health care interpreter's registry number; and

(c) The language interpreted.

(5) The boards and agencies described in section 3 of this 2021 Act shall adopt rules to carry out the provisions of this section, which may include additional exemptions under subsection (2) of this section.

SECTION 3. Section 2 of this 2021 Act may be enforced by any means permitted under law by:

(1) A health professional regulatory board with respect to a health care provider under the jurisdiction of the board.

(2) The Oregon Health Authority or the Department of Human Services with regard to health care providers or facilities regulated by the authority or the department and health care providers enrolled in the medical assistance program.

(3) The authority with regard to emergency medical services providers licensed under ORS 682.216 and clinical laboratories licensed under ORS 438.110.

SECTION 4. (1) An interpretation service company operating in this state:

(a) Except as provided in paragraph (b) of this subsection, may not arrange for a health care interpreter to provide interpretation services in health care settings if the health care interpreter is not listed on the health care interpreter registry described in ORS 413.558.

(b) May arrange for a health care interpreter who is not listed on the health care interpreter registry to provide interpretation services in health care settings only if:

(A) A health care provider represents to the interpretation service company that the health care provider:

(i) Has taken appropriate steps necessary to arrange for a health care interpreter from the health care interpreter registry in the manner prescribed by rule under section 2 of this 2021 Act; and

(ii) Was unable to arrange for a health care interpreter from the health care interpreter registry; and

(B) The interpretation service company does not employ a health care interpreter listed on the health care interpreter registry who is available to provide interpretation services to the health care provider.

(c) May not represent to a health care provider that a contracted or employed health care interpreter referred by the company is a certified health care interpreter unless the interpreter has met the requirements for certification under ORS 413.558 and has been issued a valid certification by the authority.

(d) May not require or suggest to a health care interpreter that the health care interpreter procure the health care interpreter's own personal protective equipment as a condition of receiving a referral.

(2) An interpretation service company shall maintain records of each encounter in which the company refers to a health care provider worked with a health care interpreter from the health care interpreter registry or a health care interpreter who is not on the registry. The records must include:

(a) The name of the health care interpreter; and

(b) The health care interpreter's registry number, if applicable.

SECTION 5. Section 6 of this 2021 Act is added to and made a part of ORS chapter 414.

SECTION 6. (1) As used in this section:

(a) "Certified health care interpreter" has the meaning given that term in ORS 413.550.

(b) "Qualified health care interpreter" has the meaning given that term in ORS 413.550.

(2) The Oregon Health Authority shall adopt rules to ensure that a coordinated care organization, in accordance with ORS 414.572 (2)(e), and any other health care provider that is reimbursed for the cost of health care by the state medical assistance program:

(a) Works with a certified health care interpreter or a qualified health care interpreter when interacting with a recipient of medical assistance, or a caregiver of a recipient of medical assistance, who has limited English proficiency or who communicates in signed language; and

(b) Is reimbursed for the cost of the certified health care interpreter or qualified health care interpreter.

SECTION 7. (1) As used in this section, "health care interpreter" has the meaning given that term in ORS 413.550.

(2) The Oregon Health Authority shall, in collaboration with the Oregon Council on Health Care Interpreters and health care interpreters, conduct a study:

(a) Of the best model for an online platform for patients and health care providers to contract with health care interpreters and on how to use state and federal funds to finance the platform, to be completed no later than July 1, 2022; and

(b) Regarding sight translation as it pertains to the definition of "health care interpreter" in ORS 413.550 and related best practices.

(3) No later than January 1, 2022, the authority shall report to the interim committees of the Legislative Assembly related to health the results of the studies described in subsection (2) of this section and recommendations for legislative changes, if necessary, to implement the findings of the studies.

SECTION 8. ORS 413.550 is amended to read:

413.550. As used in ORS 413.550 to 413.558:

(1) "Certified health care interpreter" means an individual who has been approved and certified by the Oregon Health Authority **under ORS 413.558.**

(2) "Coordinated care organization" has the meaning given that term in ORS 414.025.

[*(2)*] **(3)** "Health care" means medical, surgical**, oral** or hospital care or any other remedial care recognized by state law, including physical and behavioral health care.

[*(3)*] **(4)(a)** "Health care interpreter" means an individual who is readily able to:

[*(a)*] **(A) Communicate in English and** communicate with a person with limited English proficiency **or who communicates in signed language**;

[*(b)*] **(B)** Accurately interpret the oral statements of a person with limited English proficiency, or the statements of a person who communicates in [*sign*] **signed** language, into English;

(C) Accurately interpret oral statements in English to a person with limited English proficiency or who communicates in signed language;

[*(c)*] **(D)** Sight translate documents from a person with limited English proficiency; **and**

[*(d)*] **(E)** Interpret the oral statements of other persons into the language of the person with limited English proficiency or into [*sign*] **signed** language[*; and*]**.**

[*(e) Sight translate documents in English into the language of the person with limited English proficiency.*]

(b) "Health care interpreter" also includes an individual who can provide the services described in paragraph (a) of this subsection using relay or indirect interpretation.

(5) "Health care interpreter registry" means the registry described in ORS 413.558 that is administered by the authority.

(6) "Health care provider" means any of the following that are reimbursed with public funds, in whole or in part:

(a) An individual licensed or certified by the:

(A) State Board of Examiners for Speech-Language Pathology and Audiology;

(B) State Board of Chiropractic Examiners;

(C) State Board of Licensed Social Workers;

(D) Oregon Board of Licensed Professional Counselors and Therapists;

(E) Oregon Board of Dentistry;

(F) State Board of Massage Therapists;

(G) Oregon Board of Naturopathic Medicine;

(H) Oregon State Board of Nursing;

(I) Oregon Board of Optometry;

(J) State Board of Pharmacy;

(K) Oregon Medical Board;

(L) Occupational Therapy Licensing Board;

(M) Oregon Board of Physical Therapy;

(N) Oregon Board of Psychology;

(O) Board of Medical Imaging;

(P) State Board of Direct Entry Midwifery;

(Q) Respiratory Therapist and Polysomnographic Technologist Licensing Board;

(R) Board of Registered Polysomnographic Technologists;

(S) Board of Licensed Dietitians; and

(T) State Mortuary and Cemetery Board;

(b) An emergency medical services provider licensed by the Oregon Health Authority under ORS 682.216;

(c) A clinical laboratory licensed under ORS 438.110;

(d) A health care facility as defined in ORS 442.015;

(e) A home health agency licensed under ORS 443.015;

(f) A hospice program licensed under ORS 443.860; or

(g) Any other person that provides health care or that bills for or is compensated for health care provided, in the normal course of business.

(7) "Interpretation service company" means an entity, or a person acting on behalf of an entity, that is in the business of arranging for health care interpreters to work with health care providers in this state.

[*(4)*] **(8)** "Person with limited English proficiency" means a person who, by reason of place of birth or culture, [*speaks*] **communicates in** a language other than English and does not [*speak*] **communicate in** English with adequate ability to communicate effectively with a health care provider.

(9) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.025.

[*(5)*] **(10)** "Qualified health care interpreter" means an individual who has [*received*] **been issued** a valid letter of qualification from the authority **under ORS 413.558**.

[*(6)*] **(11)** "Sight translate" means to translate a written document into spoken or [*sign*] **signed** language.

SECTION 9. ORS 413.552 is amended to read:

413.552. (1) The Legislative Assembly finds that persons with limited English proficiency, or who communicate in [*sign*] **signed** language, are often unable to interact effectively with health care providers. Because of language differences, persons with limited English proficiency, or who communicate in [*sign*] **signed** language, are often excluded from health care services, experience delays or denials of health care services or receive health care services based on inaccurate or incomplete information.

(2) The Legislative Assembly further finds that the lack of competent health care interpreters among health care providers impedes the free flow of communication between the health care provider and patient, **negatively impacting health outcomes and** preventing clear and accurate communication and the development of empathy, confidence and mutual trust that is essential for an effective relationship between health care provider and patient.

(3) It is the policy of the Legislative Assembly to require [*the use of*] **working with** certified health care interpreters or qualified health care interpreters [*whenever possible*] to ensure the accurate and adequate provision of health care to persons with limited English proficiency and to persons who communicate in [*sign*] **signed** language.

(4) It is the policy of the Legislative Assembly that health care for persons with limited English proficiency be provided according to the guidelines established under the policy statement issued August 30, 2000, by the U.S. Department of Health and Human Services, Office for Civil Rights, entitled, "Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency," and the 1978 Patient's Bill of Rights.

SECTION 10. ORS 413.556 is amended to read:

413.556. The Oregon Council on Health Care Interpreters shall work in cooperation with the Oregon Health Authority to:

(1) Develop **and approve** testing, qualification and certification standards**, consistent with national standards,** for health care interpreters for persons with limited English proficiency and for persons who communicate in [*sign*] **signed** language.

[*(2) Coordinate with other states, the federal government or professional organizations to develop and implement educational and testing programs for health care interpreters.*]

[*(3) Examine operational and funding issues, including but not limited to the feasibility of developing a central registry and annual subscription mechanism for health care interpreters.*]

[*(4)*] **(2)** Do all other acts as shall be necessary or appropriate under the provisions of ORS 413.550 to 413.558.

SECTION 11. ORS 413.558 is amended to read:

413.558. (1) In consultation with the Oregon Council on Health Care Interpreters, the Oregon Health Authority shall by rule establish procedures for testing, qualification and certification of health care interpreters for persons with limited English proficiency or for persons who communicate in [*sign*] **signed** language, including but not limited to:

(a) Minimum standards for qualification and certification as a health care interpreter, **which may be modified as necessary,** including:

(A) Oral [*and written*] **or signed** language skills in English and in the language for which health care interpreter qualification or certification is granted; and

(B) Formal education or training in **interpretation,** medical **behavioral or oral health** terminology, anatomy and physiology[*, medical interpreting ethics and interpreting skills*];

(b) Categories of expertise of health care interpreters based on the English and non-English skills, or interpreting skills, and the medical terminology skills of the person seeking qualification or certification;

(c) Procedures for receiving applications and for examining applicants for qualification or certification;

(d) The content and administration of required examinations;

(e) The requirements and procedures for reciprocity of qualification and certification for health care interpreters qualified or certified in another state or territory of the United States or by another certifying body in the United States; and

(f) Fees for application, examination, initial issuance, renewal and reciprocal acceptance of qualification or certification as a health care interpreter if deemed necessary by the authority.

(2) Any person seeking qualification or certification as a health care interpreter must submit an application to the authority. If the applicant meets the requirements for qualification or certification established by the authority under this section, the authority shall issue a letter of qualification or a certification to the health care interpreter. **The authority shall notify a person of the authority's determination on the person's application no later than 60 days after the date the application is received by the authority.**

(3) The authority shall work with other states, the federal government or professional organizations to develop educational and testing programs and procedures for the qualification and certification of health care interpreters.

(4) In addition to the requirements for qualification established under subsection (1) of this section, a person may be qualified as a health care interpreter only if the person:

(a) Is able to fluently interpret [*the dialect,*] slang**, idioms and specialized vocabulary in English and the slang, idioms** or specialized vocabulary of the non-English language for which qualification is sought; and

(b) Has had at least 60 hours of health care interpreter training that includes anatomy and physiology and concepts of [*medical*] **health care** interpretation.

(5) A person may not use the title of "qualified health care interpreter" in this state**, or any other title, designation, words, letters, abbreviation, sign or device tending to indicate that the person is a qualified health care interpreter,** unless the person has met the requirements for qualification established under subsections (1) and (4) of this section and has been issued a valid letter of qualification by the authority.

(6) In addition to the requirements for certification established under subsection (1) of this section, a person may be certified as a health care interpreter only if:

(a) The person has met all the requirements established under subsection (4) of this section; and

(b) The person has passed written and oral examinations required by the authority in English, in a non-English language or [*sign*] **signed** language and in medical terminology.

(7) A person may not use the title of "certified health care interpreter" in this state**, or any other title, designation, words, letters, abbreviation, sign or device tending to indicate that the person is a certified health care interpreter,** unless the person has met the requirements for certification established under subsections (1) and (6) of this section and has been issued a valid certification by the authority.

(8) The authority shall:

(a) Provide health care interpreter training and continuing education in accordance with standards adopted by the Oregon Council on Health Care Interpreters under ORS 413.556 to professionalize the health care interpreter workforce in this state. The training may be provided at no cost or, if not, must be affordable.

(b) Maintain a record of all health care interpreters who have completed an approved training program.

(c) Establish and maintain a central registry for all health care interpreters who are qualified or certified by the authority and establish a process for health care interpreters to biennially update their contact information and confirm their participation in the registry.

(d) Adopt rules to carry out the provisions of this section.

(9) The authority shall provide the notice described in ORS 183.335 (1) to all certified and qualified health care interpreters listed on the registry prior to the adoption, amendment or repeal of any rule concerning qualified or certified health care interpreter services.

SECTION 12. The amendments to ORS 413.558 by section 11 of this 2021 Act do not require the Oregon Health Authority or the Oregon Council on Health Care Interpreters to

establish a new health care interpreter registry in addition to the health care interpreter registry in effect on the effective date of this 2021 Act.

SECTION 13. ORS 414.572 is amended to read:

414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria and requirements adopted by the authority under this section must include, but are not limited to, a requirement that the coordinated care organization:

(a) Have demonstrated experience and a capacity for managing financial risk and establishing financial reserves.

(b) Meet the following minimum financial requirements:

(A) Maintain restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above $250,000.

(B) Maintain capital or surplus of not less than $2,500,000 and any additional amounts necessary to ensure the solvency of the coordinated care organization, as specified by the authority by rules that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

(C) Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements specified in this paragraph on services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).

(c) Operate within a fixed global budget and, by January 1, 2023, spend on primary care, as defined in section 2, chapter 575, Oregon Laws 2015, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

(d) Develop and implement alternative payment methodologies that are based on health care quality and improved health outcomes.

(e) Coordinate the delivery of physical health care, [*mental health and chemical dependency services*] **behavioral health care**, oral health care and covered long-term care services.

(f) Engage community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.

(2) In addition to the criteria and requirements specified in subsection (1) of this section, the authority must adopt by rule requirements for coordinated care organizations contracting with the authority so that:

(a) Each member of the coordinated care organization receives integrated person centered care and services designed to provide choice, independence and dignity.

(b) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.

(c) The supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient centered primary care homes, behavioral health homes or other models that support patient centered primary care and behavioral health care and individualized care plans to the extent feasible.

(d) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.

(e) Members [*receive*] **are provided:**

(A) Assistance in navigating the health care delivery system**;**

(B) Assistance [*and*] in accessing community and social support services and statewide resources[*, including through the use of certified health care interpreters and qualified health care interpreters, as those terms are defined in ORS 413.550*]**;**

(C) Meaningful language access as required by federal and state law including, but not limited to, 42 U.S.C. 18116, Title VI of the Civil Rights Act of 1964, Title VI Guidance issued by the United States Department of Justice and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as issued by the United States Department of Health and Human Services; and

(D) Qualified health care interpreters or certified health care interpreters listed on the health care interpreter registry, as those terms are defined in ORS 413.550.

(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.

(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

(h) Each coordinated care organization complies with the safeguards for members described in ORS 414.605.

(i) Each coordinated care organization convenes a community advisory council that meets the criteria specified in ORS 414.575.

(j) Each coordinated care organization prioritizes working with members who have high health care needs, multiple chronic conditions[*, mental illness or chemical dependency*] **or behavioral health conditions** and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services, including the services described in ORS 414.766, to reduce the use of avoidable emergency room visits and hospital admissions.

(k) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization:

(A) Work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of members.

(B) Are educated about the integrated approach and how to access and communicate within the integrated system about a patient's treatment plan and health history.

(C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication.

(D) Are permitted to participate in the networks of multiple coordinated care organizations.

(E) Include providers of specialty care.

(F) Are selected by coordinated care organizations using universal application and credentialing procedures and objective quality information and are removed if the providers fail to meet objective quality standards.

(G) Work together to develop best practices for culturally **and linguistically** appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.

(L) Each coordinated care organization reports on outcome and quality measures adopted under ORS 414.638 and participates in the health care data reporting system established in ORS 442.372 and 442.373.

(m) Each coordinated care organization uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks.

(n) Each coordinated care organization participates in the learning collaborative described in ORS 413.259 (3).

(o) Each coordinated care organization has a governing body that complies with ORS 414.584 and that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

(B) A representative of a dental care organization selected by the coordinated care organization;

(C) The major components of the health care delivery system;

(D) At least two health care providers in active practice, including:

(i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS 678.375, whose area of practice is primary care; and

(ii) A [*mental health or chemical dependency treatment*] **behavioral health** provider;

(E) At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and

(F) At least two members of the community advisory council, one of whom is or was within the previous six months a recipient of medical assistance and is at least 16 years of age, or a parent, guardian or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.

(p) Each coordinated care organization's governing body establishes standards for publicizing the activities of the coordinated care organization and the organization's community advisory councils, as necessary, to keep the community informed.

(q) Each coordinated care organization publishes on a website maintained by or on behalf of the coordinated care organization, in a manner determined by the authority, a document designed to educate members about best practices, care quality expectations, screening practices, treatment options and other support resources available for members who have mental illnesses or substance use disorders.

(r) Each coordinated care organization works with the Tribal Advisory Council established in ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

(A) Facilitate a resolution of any issues that arise between the coordinated care organization and a provider of Indian health services within the area served by the coordinated care organization;

(B) Participate in the community health assessment and the development of the health improvement plan;

(C) Communicate regularly with the Tribal Advisory Council; and

(D) Be available for training by the office within the authority that is responsible for tribal affairs, any federally recognized tribe in Oregon and the urban Indian health program that is located within the area served by the coordinated care organization and operated by an urban Indian organization pursuant to 25 U.S.C. 1651.

(3) The authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of coordinated care organizations.

(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

(a) For members and potential members, optimize access to care and choice of providers;

(b) For providers, optimize choice in contracting with coordinated care organizations; and

(c) Allow more than one coordinated care organization to serve the geographic area if necessary to optimize access and choice under this subsection.

(5) On or before July 1, 2014, each coordinated care organization must have a formal contractual relationship with any dental care organization that serves members of the coordinated care organization in the area where they reside.

SECTION 14. ORS 414.572, as amended by section 14, chapter 489, Oregon Laws 2017, section 4, chapter 49, Oregon Laws 2018, section 8, chapter 358, Oregon Laws 2019, section 2, chapter 364, Oregon Laws 2019, section 58, chapter 478, Oregon Laws 2019, and section 7, chapter 529, Oregon Laws 2019, is amended to read:

414.572. (1) The Oregon Health Authority shall adopt by rule the qualification criteria and requirements for a coordinated care organization and shall integrate the criteria and requirements into each contract with a coordinated care organization. Coordinated care organizations may be

local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria and requirements adopted by the authority under this section must include, but are not limited to, a requirement that the coordinated care organization:

(a) Have demonstrated experience and a capacity for managing financial risk and establishing financial reserves.

(b) Meet the following minimum financial requirements:

(A) Maintain restricted reserves of $250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above $250,000.

(B) Maintain capital or surplus of not less than $2,500,000 and any additional amounts necessary to ensure the solvency of the coordinated care organization, as specified by the authority by rules that are consistent with ORS 731.554 (6), 732.225, 732.230 and 750.045.

(C) Expend a portion of the annual net income or reserves of the coordinated care organization that exceed the financial requirements specified in this paragraph on services designed to address health disparities and the social determinants of health consistent with the coordinated care organization's community health improvement plan and transformation plan and the terms and conditions of the Medicaid demonstration project under section 1115 of the Social Security Act (42 U.S.C. 1315).

(c) Operate within a fixed global budget and spend on primary care, as defined by the authority by rule, at least 12 percent of the coordinated care organization's total expenditures for physical and mental health care provided to members, except for expenditures on prescription drugs, vision care and dental care.

(d) Develop and implement alternative payment methodologies that are based on health care quality and improved health outcomes.

(e) Coordinate the delivery of physical health care, [*mental health and chemical dependency services*] **behavioral health care**, oral health care and covered long-term care services.

(f) Engage community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.

(2) In addition to the criteria and requirements specified in subsection (1) of this section, the authority must adopt by rule requirements for coordinated care organizations contracting with the authority so that:

(a) Each member of the coordinated care organization receives integrated person centered care and services designed to provide choice, independence and dignity.

(b) Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.

(c) The supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient centered primary care homes, behavioral health homes or other models that support patient centered primary care and behavioral health care and individualized care plans to the extent feasible.

(d) Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.

(e) Members [*receive*] **are provided:**

(A) Assistance in navigating the health care delivery system**;**

(B) Assistance [*and*] in accessing community and social support services and statewide resources[*, including through the use of certified health care interpreters and qualified health care interpreters, as those terms are defined in ORS 413.550*]**;**

(C) Meaningful language access as required by federal and state law including, but not limited to, 42 U.S.C. 18116, Title VI of the Civil Rights Act of 1964, Title VI Guidance issued by the United States Department of Justice and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care as issued by the United States Department of Health and Human Services; and

(D) Qualified health care interpreters or certified health care interpreters listed on the health care interpreter registry, as those terms are defined in ORS 413.550.

(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.

(g) Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable and if financially viable.

(h) Each coordinated care organization complies with the safeguards for members described in ORS 414.605.

(i) Each coordinated care organization convenes a community advisory council that meets the criteria specified in ORS 414.575.

(j) Each coordinated care organization prioritizes working with members who have high health care needs, multiple chronic conditions[*, mental illness or chemical dependency*] **or behavioral health conditions** and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services, including the services described in ORS 414.766, to reduce the use of avoidable emergency room visits and hospital admissions.

(k) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization:

(A) Work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of members.

(B) Are educated about the integrated approach and how to access and communicate within the integrated system about a patient's treatment plan and health history.

(C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication.

(D) Are permitted to participate in the networks of multiple coordinated care organizations.

(E) Include providers of specialty care.

(F) Are selected by coordinated care organizations using universal application and credentialing procedures and objective quality information and are removed if the providers fail to meet objective quality standards.

(G) Work together to develop best practices for culturally **and linguistically** appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.

(L) Each coordinated care organization reports on outcome and quality measures adopted under ORS 414.638 and participates in the health care data reporting system established in ORS 442.372 and 442.373.

(m) Each coordinated care organization uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks.

(n) Each coordinated care organization participates in the learning collaborative described in ORS 413.259 (3).

(o) Each coordinated care organization has a governing body that complies with ORS 414.584 and that includes:

(A) At least one member representing persons that share in the financial risk of the organization;

(B) A representative of a dental care organization selected by the coordinated care organization;

(C) The major components of the health care delivery system;

(D) At least two health care providers in active practice, including:

(i) A physician licensed under ORS chapter 677 or a nurse practitioner licensed under ORS 678.375, whose area of practice is primary care; and

(ii) A [*mental health or chemical dependency treatment*] **behavioral health** provider;

(E) At least two members from the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and

(F) At least two members of the community advisory council, one of whom is or was within the previous six months a recipient of medical assistance and is at least 16 years of age or a parent, guardian or primary caregiver of an individual who is or was within the previous six months a recipient of medical assistance.

(p) Each coordinated care organization's governing body establishes standards for publicizing the activities of the coordinated care organization and the organization's community advisory councils, as necessary, to keep the community informed.

(q) Each coordinated care organization publishes on a website maintained by or on behalf of the coordinated care organization, in a manner determined by the authority, a document designed to educate members about best practices, care quality expectations, screening practices, treatment options and other support resources available for members who have mental illnesses or substance use disorders.

(r) Each coordinated care organization works with the Tribal Advisory Council established in ORS 414.581 and has a dedicated tribal liaison, selected by the council, to:

(A) Facilitate a resolution of any issues that arise between the coordinated care organization and a provider of Indian health services within the area served by the coordinated care organization;

(B) Participate in the community health assessment and the development of the health improvement plan;

(C) Communicate regularly with the Tribal Advisory Council; and

(D) Be available for training by the office within the authority that is responsible for tribal affairs, any federally recognized tribe in Oregon and the urban Indian health program that is located within the area served by the coordinated care organization and operated by an urban Indian organization pursuant to 25 U.S.C. 1651.

(3) The authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of coordinated care organizations.

(4) In selecting one or more coordinated care organizations to serve a geographic area, the authority shall:

(a) For members and potential members, optimize access to care and choice of providers;

(b) For providers, optimize choice in contracting with coordinated care organizations; and

(c) Allow more than one coordinated care organization to serve the geographic area if necessary to optimize access and choice under this subsection.

(5) On or before July 1, 2014, each coordinated care organization must have a formal contractual relationship with any dental care organization that serves members of the coordinated care organization in the area where they reside.

SECTION 15. ORS 656.027 is amended to read:

656.027. All workers are subject to this chapter except those nonsubject workers described in the following subsections:

(1) A worker employed as a domestic servant in or about a private home. For the purposes of this subsection "domestic servant" means any worker engaged in household domestic service by private employment contract, including, but not limited to, home health workers.

(2) A worker employed to do gardening, maintenance, repair, remodeling or similar work in or about the private home of the person employing the worker.

(3)(a) A worker whose employment is casual and either:

(A) The employment is not in the course of the trade, business or profession of the employer; or

(B) The employment is in the course of the trade, business or profession of a nonsubject employer.

(b) For the purpose of this subsection, "casual" refers only to employments where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $500.

(4) A person for whom a rule of liability for injury or death arising out of and in the course of employment is provided by the laws of the United States.

(5) A worker engaged in the transportation in interstate commerce of goods, persons or property for hire by rail, water, aircraft or motor vehicle, and whose employer has no fixed place of business in this state.

(6) Firefighter and police employees of any city having a population of more than 200,000 that provides a disability and retirement system by ordinance or charter.

(7)(a) Sole proprietors, except those described in paragraph (b) of this subsection. When labor or services are performed under contract, the sole proprietor must qualify as an independent contractor **to be a nonsubject worker**.

(b) Sole proprietors actively licensed under ORS 671.525 or 701.021. When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the sole proprietor must qualify as an independent contractor. Any sole proprietor licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(8) Except as provided in subsection (23) of this section, partners who are not engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto. When labor or services are performed under contract, the partnership must qualify as an independent contractor **to be a nonsubject worker**.

(9) Except as provided in subsection (25) of this section, members, including members who are managers, of limited liability companies, regardless of the nature of the work performed. However, members, including members who are managers, of limited liability companies with more than one member, while engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto, are subject workers. When labor or services are performed under contract, the limited liability company must qualify as an independent contractor **to be a nonsubject worker**.

(10) Except as provided in subsection (24) of this section, corporate officers who are directors of the corporation and who have a substantial ownership interest in the corporation, regardless of the nature of the work performed by such officers, subject to the following limitations:

(a) If the activities of the corporation are conducted on land that receives farm use tax assessment pursuant to ORS chapter 308A, corporate officer includes all individuals identified as directors in the corporate bylaws, regardless of ownership interest, and who are members of the same family, whether related by blood, marriage or adoption.

(b) If the activities of the corporation involve the commercial harvest of timber and all officers of the corporation are members of the same family and are parents, daughters or sons, daughters-in-law or sons-in-law or grandchildren, then all such officers may elect to be nonsubject workers. For all other corporations involving the commercial harvest of timber, the maximum number of exempt corporate officers for the corporation shall be whichever is the greater of the following:

(A) Two corporate officers; or

(B) One corporate officer for each 10 corporate employees.

(c) When labor or services are performed under contract, the corporation must qualify as an independent contractor **to be a nonsubject worker**.

(11) A person performing services primarily for board and lodging received from any religious, charitable or relief organization.

(12) A newspaper carrier utilized in compliance with the provisions of ORS 656.070 and 656.075.

(13) A person who has been declared an amateur athlete under the rules of the United States Olympic Committee or the Canadian Olympic Committee and who receives no remuneration for performance of services as an athlete other than board, room, rent, housing, lodging or other reasonable incidental subsistence allowance, or any amateur sports official who is certified by a recognized Oregon or national certifying authority, which requires or provides liability and accident insurance for such officials. A roster of recognized Oregon and national certifying authorities will be maintained by the Department of Consumer and Business Services, from lists of certifying organizations submitted by the Oregon School Activities Association and the Oregon Park and Recreation Society.

(14) Volunteer personnel participating in the ACTION programs, organized under the Domestic Volunteer Service Act of 1973, P.L. 93-113, known as the Foster Grandparent Program and the Senior Companion Program, whether or not the volunteers receive a stipend or nominal reimbursement for time and travel expenses.

(15) A person who has an ownership or leasehold interest in equipment and who furnishes, maintains and operates the equipment. As used in this subsection "equipment" means:

(a) A motor vehicle used in the transportation of logs, poles or piling.

(b) A motor vehicle used in the transportation of rocks, gravel, sand, dirt or asphalt concrete.

(c) A motor vehicle used in the transportation of property by a for-hire motor carrier that is required under ORS 825.100 or 825.104 to possess a certificate or permit or to be registered.

(16) A person engaged in the transportation of the public for recreational down-river boating activities on the waters of this state pursuant to a federal permit when the person furnishes the equipment necessary for the activity. As used in this subsection, "recreational down-river boating activities" means those boating activities for the purpose of recreational fishing, swimming or sightseeing utilizing a float craft with oars or paddles as the primary source of power.

(17) A person who receives no wage other than ski passes or other noncash remuneration for performing volunteer:

(a) Ski patrol activities; or

(b) Ski area program activities sponsored by a ski area operator, as defined in ORS 30.970, or by a nonprofit corporation or organization.

(18) A person 19 years of age or older who contracts with a newspaper publishing company or independent newspaper dealer or contractor to distribute newspapers to the general public and perform or undertake any necessary or attendant functions related thereto.

(19) A person performing foster parent or adult foster care duties pursuant to [*ORS 412.001 to 412.161 and 412.991 or*] ORS chapter [*411,*] 418, 430 or 443.

(20) A person performing services on a volunteer basis for a nonprofit, religious, charitable or relief organization, whether or not such person receives meals or lodging or nominal reimbursements or vouchers for meals, lodging or expenses.

(21) A person performing services under a property tax work-off program established under ORS 310.800.

(22) A person who performs service as a caddy at a golf course in an established program for the training and supervision of caddies under the direction of a person who is an employee of the golf course.

(23)(a) Partners who are actively licensed under ORS 671.525 or 701.021 and who have a substantial ownership interest in a partnership. If all partners are members of the same family and are parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law or grandchildren, all such partners may elect to be nonsubject workers. For all other partnerships licensed under ORS 671.510 to 671.760 or 701.021, the maximum number of exempt partners shall be whichever is the greater of the following:

(A) Two partners; or

(B) One partner for each 10 partnership employees.

(b) When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the partnership qualifies as an independent contractor. Any partnership licensed under

ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(24)(a) Corporate officers who are directors of a corporation actively licensed under ORS 671.525 or 701.021 and who have a substantial ownership interest in the corporation, regardless of the nature of the work performed. If all officers of the corporation are members of the same family and are parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law or grandchildren, all such officers may elect to be nonsubject workers. For all other corporations licensed under ORS 671.510 to 671.760 or 701.021, the maximum number of exempt corporate officers shall be whichever is the greater of the following:

(A) Two corporate officers; or

(B) One corporate officer for each 10 corporate employees.

(b) When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the corporation qualifies as an independent contractor. Any corporation licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(25)(a) Limited liability company members who are members of a company actively licensed under ORS 671.525 or 701.021 and who have a substantial ownership interest in the company, regardless of the nature of the work performed. If all members of the company are members of the same family and are parents, spouses, sisters, brothers, daughters or sons, daughters-in-law or sons-in-law or grandchildren, all such members may elect to be nonsubject workers. For all other companies licensed under ORS 671.510 to 671.760 or 701.021, the maximum number of exempt company members shall be whichever is the greater of the following:

(A) Two company members; or

(B) One company member for each 10 company employees.

(b) When labor or services are performed under contract for remuneration, notwithstanding ORS 656.005 (30), the company qualifies as an independent contractor. Any company licensed under ORS 671.525 or 701.021 and involved in activities subject thereto is conclusively presumed to be an independent contractor.

(26) A person serving as a referee or assistant referee in a youth or adult recreational soccer match whose services are retained on a match-by-match basis.

[*(27) A person performing language translator or interpreter services that are provided for others through an agent or broker.*]

[*(28)*] **(27)** A person who operates, and who has an ownership or leasehold interest in, a passenger motor vehicle that is operated as a taxicab or for nonemergency medical transportation. As used in this subsection:

(a) "Lease" means a contract under which the lessor provides a vehicle to a lessee for consideration.

(b) "Leasehold" includes, but is not limited to, a lease for a shift or a longer period.

(c) "Passenger motor vehicle that is operated as a taxicab" means a vehicle that:

(A) Has a passenger seating capacity that does not exceed seven persons;

(B) Is transporting persons, property or both on a route that begins or ends in Oregon; and

(C)(i) Carries passengers for hire when the destination and route traveled may be controlled by a passenger and the fare is calculated on the basis of any combination of an initial fee, distance traveled or waiting time; or

(ii) Is in use under a contract to provide specific service to a third party to transport designated passengers or to provide errand services to locations selected by the third party.

(d) "Passenger motor vehicle that is operated for nonemergency medical transportation" means a vehicle that:

(A) Has a passenger seating capacity that does not exceed seven persons;

(B) Is transporting persons, property or both on a route that begins or ends in Oregon; and

(C) Provides medical transportation services under contract with or on behalf of a mass transit or transportation district.

SECTION 16. ORS 657.046 is amended to read:

657.046. (1) As used in this chapter, "employment" does not include service performed in the operation of a passenger motor vehicle that is operated as a taxicab or a passenger motor vehicle that is operated for nonemergency medical transportation, by a person who has an ownership or leasehold interest in the passenger motor vehicle, for an entity that is operated by a board of owner-operators elected by the members of the entity.

(2) As used in this section:

(a) "Leasehold" has the meaning given that term in ORS 656.027 [*(28)*] **(27)**.

(b) "Passenger motor vehicle that is operated as a taxicab" means a vehicle that:

(A) Has a passenger seating capacity of at least three persons and not more than seven persons;

(B) On a route that begins or ends in Oregon, is used primarily to transport persons;

(C)(i) Carries passengers for hire when the destination and route traveled may be controlled by a passenger and the fare is calculated on the basis of any combination of an initial fee, distance traveled or waiting time; or

(ii) Is in use under a contract to provide specific service to a third party to transport designated passengers to locations selected by the third party; and

(D) Is not used more than secondarily or incidentally for errand services or to transport property, instead of or in addition to transporting passengers.

(c) "Passenger motor vehicle that is operated for nonemergency medical transportation" means a vehicle that:

(A) Has a passenger seating capacity of at least three persons and not more than seven persons;

(B) On a route that begins or ends in Oregon, is used primarily to transport persons;

(C) Provides medical transportation services under contract with or on behalf of a mass transit or transportation district; and

(D) Is not used more than secondarily or incidentally for errand services or to transport property, instead of or in addition to transporting passengers.

(3) The provisions of this section do not apply to service performed for:

(a) A nonprofit employing unit;

(b) This state;

(c) A political subdivision of this state; or

(d) An Indian tribe.

SECTION 17. ORS 657.048 is repealed.

SECTION 18. (1) Section 4 of this 2021 Act and the amendments to ORS 413.550, 413.552 and 413.556 by sections 8 to 10 of this 2021 Act become operative on September 1, 2022.

(2) Sections 2, 3 and 6 of this 2021 Act and the amendments to ORS 414.572 by section 13 of this 2021 Act become operative on July 1, 2022.

SECTION 19. Notwithstanding any other provision of law, the General Fund appropriation made to the Oregon Health Authority by section 1 (3), chapter _____, Oregon Laws 2021 (Enrolled House Bill 5024), for the biennium beginning July 1, 2021, for central services, state assessments and enterprise-wide costs, is increased by $670,664 for carrying out the provisions of this 2021 Act.

SECTION 20. Notwithstanding any other law limiting expenditures, the limitation on expenditures established by section 2 (3), chapter _____, Oregon Laws 2021 (Enrolled House Bill 5024), for the biennium beginning July 1, 2021, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, tobacco tax receipts, marijuana tax receipts, beer and wine tax receipts, provider taxes and Medicare receipts, but excluding lottery funds and federal funds not described in section 2, chapter _____, Oregon Laws 2021 (Enrolled House Bill 5024), collected or received by the Oregon Health Authority, for central services, state assessments and enterprise-wide costs, is increased by $66,812 for carrying out the provisions of this 2021 Act.

SECTION 21. Notwithstanding any other law limiting expenditures, the limitation on expenditures established by section 5 (3), chapter _____, Oregon Laws 2021 (Enrolled House

Bill 5024), for the biennium beginning July 1, 2021, as the maximum limit for payment of expenses from federal funds, excluding federal funds described in section 2, chapter _____, Oregon Laws 2021 (Enrolled House Bill 5024), collected or received by the Oregon Health Authority, for central services, state assessments and enterprise-wide costs, is increased by $118,194 for the purpose of carrying out the provisions of this 2021 Act.

SECTION 22. This 2021 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2021 Act takes effect on its passage.

Passed by House June 17, 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

Oregon Health Care Interpreter Program Requirements

Oregon's Health Care Interpreter Program includes two levels of credentialing (qualification and certification). A qualified or certified health care interpreter must meet all of the requirements listed below and provide all of the supporting documentation.

	Qualification	Certification
Requirements and documentation	• Must be at least 18 years of age. ☐ Copy of an Oregon driver's license or passport • Must not be on the Medicaid Exclusion List: http://exclusions.oig.hhs.gov/. ☐ Printout of search results. • Must pass a background check. • Must have at least 60 hours of formal health care interpreter training. ☐ Proof of successful completion of training at OHA-approved training center or equivalent • Must have language proficiency in English and the target language (see next page for more information). ☐ Proof of passing a language proficiency test at an approved testing center ☐ **Or**, demonstration of having met equivalent language proficiency requirements • Must have at least **15 hours** of documented interpreting experience. • $25 qualification fee payable (by check or money order) to OHA/OEI Health Care Interpreter Program (includes registration fee) • Send completed application and check to: Health Care Interpreter Program Office of Equity and Inclusion 421 SW Oak St. Suite 750 Portland, Oregon 97204	• Must be at least 18 years of age. ☐ Copy of an Oregon driver's license or passport • Must not be on the Medicaid Exclusion List: http://exclusions.oig.hhs.gov/. ☐ Printout of search results. • Must pass a background check. • Must have at least 60 hours of formal health care interpreter training. ☐ Proof of successful completion of training at OHA-approved training center or equivalent • Must have at least **30 hours** of documented interpreting experience. ☐ Proof of passing certification tests from one of the following: • National Board of Certification for Medical Interpreters • Certification Commission for Healthcare Interpreters • Oregon Court Interpreter Certification • Federal Court Interpreter Certification exams • American Sign Language (ASL) Certification • $25 certification fee payable (by check or money order) to OHA/OEI Health Care Interpreter Program (includes registration fee) • Send completed application and check to: Health Care Interpreter Program Office of Equity and Inclusion 421 SW Oak St. Suite 750 Portland, Oregon 97204
Valid period	Four years	Four years

*Oral certification test is available in Spanish, Mandarin, Cantonese, Russian, Korean, Arabic and Vietnamese.
Questions? Contact the Oregon Health Care Interpreter Program: hci.program@dhsoha.state.or.us, 971-673-3328, www.oregon.gov/oha/oei, or call us to schedule an appointment in person.

Oregon Health Authority | Office of Equity & Inclusion

Oregon Health Care Interpreter Program

Meeting the language proficiency requirements for HCI qualification and certification

Oregon Health Authority approved language proficiency testing centers include:

- Language Line University Level 2 or above ((Interavency Language Roundtable (ILR) equivalent, based on website information)).
- Language Testing International testing is based on American Council on the Teaching of Foreign Languages {ACTFL) assessment. Both the optional phone interpreter (OPI — telephonic) and OPIc (computer recording) are acceptable.
- The passing level for all language testing is advanced mid-level on the ACTFL scale.

Oral proficiency in both English and the non-English language (L2) may be demonstrated by passing any of the exams listed above (not expired) plus:

- Oregon Court Interpreter Registered status – not expired

One of the following may demonstrate oral proficiency in English:

- Bachelor, masters, doctorate or any other degree from any U.S. institution of higher education.
- Graduation from any high school in an English language speaking country where English is the primary language of instruction.
- Graduation from a higher education institution abroad where English is the primary language of instruction.
- One of the following tests (subject to change). Test results must be from no more than three years ago to be considered valid.
  - » Test of English as a Foreign Language (TOEFL): 570+ on paper; 230+ on computer version; 90+ on iBT
  - » Certificate in Advanced English (CAE), Level 4: B
  - » Certificate of Proficiency in English (CPE), Level 5: B
  - » International English Language Testing System (IELTS): 7.0+
  - » Interagency Language Roundtable (ILR): 2+
  - » Common European Framework (CEFR): B2
  - » Oral Proficiency Interview at the advanced mid-level on the ACTFL scale

One of the following may demonstrate oral proficiency in the non-English language:

- Bachelor, masters, doctorate or any other degree from an institution of higher education where instruction is primarily in the non-English language and the person submitting proof is a non-English language native speaker.
- Graduation from high school in a country where instruction is primarily in the non-English language and the person submitting proof is a native speaker of the non-English language.
- One of the following tests (subject to change). Test results must be from no more than three years ago to be considered valid:
  - » Interagency Language Round Table (ILR): 2+ from federal government testing agencies
  - » Common European Framework (CEFR): B2
  - » Oral Proficiency Interview at the advanced mid-level on the ACTFL scale

You can get this document in other languages, large print, braille or a format you prefer. Contact the Health Care Interpreter Program, Office of Equity and Inclusion, at 971-673-3328 (711 for TTY) or email hci.program@state.or.us.

OHA 8923 (7/2017)

Board of Dentistry Draft rule changes - HB 2359

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 or dental hygiene.
(16) Practice dentistry or dental hygiene 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 or dental hygiene.
(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 DEA registration.
(24) Fail to comply with ORS 413.550-413.558, if applicable. If the Board receives information of failure to comply with these laws, the Board may open an investigation that may result in discipline.

Enrolled
House Bill 4096

Sponsored by Representative HAYDEN, Senator STEINER HAYWARD, Representative PRUSAK, Senator PATTERSON; Representatives ALONSO LEON, BONHAM, BYNUM, DEXTER, GRAYBER, MOORE-GREEN, NOBLE, SALINAS, SMITH DB, Senator SOLLMAN (Presession filed.)

CHAPTER .....

AN ACT

Relating to volunteer health care practitioners; creating new provisions; amending ORS 677.080, 677.135, 678.021, 679.025, 680.020, 683.020, 685.020 and 689.225; and prescribing an effective date.

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

SECTION 1. (1) As used in this section:

(a) "Health care practitioner" means a person authorized in another state or United States territory to practice as a physician, physician assistant, nurse, nurse practitioner, clinical nurse specialist, dentist, dental hygienist, dental therapist, pharmacist, optometrist or naturopathic physician.

(b) "Health professional regulatory board" means the:

(A) Oregon Board of Dentistry;

(B) Oregon Board of Naturopathic Medicine;

(C) Oregon Board of Optometry;

(D) Oregon Medical Board;

(E) Oregon State Board of Nursing; and

(F) State Board of Pharmacy.

(2) A health care practitioner may practice, without compensation and in connection with a coordinating organization or other entity, the health care profession that the health care practitioner is authorized to practice for 30 days each calendar year or the number of days otherwise provided pursuant to subsection (8) of this section. A health care practitioner is not required to apply for licensure or other authorization from a health professional regulatory board in order to practice under this section.

(3) To practice under this section, a health care practitioner shall submit, at least 10 days prior to commencing practice in this state, to the health professional regulatory board substantially similar to the health care practitioner's licensing agency:

(a) Proof that the health care practitioner is in good standing and is not the subject of an active disciplinary action;

(b) An acknowledgement that the health care practitioner may provide services only within the scope of practice of the health care profession that the health care practitioner is authorized to practice and will provide services pursuant to the scope of practice of this state or the health care practitioner's licensing agency, whichever is more restrictive;

(c) An attestation that the health care practitioner will not receive compensation for practice in this state;

(d) The name and contact information of the coordinating organization or other entity through which the health care practitioner will practice; and

(e) The dates on which the health care practitioner will practice in this state.

(4) Except as otherwise provided, a health care practitioner practicing under this section is subject to the laws and rules governing the health care profession that the health care practitioner is authorized to practice and to disciplinary action by the appropriate health professional regulatory board.

(5) A health care practitioner who is authorized to practice in more than one other jurisdiction shall provide to the appropriate health professional regulatory board proof, as determined sufficient by the health professional regulatory board, that the health care practitioner is in good standing and not subject to any active disciplinary actions in any jurisdiction in which the health care practitioner is authorized to practice.

(6)(a) The coordinating organization or other entity that uses the services of a health care practitioner shall confirm with the health care practitioner's licensing agency that the health care practitioner is:

(A) Authorized to practice the health care profession claimed by the health care practitioner;

(B) In good standing; and

(C) Not subject to any active disciplinary actions.

(b) The coordinating organization or other entity shall maintain:

(A) Records of the information described in paragraph (a) of this subsection related to a health care practitioner for two years after the termination of the health care practitioner's practice in this state.

(B) Records of patients to whom a health care practitioner provided services, in compliance with all patient confidentiality requirements of this state, except as those requirements are expressly prohibited by the law of any other state where a patient's medical records are maintained.

(c) A coordinating organization or other entity may pay or reimburse a health care practitioner for actual incurred travel costs associated with the health care practitioner's practice under this section.

(7) A hospital or other health care facility may not use the services of a health care practitioner in order to meet staffing needs during a labor dispute at the hospital or facility.

(8)(a) A health professional regulatory board may adopt by rule a duration longer than 30 days each calendar year during which a health care practitioner may practice under subsection (2) of this section.

(b) A health professional regulatory board may adopt other rules necessary to carry out this section, including rules requiring a health care practitioner to receive approval of and confirmation from the health professional regulatory board that the health care practitioner is authorized to practice under this section.

(9) This section does not create a private right of action against a health professional regulatory board or limit the liability of a health professional regulatory board under any other provision of law.

SECTION 2. ORS 677.080 is amended to read:

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

(1) Knowingly make any false statement or representation on a matter, or willfully conceal any fact material to the right of the person to practice medicine or to obtain a license under this chapter.

(2) Sell or fraudulently obtain or furnish any medical and surgical diploma, license, record or registration, or aid or abet in the same.

(3) Impersonate anyone to whom a license has been granted by the Oregon Medical Board.

(4) Except as provided in ORS 677.060 **and section 1 of this 2022 Act**, practice medicine in this state without a license required by this chapter.

SECTION 3. ORS 677.135 is amended to read:

677.135. As used in ORS 677.135 to 677.141[*,*]**:**

(1) "The practice of medicine across state lines" means:

[*(1)*] **(a)** The rendering directly to a person of a written or otherwise documented medical opinion concerning the diagnosis or treatment of that person located within this state for the purpose of patient care by a physician or physician assistant located outside this state as a result of the transmission of individual patient data by electronic or other means from within this state to that physician, the physician's agent or a physician assistant; or

[*(2)*] **(b)** The rendering of medical treatment directly to a person located within this state by a physician or a physician assistant located outside this state as a result of the outward transmission of individual patient data by electronic or other means from within this state to that physician, the physician's agent or a physician assistant.

(2) "The practice of medicine across state lines" does not include the practice of medicine by a person practicing in this state under section 1 of this 2022 Act.

SECTION 4. ORS 678.021 is amended to read:

678.021. **Except as provided in section 1 of this 2022 Act,** it [*shall be*] **is** unlawful for any person to practice nursing or offer to practice nursing in this state or to use any title or abbreviation, sign, card or device to indicate the person is practicing either practical or registered nursing unless the person is licensed under ORS 678.010 to 678.410 at the level for which the indication of practice is made and the license is valid and in effect.

SECTION 5. ORS 679.025 is amended to read:

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

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

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

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

(c) Bona fide full-time students of dentistry who, during the period of their enrollment and as a part of the course of study in a dental education program located outside of Oregon that is accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency, 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 **who are** employed by public health agencies **and** who are not engaged in the direct delivery of clinical dental services to patients.

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

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

(j)**(A)** Dentists licensed in another [*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*] **subparagraph** and the application is approved by the board.

(B) Dentists licensed in another state or United States territory and practicing in this state under section 1 of this 2022 Act.

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

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

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

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

SECTION 6. ORS 680.020 is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) Dental hygienists licensed in another state [*and in good standing, while practicing dental hygiene without compensation for no more than five consecutive days in any 12-month period, provided the dental hygienist submits an application to the Oregon Board of Dentistry at least 10 days before practicing dental hygiene under this paragraph and the application is approved by the board*] **or United States territory and practicing in this state under section 1 of this 2022 Act**.

SECTION 7. ORS 683.020 is amended to read:

683.020. [*No person shall*] **Except as provided in section 1 of this 2022 Act, a person may not** engage in the practice of optometry or purport in any way to be an optometrist or an expert in the field of optometry without having first obtained a license from the Oregon Board of Optometry as provided for in ORS 683.010 to 683.340. In any prosecution for the violation of this section, the use of test cards, test lenses or of trial frames is prima facie evidence of the practice of optometry.

SECTION 8. ORS 685.020 is amended to read:

685.020. (1) Except as provided in subsection (3) of this section, [*no person shall*] **a person may not** practice, attempt to practice, or claim to practice naturopathic medicine in this state without first complying with the provisions of this chapter.

(2) Only licensees under this chapter may use any or all of the following terms, consistent with academic degrees earned: "Doctor of Naturopathy" or its abbreviation, "N.D.," "Naturopath" or "Naturopathic Physician." However, none of these terms, or any combination of them, shall be so used as to convey the idea that the physician who uses them practices anything other than naturopathic medicine.

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

(a) A bona fide student of naturopathic medicine who, during the period of the student's enrollment and as part of a doctoral course of study in an Oregon accredited naturopathic educational institution, engages in clinical training under the supervision of institution faculty, if the clinical training facility and level of supervision meet the standards adopted by the Oregon Board of Naturopathic Medicine by rule.

(b) A person authorized to practice under section 1 of this 2022 Act.

SECTION 9. ORS 689.225 is amended to read:

689.225. (1) A person may not engage in the practice of pharmacy unless the person is licensed under this chapter **or authorized in another state or United States territory and is practicing under section 1 of this 2022 Act**. Nothing in this section prevents physicians, dentists, veterinarians or other practitioners of the healing arts who are licensed under the laws of this state from dispensing and administering prescription drugs to their patients in the practice of their respective professions where specifically authorized to do so by law of this state.

(2) A person may not take, use or exhibit the title of pharmacist or the title of druggist or apothecary, or any other title or description of like import unless the person is licensed to practice pharmacy under this chapter.

(3) A pharmacist may not possess personally or store drugs other than in a licensed pharmacy except for those drugs legally prescribed for the personal use of the pharmacist or when the

pharmacist possesses or stores the drugs in the usual course of business and within the pharmacist's scope of practice. An employee, agent or owner of any registered manufacturer, wholesaler or pharmacy may lawfully possess legend drugs if the person is acting in the usual course of the business or employment of the person.

(4) The State Board of Pharmacy shall adopt rules relating to the use of pharmacy technicians working under the supervision, direction and control of a pharmacist. For retail and institutional drug outlets, the board shall adopt rules which include requirements for training, including provisions for appropriate on-the-job training, guidelines for adequate supervision, standards and appropriate ratios for the use of pharmacy technicians. Improper use of pharmacy technicians is subject to the reporting requirements of ORS 689.455.

(5) The mixing of intravenous admixtures by pharmacy technicians working under the supervision, direction and control of a pharmacist is authorized and does not constitute the practice of pharmacy by the pharmacy technicians.

(6) Any person who is found to have unlawfully engaged in the practice of pharmacy is guilty of a Class A misdemeanor.

SECTION 10. (1) Section 1 of this 2022 Act and the amendments to ORS 677.080, 677.135, 678.021, 679.025, 680.020, 683.020, 685.020 and 689.225 by sections 2 to 9 of this 2022 Act become operative on January 1, 2023.

(2) The Oregon Board of Dentistry, Oregon Board of Naturopathic Medicine, Oregon Board of Optometry, Oregon Medical Board, Oregon State Board of Nursing and State Board of Pharmacy may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the boards to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the boards by section 1 of this 2022 Act and the amendments to ORS 677.080, 677.135, 678.021, 679.025, 680.020, 683.020, 685.020 and 689.225 by sections 2 to 9 of this 2022 Act.

SECTION 11. This 2022 Act takes effect on the 91st day after the date on which the 2022 regular session of the Eighty-first Legislative Assembly adjourns sine die.

Passed by House February 21, 2022

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

.....
Dan Rayfield, Speaker of House

Passed by Senate February 28, 2022

.....
Peter Courtney, President of Senate

Received by Governor:

.....M.,....., 2022

Approved:

.....M.,....., 2022

.....
Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2022

.....
Shemia Fagan, Secretary of State

Board of Dentistry Draft rule HB 4096

OAR 818-021-XXXX Temporary Practice Approval

1) A dentist, dental therapist or dental hygienist may practice, without compensation and in connection with a coordinating organization or other entity, the health care profession that the health care practitioner is authorized to practice for a maximum of 30 days each calendar year without licensure requirement. Compensation is defined as something given or received as payment including but not limited to bartering, tips, monies, donations, or services.
2) A dentist, dental therapist or dental hygienist is not required to apply for licensure or other authorization from the Board in order to practice under this rule.
3) To practice under this rule, a dentist, dental therapist or dental hygienist shall submit, at least 10 days prior to commencing practice in this state, to the Board:
   (a) Out-of State volunteer application;
   (b) Proof that the practitioner is in good standing and is not the subject of an active disciplinary action;
   (c) An acknowledgement that the practitioner may provide services only within the scope of practice of the health care profession that the practitioner is authorized to practice and will provide services pursuant to the scope of practice of Oregon or the health care practitioner's licensing agency, whichever is more restrictive;
   (d) An attestation from dentist or hygienist that the practitioner will not receive compensation for practice in this state;
   (e) The name and contact information of the dental director of the coordinating organization or other entity through which the practitioner will practice; and
   (f) The dates on which the practitioner will practice in this state.
   Failure to submit (a)-(e) above will result in non-approval.
4) Misrepresentation as to information provided in the application for the temporary practice approval may be grounds to open a disciplinary investigation that may result in discipline under OAR 818-012-0060.
5) Practitioner acknowledges they are subject to the laws and rules governing the health care profession in Oregon and that the practitioner is authorized to practice and are subject to disciplinary action by the Board.
6) A practitioner who is authorized to practice in more than one other jurisdiction shall provide to the Board proof from the National Practitioner Data Bank and their other state licensing Board that the practitioner is in good standing and not subject to any active disciplinary actions in any jurisdiction in which the practitioner is authorized to practice.

OFFICE OF THE SECRETARY OF STATE
SHEMIA FAGAN
SECRETARY OF STATE

CHERYL MYERS
DEPUTY SECRETARY OF STATE

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OBD 2-2021
CHAPTER 818
OREGON BOARD OF DENTISTRY

FILING CAPTION: The Board approved these five rule changes at its 10/22/2021 Board Meeting.

EFFECTIVE DATE: 07/01/2022

AGENDA APPROVED DATE: 10/22/2021

CONTACT: Stephen Prisby
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Suite #770
Portland,OR 97201

Filed By:
Stephen Prisby
Rules Coordinator

RULES:
818-012-0005, 818-021-0010, 818-021-0011, 818-021-0017, 818-021-0060

AMEND: 818-012-0005

NOTICE FILED DATE: 08/30/2021

RULE SUMMARY: A dentist must meet certain requirements to place dental implants and also complete seven (7) hours of continuing education requirements each licensure period.

CHANGES TO RULE:

818-012-0005
Scope of Practice ¶

(1) No dentist may perform any of the procedures listed below:¶
(a) Rhinoplasty;¶
(b) Blepharoplasty;¶
(c) Rhytidectomy;¶
(d) Submental liposuction;¶
(e) Laser resurfacing;¶
(f) Browlift, either open or endoscopic technique;¶
(g) Platysmal muscle plication;¶
(h) Otoplasty;¶
(i) Dermabrasion;¶
(j) Hair transplantation, not as an isolated procedure for male pattern baldness; and¶
(k) Harvesting bone extra orally for dental procedures, including oral and maxillofacial procedures.¶
(2) Unless the dentist:¶
(a) Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by the American Dental Association, Commission on Dental Accreditation (CODA), or¶
(b) Holds privileges either:¶
(A) Issued by a credentialing committee of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to perform these procedures in a hospital setting; or¶
(B) Issued by a credentialing committee for an ambulatory surgical center licensed by the State of Oregon and accredited by either the JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC).¶

(3) A dentist may utilize Botulinum Toxin Type A and dermal fillers to treat a condition that is within the scope of the practice of dentistry after completing a minimum of 20 hours in a hands on clinical course(s), which includes both Botulinum Toxin Type A and dermal fillers, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). ¶
(4) A dentist may place endosseous implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE), by the American Dental Association Continuing Education Recognition Program (ADA CERP) or by a Commission on Dental Accreditation (CODA) approved graduate dental education program.¶
(5) A dentist placing endosseous implants must complete at least seven (7) hours of continuing education related to the placement and or restoration of dental implants every licensure renewal period (Effective July 1, 2022).
Statutory/Other Authority: ORS 679, 680
Statutes/Other Implemented: ORS 679.010(2), 679.140(1)(c), 679.140(2), 679.170(6), 680.100

AMEND: 818-021-0010

NOTICE FILED DATE: 08/30/2021

RULE SUMMARY: Prior to initial licensure an applicant must complete a one hour pain management course as specified in rule.

CHANGES TO RULE:

818-021-0010
Application for License to Practice Dentistry ¶

(1) An applicant to practice general dentistry, in addition to the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of:¶
(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association; or¶
(b) Having graduated from a dental school located outside the United States or Canada, completion of a predoctoral dental education program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and¶
(c) Certification of having passed the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination.¶
(2) An applicant who has not met the educational requirements for licensure may apply for examination if the Dean of an accredited school 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, or 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 school accredited by the Commission on Dental Accreditation of the American Dental Association.¶
(5) Prior to initial licensure, an applicant must complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).
Statutory/Other Authority: ORS 670, 679
Statutes/Other Implemented: ORS 679.060, 679.065, 679.070, 679.080

AMEND: 818-021-0011

NOTICE FILED DATE: 08/30/2021

RULE SUMMARY: Prior to initial licensure an applicant must complete a one hour pain management course as specified in rule.

CHANGES TO RULE:

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

(1) The Oregon Board of Dentistry may grant a license without further examination to a dentist who holds a license to practice dentistry in another state or states if the dentist meets the requirements set forth in ORS 679.060 and 679.065 and submits to the Board satisfactory evidence of:¶
(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association; or¶
(b) Having graduated from a dental school located outside the United States or Canada, completion of a predoctoral dental education program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or completion of a postdoctoral General Dentistry Residency program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; and¶
(c) Having passed the dental clinical examination conducted by a regional testing agency, by a state dental licensing authority, by a national testing agency or other Board-recognized testing agency; and¶
(d) Holding an active license to practice dentistry, without restrictions, in any state; including documentation from the state dental board(s) or equivalent authority, that the applicant was issued a license to practice dentistry, without restrictions, and whether or not the licensee is, or has been, the subject of any final or pending disciplinary action; and¶
(e) Having conducted licensed clinical practice in Oregon, other states or in the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately preceding application. Licensed clinical practice could include hours devoted to teaching by dentists employed by a dental education program in a CODA accredited dental school, with verification from the dean or appropriate administration of the institution documenting the length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dentistry, and any adverse actions or restrictions; and¶
(f) Having completed 40 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.¶
(2) Applicants must pass the Board's Jurisprudence Examination.¶
(3) Prior to initial licensure, an applicant must complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).¶
(4) A dental license granted under this rule will be the same as the license held in another state; i.e., if the dentist holds a general dentistry license, the Oregon Board will issue a general (unlimited) dentistry license. If the dentist holds a license limited to the practice of a specialty, the Oregon Board will issue a license limited to the practice of that specialty. If the dentist holds more than one license, the Oregon Board will issue a dental license which is least restrictive.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.060, 679.065, 679.070, 679.080, 679.090

AMEND: 818-021-0017

NOTICE FILED DATE: 08/30/2021

RULE SUMMARY: Prior to licensure an applicant must complete a one hour pain management course as specified in rule.

CHANGES TO RULE:

818-021-0017
Application to Practice as a Specialist ¶

(1) A dentist who wishes to practice as a specialist in Oregon, who does not have a current Oregon license, in addition to meeting the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of:¶
(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association and active licensure as a general dentist in another state. Licensure as a general dentist must have been obtained as a result of the passage of any clinical Board examination administered by any state or regional testing agency;¶
(b) Certification of having passed the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination; and¶
(c) Proof of satisfactory completion of a post-graduate specialty program accredited by the Commission on Dental Accreditation of the American Dental Association. ¶
(d) Passing the Board's jurisprudence examination.¶
(2) A dentist who graduated from a dental school located outside the United States or Canada who wishes to practice as a specialist in Oregon, who does not have a current Oregon license, in addition to meeting the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of:¶
(a) Completion of a post-graduate specialty program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, proficiency in the English language, and evidence of active licensure as a general dentist in another state obtained as a result of the passage of any clinical Board examination administered by any state or regional testing agency; or¶
(b) Completion of a post-graduate specialty program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, proficiency in the English language and certification of having successfully passed the clinical examination administered by any state or regional testing agency within the five years immediately preceding application; and¶
(c) Certification of having passed the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination; and¶
(d) Passing the Board's jurisprudence examination; and¶
(e) Completion of a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).¶
(3) An applicant who meets the above requirements shall be issued a specialty license upon:¶
(a) Passing a specialty examination approved by the Board within the five years immediately preceding application; or¶
(b) Passing a specialty examination approved by the Board greater than five years prior to application; and¶
(A) Having conducted licensed clinical practice in the applicant's postdoctoral dental specialty in Oregon, other states or in the Armed Forces of the United States, the United States Public Health Service or the United States Department of Veterans Affairs for a minimum of 3,500 hours in the five years immediately preceding application. Licensed clinical practice could include hours devoted to teaching the applicant's dental specialty by dentists employed by a dental education program in a CODA-accredited dental school, with verification from the dean or appropriate administration of the institution documenting the length and terms of employment, the applicant's duties and responsibilities, the actual hours involved in teaching clinical dentistry in the specialty applicant is applying for, and any adverse actions or restrictions; and;¶
(B) Having completed 40 hours of continuing education in accordance with the Board's continuing education requirements contained in these rules within the two years immediately preceding application.¶
(4) Any applicant who does not pass the first examination for a specialty license may apply for a second and third regularly scheduled specialty examination. If the applicant fails to pass the third examination for the practice of a recognized specialty, the applicant will not be permitted to retake the particular specialty examination until he/she has attended and successfully passed a remedial program prescribed by a dental school accredited by the Commission on Dental Accreditation of the American Dental Association and approved by the Board.¶
(5) Licenses issued under this rule shall be limited to the practice of the specialty only.

Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.140, 679.060, 679.065, 679.070, 679.080 679.090

AMEND: 818-021-0060

NOTICE FILED DATE: 08/30/2021

RULE SUMMARY: Clarifies that all dentists must complete pain management course prior license renewal and that at least seven (7) hours of continuing education every renewal period are required to place dental implants.

CHANGES TO RULE:

818-021-0060
Continuing Education - Dentists ¶

(1) Each dentist must complete 40 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.¶
(2) Dentists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dentists is April 1 through March 31.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.¶
(3) Continuing education includes:¶
(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.¶
(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than 12 hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)¶
(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course includes an examination and the dentist passes the examination.¶
(d) Continuing education credit can be given for volunteer pro bono dental services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Examinations taken after initial licensure; a recognized specialty examination taken after initial licensure; or test development for clinical dental, dental hygiene or specialty examinations. No more than 6 hours of credit may be in these areas.¶
(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than four hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.¶
(5) A<u>t each renewal, a</u>ll dentists licensed by the Oregon Board of Dentistry will complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority~~. All applicants or licensees shall complete this requirement by January 1, 2010 or within 24 months of the first renewal of the dentist's license~~ <u>(Effective July 1, 2022)</u>.¶
(6) At least two (2) hours of continuing education must be related to infection control.¶
(7) At least two (2) hours of continuing education must be related to cultural competency (Effective January 1, 2021).¶
<u>(8) A dentist placing endosseous implants must complete at least seven (7) hours of continuing education related to the placement of dental implants every licensure renewal period (Effective July 1, 2022).</u>
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.250(9)

OBD Staff Internal Position Statement:

Historically, dentists have received training in the surgical placement of implants in a variety of different ways. Beginning July 1, 2022, Oregon dentists will be required to complete 56 hours of hands-on clinical implant course(s), at an appropriate postgraduate level, prior to surgically placing dental implants. The OBD recommends that proof of meeting the training requirements be maintained indefinitely, as copies may be requested at random audits or complaint investigations.

Graduates of specialty training programs in OMS, Periodontics, and Prosthodontics that follow CODA standard 4 curriculum guidelines (or similar educational requirements) that have been trained to competency in surgical implant placement may qualify to surgically place implants with documentation of the required training.

Accredited universities, independent study clubs, formal mentoring agreements, and dental product manufactures may also offer hands on implant training on surgical placement. However, only hours completed as part of CODA-accredited graduate dental programs, or through education providers that are AGD PACE or ADA CERP-approved will qualify to meet the initial 56-hour training requirement.

FAQs for Dental Implants:

What language (effective July 1, 2022) was added to the Scope of Practice Rule OAR 818-012-0005?

> **(4) A dentist may place endosseous implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE), by the American Dental Association Continuing Education Recognition Program (ADA CERP) or by a Commission on Dental Accreditation (CODA) approved graduate dental education program.**
> **(5) A dentist placing endosseous implants must complete at least seven (7) hours of continuing education related to the placement and or restoration of dental implants every licensure renewal period (Effective July 1, 2022.)**

What language (effective July 1, 2022) was added to the Continuing Education requirements of OAR 818-021-0060?

> **(8) A dentist placing endosseous implants must complete at least seven (7) hours of continuing education related to the placement of dental implants every licensure renewal period (Effective July 1, 2022.)**

I obtained my Oregon dental license prior to July 1, 2022. Am I required to take 56 hours of hands on clinical implant course(s) prior to placing dental implants?

Yes. The Oregon Board of Dentistry investigated 82 dental implants cases between February 2014 and August 2017. Of those cases, 41% resulted in Disciplinary Action, which was equally distributed between specialists and general practitioners. In order to effectively protect the public, the OBD has implemented new requirements to ensure that all Oregon-licensed dentists placing implants have the necessary skills, training, and knowledge. If you have already completed the required training hours, the OBD recommends that you obtain a letter of verification, signed by your training director, certifying that you have completed the required training as stated in the rule. The OBD recommends you maintain easily accessible copies of that documentation throughout your career in Oregon.

I obtained my Oregon dental license on, or after, July 1, 2022. Am I required to take 56 hours of hands on clinical implant course(s) prior to placing dental implants?

Yes. Once you have completed the 56 hours of hands on clinical course(s), or if you have already completed the required training hours, the OBD recommends that you obtain a letter of verification, signed by your training director, certifying that you have completed the required training as stated in the rule. The OBD recommends that you maintain easily accessible copies of that documentation throughout your career in Oregon.

I just completed a CODA-accredited specialty program, a GPR, or AEGD program. Does this automatically qualify me to surgically place dental implants in Oregon?

No. If you completed hands-on clinical implant training as part of completing a CODA-accredited specialty program, GPR, or AEGD program, and the training meets the requirements included in the rule, you may count those hours towards the 56 hours of hands on clinical course(s) required by the rule. As with all implant training, you would need to maintain specific documentation of completion of the required training, such as a letter from the Program Director or Chair certifying that you completed the required training, as stated in the rule, as part of your CODA-accredited specialty program(s), GPR, or AEGD program(s).

I have not completed the required 56 hours of hands on clinical implant course(s). Can I continue to provide bone grafts in extraction sites, sinus lift procedures, and periodontal surgical procedures related to implants?

A dentist can continue to perform implant site development procedures related to dental implants, as long as they have the proper training and skill. The quality and type of bone grafts, soft tissue grafts, or other related procedures, are expected to meet clinical standards equivalent to the training standards of a specialist. Complications with implant site development, implant placement, and sinus lift procedure are another frequent area of litigation.

I have completed the required 56 hours of hands on clinical implant course(s). Can I harvest extraoral bone for my implant placement?

Under OAR 818-012-0005(2), only dentists that have successfully completed a CODA-accredited OMS specialty residency may harvest bone extra orally. Additionally, dentists who hold privileges issued by a credentialling committee of a JCAHO-accredited hospital or AAAHC-accredited ambulatory surgical center may harvest bone extra orally in the hospital or ambulatory surgical center setting.

Can I place endosteal implants, transosteal implants, subperiosteal implants, zygomatic implants, interim implants, mini-implants, eposteal implants, TADs (temporary anchorage devices), or other future technical advancements?

You still need to complete the required 56 hours of hands on clinical course(s) related to surgical implant placement, regardless of the terminology you are using.

What kind of ongoing CE is required once I meet the initial qualification to surgically place implants? Does this CE need to be AGD PACE or ADA CERP approved?

A dentist placing endosseous implants must complete at least seven (7) hours of continuing education related to the placement and/or restoration of dental implants every licensure renewal period. Effective July 1, 2022, you must complete a minimum of seven hours of CE related to surgical placement of implants as set forth in ORS 818-021-0060. The seven hours of CE required for each renewal cycle needs does not necessarily need to be AGD PACE or ADA CERP approved.

I completed a residency in OMS, Periodontics, or Prosthodontics, do I still need to take the CE related to the placement and/or restoration of dental implants every license renewal?

Yes. Seven hours of CE related to the placement and/or restoration of dental implants will also need to be completed every licensure renewal period. The implant placement

surgeon is expected to complete ongoing CE every licensure period to stay current with the therapeutic practice of implants.

Staff recommends the Board move these rule changes and recommendations to the next regularly scheduled Licensing, Standards, and Competency Committee meeting for further review and discussion.

1. **STAFF RECOMMENDATION – RULE CHANGE**

OAR 818-012-0005 – Scope of Practice

(4) A dentist may place endosseous **or other dental** implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical **dental implant** course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is **a Commission on Dental Accreditation (CODA)-accredited graduate dental education program, or a provider that has been** approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE), **or** by the American Dental Association Continuing Education Recognition Program (ADA CERP) ~~or by a Commission on Dental Accreditation (CODA) approved graduate dental education program~~.

(5) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement and**/**or restoration of dental implants every licensure renewal period. (Effective July 1, 2022.)

OAR 818-021-0060 – Continuing Education-Dentists

(8) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement **and/or restoration** of dental implants every licensure renewal period (Effective July 1, 2022.)

2. **STAFF RECOMMENDATION – RULE CHANGE**:
3.

OAR 818-012-0005 – Scope of Practice

(4) A dentist may place endosseous **or other dental** implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical **dental implant** course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is **a Commission on Dental Accreditation (CODA)-accredited graduate dental education program, or a provider that has been** approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE), **or** by the American Dental Association Continuing Education Recognition Program (ADA CERP) ~~or by a Commission on Dental Accreditation (CODA) approved graduate dental education program~~.

4. **STAFF RECOMMENDATION – RULE CHANGE**:

OAR 818-012-0005 – Scope of Practice

(4) A dentist may place endosseous **or other dental** implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical **dental implant** course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is **a Commission on Dental Accreditation (CODA)-accredited graduate dental education**

program, or a provider that has been approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE), **or** by the American Dental Association Continuing Education Recognition Program (ADA CERP) ~~or by a Commission on Dental Accreditation (CODA) approved graduate dental education program~~.

(5) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement and**/**or restoration of dental implants every licensure renewal period. (Effective July 1, 2022.)

OAR 818-021-0060 – Continuing Education-Dentists
(8) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement **and/or restoration** of dental implants every licensure renewal period (Effective July 1, 2022.)

5. **STAFF RECOMMENDATION - CLEAN-UP**: Small changes to bring the phrasing included in OAR 818-012-0005 and OAR 818-021-0060 into agreement.

OAR 818-012-0005 – Scope of Practice
(4) A dentist may place endosseous **or other dental** implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical **dental implant** course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is **a Commission on Dental Accreditation (CODA)-accredited graduate dental education program, or a provider that has been** approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE), **or** by the American Dental Association Continuing Education Recognition Program (ADA CERP) ~~or by a Commission on Dental Accreditation (CODA) approved graduate dental education program~~.

(5) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement and**/**or restoration of dental implants every licensure renewal period. (Effective July 1, 2022.)

OAR 818-021-0060 – Continuing Education-Dentists
(8) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement **and/or restoration** of dental implants every licensure renewal period (Effective July 1, 2022.)

6. **CONSIDERATION – NO CHANGE RECOMMENDED**:

OAR 818-012-0005 – Scope of Practice
(4) A dentist may place endosseous **or other dental** implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical **dental implant** course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is **a Commission on Dental Accreditation (CODA)-accredited graduate dental education program, or a provider that has been** approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE), **or** by the American Dental Association Continuing Education Recognition Program (ADA CERP) ~~or by a Commission~~

~~on Dental Accreditation (CODA) approved graduate dental education program~~. **Evidence of completion of the required training must be provided to the Board upon request.**

(5) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement and/or restoration of dental implants every licensure renewal period. (Effective July 1, 2022.)

OAR 818-021-0060 – Continuing Education-Dentists

(8) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement **and/or restoration** of dental implants every licensure renewal period (Effective July 1, 2022.)

7. **QUESTION ABOUT BOARD INTENT – NO CHANGE RECOMMENDED**:

OAR 818-012-0005 – Scope of Practice

(4) A dentist **first licensed in Oregon after July 1, 2022** may place endosseous **or other dental** implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical **dental implant** course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is **a Commission on Dental Accreditation (CODA)-accredited graduate dental education program, or a provider that has been** approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE), **or** by the American Dental Association Continuing Education Recognition Program (ADA CERP) ~~or by a Commission on Dental Accreditation (CODA) approved graduate dental education program~~. **Evidence of completion of the required training must be provided to the Board upon request.**

(5) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement and/or restoration of dental implants every licensure renewal period. (Effective July 1, 2022.)

OAR 818-021-0060 – Continuing Education-Dentists

(8) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement **and/or restoration** of dental implants every licensure renewal period (Effective July 1, 2022.)

CORRESPONDENCE

From: Carly Olynyk <carly@ptifa.com>
Sent: Wednesday, March 9, 2022 2:20 PM
To: PRISBY Stephen * OBD <Stephen.PRISBY@obd.oregon.gov>; stephen.prisby@state.or.us <stephen.prisby@state.or.us>
Subject: Standard for Facial Esthetic Therapies

Stephen,

I hope this email finds you well. I wanted to reach out in regards to the guidelines for Oregon dentists wanting to practice botulinum toxin and dermal fillers and see if the Board was aware of the Canadian "Standard for Facial Esthetic Therapies" (attached to this email)?

In 2014, the Alberta Dental Association & College (ADA&C) developed the "Standard for Facial Esthetic Therapies" in Canada. Their goal was a tiered and gated program which ensured practitioners achieved a high level of proficiency prior to learning more advanced techniques. Since then, many provinces and Colleges have adopted their Standard. The Standard is based on the minimum requirements for patient care for practitioner proficiency and competency. Numerous training programs have applied to the ADA&C for accreditation, however they do not meet the hours of training/criteria required in the Standard. In 2019, Cayton did a report for the BC Minister of Health. Cayton established that there can only be one level of patient care – that is the highest. Is the Oregon Board of Dentistry aware of the 2014 Canadian Standard in Facial Esthetic Therapies and the 2019 Cayton Report?

I understand the Board is scheduled to meet on April 22nd. Would it be possible to have them review the enclosure and hear their comments?

Thank you and I look forward to hearing from you,

--

Carly Olynyk, BBA carly@ptifa.com
Executive Director

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The Pacific Training Institute for Facial Aesthetics & Therapeutics www.ptifa.com

Recognized Provider: *Canadian Standard of Practice for Facial Aesthetics & ADA CERP*

818-012-0005

Scope of Practice

(1) No dentist may perform any of the procedures listed below:

(a) Rhinoplasty;

(b) Blepharoplasty;

(c) Rhytidectomy;

(d) Submental liposuction;

(e) Laser resurfacing;

(f) Browlift, either open or endoscopic technique;

(g) Platysmal muscle plication;

(h) Otoplasty;

(i) Dermabrasion;

(j) Hair transplantation, not as an isolated procedure for male pattern baldness; and

(k) Harvesting bone extra orally for dental procedures, including oral and maxillofacial procedures.

(2) Unless the dentist:

(a) Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by the American Dental Association, Commission on Dental Accreditation (CODA), or

(b) Holds privileges either:

(A) Issued by a credentialing committee of a hospital accredited by the Joint Commission on

Accreditation of Healthcare Organizations (JCAHO) to perform these procedures in a hospital setting; or

(B) Issued by a credentialing committee for an ambulatory surgical center licensed by the State of Oregon and accredited by either the JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC).

(3) A dentist may utilize Botulinum Toxin Type A and dermal fillers to treat a condition that is within the scope of the practice of dentistry after completing a minimum of 20 hours in a hands on clinical course(s), which includes both Botulinum Toxin Type A and dermal fillers, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP).

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.010(2), 679.140(1)(c), 679.140(2), 679.170(6) & 680.100

Hist.: OBD 6-2001, f. & cert. ef. 1-8-01; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 3-2013, f. 10-24-13, cert. ef. 1-1-14; OBD 6-2014, f. 7-2-14, cert. ef. 8-1-2014; OBD 2-2016, f. 11-2-16, cert. ef. 3-1-17, OBD 2-2019, f. 10/29/2019, cert. ef. 1/1/2020

alberta dental association + college

Standard of Practice:

Facial Esthetic Therapies and Adjunctive Procedures

Introduction

The Standard of Practice: Facial Esthetic Therapies and Adjunctive Procedures applies to dentists who are administering Schedule 1 drugs such as neuromodulators (e.g. Botulinum Toxin Type A), dermal fillers, other agents (injected and/or topical) and adjunctive non-surgical and/or surgical therapies used to provide comprehensive therapeutic and esthetic oral and maxillofacial treatment for the restoration of a patient's appearance in form and function or to enhance their appearance, or both.

The Alberta Dental Association and College will issue a certificate based on the level of competency achieved for all dentists providing the levels of treatment described by this Standard. The Alberta Dental Association and College will maintain a list of approved programs at each level.

The Alberta Dental Association and College will review educational programs, teaching faculty, and/or training materials to determine if those educational and training programs and faculty satisfy the requirements of this Standard. All educational program faculty must be registered in the province of Alberta to provide such level of training, if such program is provided in the province of Alberta.

Dentists are advised that the core competencies and treatment levels are not all encompassing. In particular, bruxism and myofascial pain and dysfunction are complex and distinctly different diagnoses that may require multiple treatment levels that include but are not limited to neuromodulators.

Dentists must also realize that facial esthetic therapies and adjunctive procedures are constantly changing and dynamic in their application. The dentist is cautioned that new and emerging therapies may not be described or contained within this Standard. Thus, dentists are required to consult with the Alberta Dental Association and College before administering any such new or emerging therapies or adjunctive procedure for both esthetic and non-esthetic therapies.

Any prescription or administration of the Schedule 1 drugs, esthetic procedures or therapies discussed herein without acquiring the appropriate level of training and without adhering to this Standard is not permitted; failure to comply with the this Standard may constitute unprofessional conduct (per Health Professions Act 1(1)(pp)(ii)).

Dentists are advised that although neuromodulators (like most pharmacological agents) have many off-label uses supported by research, the limitation of procedures to those encompassed by this Standard and the dentist's training remains paramount. Further, patients must be specifically advised when an off-label use is being suggested and a discussion of all associated risks must occur.

Standard of Practice

1. Dentists may only prescribe or administer the agents or provide the adjunctive therapeutic and esthetic procedures in this Standard under the following circumstances (which hold whether the dentist is the primary care provider or a treating dentist via referral):

   - The patient is a "patient of record" within their dental practice, with full documentation and workup, including history, clinical examination, and photographs;
   - The esthetic or adjunctive treatment is part of a comprehensive dentofacial/maxillofacial treatment plan;
   - The patient has received a comprehensive dental/head and neck examination and treatment of primary dental disease is ongoing or completed;
   - The patient has completed a full and current dental and medical health history and has been assessed to be a suitable candidate for the recommended treatment or prescription;
   - The patient's emotional health has been assessed by the dentist and their motivation, goals, concerns and hopes for treatment have been established and documented;
   - Informed consent has been obtained for all treatments, prescriptions and/or therapies including a discussion with the patient with respect to benefits, risks, post-operative care, sequelae and potential complications;
   - The dentist is familiar with all other potential treatment and adheres to their level of training and expertise when providing appropriate therapies/care;
   - The dentist is responsible for continual reassessment and follow-up; and
   - The dentist is familiar with the limitations and emergency situations that may occur with the administration of any agent administered or therapy provided.

2. Treatment Levels

Level 1: Applied Anatomy Review and Introduction to Neuromodulators

This mandatory review will refresh and strengthen the dentist's knowledge of head and neck anatomy, its relevancy to the administration and pharmacology of neuromodulators (e.g. Botulinum Toxin Type A) and to other esthetic and non-esthetic therapies and procedures.

Level 1 does not authorize the dentist to provide any patient treatment in administering neuromodulators, dermal fillers, or other esthetic pharmaceutical agents or adjunctive therapies.

Level 2: Basic Neuromodulators: Upper Face and Bruxism Treatment

Level 2 will allow the use of neuromodulators for the superficial muscles of the upper face and for bruxism treatment of the dentist's own patients. This level is limited to: the frontalis muscle, the glabellar complex, procerus, the corrugators supercilii, and orbicularis oculi. For the treatment of bruxism, this level is limited to injection of temporalis and masseter.

Level 3: Advanced Neuromodulators: Mid-Face and Lower Face/Neck Regions and Myofascial Pain and Dysfunction Treatment

Level 3 will allow the dentist to provide advanced neuromodulator administration for mid and lower face and neck regions and for myofascial pain and dysfunction

treatment. In addition to those muscles in level 2, this level allows dentists to treat: levator labii superioris alaeque nasi, levator labii superioris, nasalis, zygomaticus major and minor, risorius, levator and depressor anguli oris, buccinator, orbicularis oris, levator and depressor labii superioris, mentalis and platysma. Treatment protocols for migraine and myofascial pain and dysfunction may be undertaken at this level if encompassed by the dentist's training.

Level 4: 4a - Dermal Fillers: Basic Facial Dermal Fillers
4b - Dermal Fillers: Advanced Facial Dermal Fillers
4N - Neuromodulators for Deep Muscles of Mastication
Level 4 will introduce the dentist to:

- 4a - Dermal fillers – the need for and use of dermal fillers for the treatment of the naso-labial fold, lip augmentation, and gingival augmentation
- 4b – Dermal fillers – the need for and use of dermal fillers in other areas of the face, including but not limited to: malar enhancement, treatment of the nasojugal groove, and the treatment of glabellar, laugh and marionette lines
- 4N - Neuromodulator treatment for deep muscles of mastication – review of deep muscle injections for temporomandibular joint dysfunction/ Myofascial Pain Dysfunction which includes deep muscles of mastication (e.g. medial and lateral pterygoid muscles)

The 4a/b and 4N streams are distinct and complex entities; dentists must only provide treatments specific to their training and expertise, in either 4a/b or 4N or both, and specific to their Alberta Dental Association and College certification. Dentists must complete level 4a before undertaking level 4b training.

Level 5: Advanced Non-Surgical Esthetic Procedures
This level covers advanced non-surgical esthetic procedures for qualified Oral and Maxillofacial Surgeons only.

This level may include but is not limited to: extraoral lasers, intense pulsed light (IPL) dermal therapies, dermabrasion, chemical peels, hair removal, injectable fat dissolving agents (eg. Deoxycholic acid) and eyelash growth stimulating agents.

Level 6: Advanced Surgical Esthetic Procedures
This level covers advanced surgical esthetic procedures for qualified Oral and Maxillofacial Surgeons only.

This level may include but is not limited to: soft tissue/hard tissue esthetic procedures for the head and neck region, hair transplants, rhinoplasty, blepharoplasty, face lifts, liposuction, and fat and blood product transfers.

3. Dentists cannot assign the administration of neuromodulators, dermal fillers, other agents (injected and/or topical) and adjunctive non-surgical and/or surgical therapies used to provide comprehensive therapeutic and esthetic oral and maxillofacial treatment for the restoration of a patient's appearance in form and function or to enhance their appearance, or both:

a. to any staff member or employee unless they are registered with a professional regulatory authority within the Province of Alberta that allows for this restricted activity
    i. the staff member or employee must meet the requirements of the regulatory authority to administer, formulate or dispense such agents, therapies or procedures.
b. to another registered Alberta healthcare provider unless the dentist delegating the procedure is also authorized by the Alberta Dental Association and College to provide the treatment/procedures assigned. A healthcare provider administering treatment assigned on a dentist's behalf in a dental clinical setting must at minimum conform in all aspects to this Standard of Practice and the Alberta Dental Association and College Standard of Practice for Infection Prevention and Control, and are additionally bound by any relevant higher Standard of their regulatory authority.

4. Dentists are not permitted to provide any level of treatment in stand-alone or mobile spas, esthetic studios, hair salons, fairs or expositions, or private residences or similar. These procedures are adjunctive to the regular provision of dental services and as such must be provided in a recognized and approved dental facility/clinical setting on patients of record.

5. The dentist is responsible to refer cases whose complexity exceeds their training to appropriately trained healthcare professionals.

6. Dentists are obligated to maintain continuity of care for their patients outside of office hours and to provide emergency care for their patients. If this obligation cannot be met, it is the dentist's responsibility to arrange such care with a practitioner of equivalent or higher qualifications. This responsibility extends to patients receiving the treatment levels discussed herein.

7. Dentists wishing to administer the agents or provide the adjunctive therapeutic and esthetic procedures outlined in this Standard are required to apply to the Alberta Dental Association and College for each individual level of treatment.

8. Dentists must be in possession of the appropriate Alberta Dental Association and College certificate before providing that level of treatment to their patients regardless of certificates issued by educational program providers.

9. Dentists are required to complete approved, structured and gated levels of training before comprehensive use of neuromodulators, dermal fillers and esthetic therapies or procedures is permitted.

10. A dentist cannot move to a subsequent level of treatments/therapies without completing the requirements of the previous level.

11. It is the dentist's responsibility to ensure that any education or training program undertaken in preparation for prescribing or administering any Schedule 1 drug, or to provide any related adjunctive esthetic or therapeutic procedures, is approved by the Alberta Dental Association and College.

12. Before a dentist can proceed to the next level of treatment they must have at least 20 documented treatments on different patients, including pre and post-treatment

photographs, during a minimum one-year period of providing the current approved level of treatment to demonstrate substantial experience and competency within the level. Multiple treatments on the same patient do not count towards the 20 patient minimum.

13. Dentists are advised that records, such as pre and post-treatment photographs, which are above and beyond usual diagnostic records, are mandatory when providing these levels of treatment.

14. Dentists must demonstrate evidence of continuing education and core competencies in the field of facial esthetics and adjunctive procedures to maintain current standards and level of competency.

15. Oral and Maxillofacial Surgeons may provide any procedures contained herein, so long as their training encompassed said procedures.

16. Treatment Level 5 and 6 are restricted treatment levels that only Oral and Maxillofacial Surgeons may provide.

17. The dentist must maintain and have all records of patients treated available at all times if a review of these records are requested by the Alberta Dental Association and College.

alberta dental association + college

Guide for

Facial Esthetic Therapies and Adjunctive Procedures

Table of Contents

Introduction

The Guide for Facial Esthetic Therapies and Adjunctive Procedures is designed to ensure Alberta dentists are provided with the educational requirements and the core competency profiles for prescription and administration of Schedule 1 drugs such as neuromodulators (e.g. Botulinum Toxin Type A), dermal fillers, other agents (injected and/or topical) and adjunctive non-surgical and/or surgical therapies used to provide comprehensive therapeutic and esthetic oral and maxillofacial treatment for the restoration of a patient's appearance in form and function or to enhance their appearance, or both.

It is the dentists responsibility to ensure that any education or training program undertaken in preparation for prescribing or administering any Schedule 1 drug (or to provide any related adjunctive esthetic or therapeutic procedures) must provide them with the knowledge and skills to administer these drugs or provide the therapies as indicated in the Alberta Dental Association and College Standard of Practice: Facial Esthetic Therapies and Adjunctive Procedures.

The Alberta Dental Association and College will issue a certificate for the competency level achieved for dentists providing the levels of treatment described in the Standard of Practice: Facial Esthetic Therapies and Adjunctive Procedures.

For the purposes of standardized education and treatment experience, the administration of neuromodulators, dermal fillers, and other esthetic agents, including esthetic and therapeutic procedures, has been divided into six structured and gated levels. The Alberta Dental Association and College will maintain a list of approved programs at each level.

Dentists are advised that the core competencies and treatment levels contained herein are not all encompassing. In particular, bruxism and myofascial pain and dysfunction are complex and distinctly different diagnoses that may require multiple treatment levels that include but are not limited to neuromodulators. Therefore it is the dentist's responsibility to ensure that they possess the appropriate core competencies and training to establish a definitive diagnosis and recommend or provide appropriate and comprehensive care.

Dentists must also realize that facial esthetic therapies and adjunctive procedures are constantly changing and dynamic in their application. The dentist is cautioned that new and emerging therapies may not be described or contained within the Standard or Guide. Thus, dentists are required to consult with the Alberta Dental Association and College before administering any such new or emerging therapies or adjunctive procedure for both esthetic and non-esthetic therapies.

Dentists wishing to provide these services are required to apply to the Alberta Dental Association and College for each individual level of treatment.

Oral and Maxillofacial Surgeons may provide any procedures contained herein, so long as their training encompassed said procedures.

Regardless of certificates issued by educational program providers, dentists must be in possession of the appropriate Alberta Dental Association and College certificate before providing these levels of treatment to their patients.

Core Competencies by Training Level

Level 1: Applied Anatomy Review and Introduction to Neuromodulators

Level 1 educational programs do not permit a dentist to administer neuromodulators, dermal fillers, or other esthetic pharmaceutical agents or adjunctive therapies for patient treatment.

This mandatory review will refresh and strengthen the dentist's knowledge of head and neck anatomy, its relevancy to the administration and pharmacology of neuromodulators (e.g. Botulinum Toxin Type A) and to other esthetic and non-esthetic therapies and procedures.

The education format must include a minimum of a 4-hour anatomical and functional hands-on cadaver laboratory and an 8-hour didactic educational program. The didactic portion of this level may be met by either an online or lecture format outlining the functional anatomy of both the head and neck.

Successful completion of a Level 1 educational program requires the understanding and application of the following core competencies:

- Head, neck, and temporomandibular joint applied anatomy, masticatory, neck and facial muscles, nerves, skin, etc. including the neurophysiology, musculature and circulatory systems;
- Facial skeletal anatomical considerations and review of aging of the face;
- Patient assessment, consultation, documentation, and continuing care for use of neuromodulators;
- Patient evaluation for optimal esthetic and therapeutic outcomes;
- Integrating neuromodulators into dental and maxillofacial treatment plans;
- Indications and contraindications for extra-oral soft tissue esthetics;
- Safety and risk issues for neuromodulator therapy (such as Botulinum Toxin Type A);
- Management and treatment of possible complications; and
- Assessing patient for signs of body dysmorphic disorder or other relevant psychiatric conditions, recognizing when not to treat, and when to refer to an appropriate health care professional for counseling.

Successful completion of an approved Level 1 program is a prerequisite to take an approved Level 2 education program.

A dentist may take an approved Level 1 educational program with no application or notification required. Upon successful completion of the Level 1 educational program, a dentist must submit a letter of confirmation and/or certificate of completion to the Alberta Dental Association and College. Upon receipt of this documentation, the Alberta Dental Association and College will issue a Level 1 certificate authorizing the dentist to progress to an approved Level 2 educational program. In the event that a dentist wishes to take a Level 2 education program immediately following a Level 1 education program, the dentist may submit the application for a Level 2 Certificate along with the Level 1 and Level 2 educational credentials from the same approved educational provider simultaneously.

Level 2: Basic Neuromodulators: Upper Face and Bruxism Treatment

In the event that a dentist wishes to take a Level 2 program immediately following a Level 1 program, the dentist may submit the application for a Level 2 Certificate along with the Level 1 and Level 2 educational credentials from the same approved educational provider.

The curriculum for Level 2 education in neuromodulator clinical procedures for upper face and bruxism treatment includes specific instructions with demonstrated proficiency in didactic knowledge and live patient hands-on treatment. Live patient hands-on instruction includes demonstration and clinical treatment in the oral and maxillofacial areas on a model patient and must meet participation course guidelines. Practitioners must demonstrate competency in the safety aspects of facial esthetics pharmaceuticals use prior to using these pharmaceuticals on patients.

Level 2 education must include a minimum of at least 8 didactic hours and at least 8 hours involving direct participation in live treatment on a minimum of 6 patients. Clinical observation of treatment being rendered by others is insufficient for the requirements of this Standard.

In addition to all Level 1 core competencies, successful completion of a Level 2 educational program requires the understanding and application of the following enhanced core competencies:

- Patient Assessment and Evaluation
    - Diagnosis, documentation, treatment planning and proper dosing and delivery of neuromodulator treatment for both upper face and bruxism treatment;
    - Indications for other treatment;
    - Indications and contraindications for these techniques and pharmaceuticals;
    - Medical history taking as it relates to injected facial pharmaceuticals;
    - Practical patient evaluation for maxillofacial esthetic and therapeutic outcomes;
    - Pharmacology of injected oral and maxillofacial pharmaceutical treatment;
    - Etiology and types of bruxism, anatomic considerations in bruxism; and
    - Accepted treatment techniques including mapping of anatomical muscle sites, muscle depths, proper preparation and dilution for oral and maxillofacial esthetic and therapeutic outcomes.

- Safety and Risk Issues
    - Proper sterile technique as it relates to the use of injected pharmacologic agents and patient treatment;
    - Safety and risk issues for injected neuromodulator therapy;
    - Knowledge of adverse reactions and how to avoid adverse reactions; and
    - Management and treatment of adverse reactions including ptosis, vascular occlusion, and injection related complications.

- Treatment Planning and Delivery
    - Integrating neuromodulators into dental therapeutic and esthetic treatment plans;
    - Upper facial treatment procedures for therapeutic and esthetic maxillofacial outcomes;
    - Continued assessment of treatment and therapeutic outcomes and standardized patient photography;
    - Integrating neuromodulators with other treatments and therapies for the treatment of

bruxism;
    - Precise delivery of injected facial pharmaceuticals; and
    - Limitations of Level 2 treatments and recognizing need for higher level treatments and referral to qualified health care professionals.

- Practice Management
    - Provide customizable office forms and informed consent needed to begin treating patients;
    - Malpractice and jurisprudence issues;
    - Ethics in oral and maxillofacial esthetic procedures;
    - Understanding of team training in facial esthetics;
    - Patient education in facial esthetics in dentistry;
    - Record keeping and facial photographic documentation; and
    - Informed consent procedures for facial esthetics treatment.

A Level 2 certificate can only be issued after successful completion of a documented examination process. The dentist must submit a letter of confirmation and/or certificate of completion to the Alberta Dental Association and College. Upon receipt of this documentation, the Alberta Dental Association and College will issue a Level 2 certificate authorizing the dentist to provide Level 2 treatment to their patients. A certificate must be granted by the Alberta Dental Association and College and in the dentist's possession before providing Level 2 treatment to the dentist's own patients.

The dentist will need to demonstrate proficiency in Level 2 treatment for a minimum of one-year before progressing to the next level.

The dentist may, after the minimum one-year period, submit an application to proceed to Level 3 training. The dentist must have at least 20 documented treatments on different patients, including pre- and post-treatment photographs, during the minimum one-year period of providing Level 2 treatments to demonstrate substantial experience and competency within the level. Multiple treatments on the same patient do not count towards the 20 patient minimum.

This application must be approved by the Alberta Dental Association and College **before** commencing Level 3 training.

Level 3: Advanced Neuromodulators: Mid-Face and Lower Face/Neck Regions and Myofascial Pain and Dysfunction Treatment

A dentist wishing to take an approved Level 3 educational program must submit an application to the Alberta Dental Association and College **before** commencing Level 3 training.

This level of education represents an advanced level of clinical competency in safety and clinical use of injected facial pharmaceuticals in oral and maxillofacial esthetics and therapeutics. The curriculum for Level 3 education in neuromodulator clinical procedures for mid-face and lower face and neck regions and for myofascial pain and dysfunction includes specific instructions with demonstrated proficiency in didactic knowledge and live patient hands-on treatment. Live patient hands-on instruction includes demonstration and clinical treatment in the oral and maxillofacial areas on a model patient and must meet participation course guidelines. Practitioners must demonstrate competency in the safety aspects of facial esthetics pharmaceuticals use prior to using these pharmaceuticals on patients. These are the core competencies that define the Standard of Practice.

Level 3 education must include a minimum of at least 8 didactic hours and at least 8 hours involving direct participation in live treatment on a minimum of 6 patients. Clinical observation of treatment being rendered by others is insufficient for the requirements of this Standard.

In addition to all Level 1 and 2 core competencies, successful completion of a Level 3 educational program requires the understanding and application of the following enhanced core competencies:

- **Patient Assessment and Evaluation**
    - Diagnosis, documentation, treatment planning and proper dosing and delivery of neuromodulator treatment for mid-face and lower Face/Neck Regions and Myofascial Pain and Dysfunction Treatment;
    - Indications for other treatment;
    - Advanced applied anatomy of the oral and maxillofacial, lower face and anterior and posterior neck, including cranial base, and related structures;
    - Advanced education in injected facial pharmaceuticals;
    - Understanding of the latest neuromodulator pharmaceuticals and introduction to dermal fillers and how the two injected levels work in tandem (note: Level 4 is required to use dermal fillers);
    - Comprehensive and definitive diagnosis of myofascial pain and dysfunction;
    - Understanding of the precise skeletal and muscle anatomy involved in maxillary gingival excess;
    - Treating maxillary gingival excess (gummy smiles) with neuromodulators as an alternative treatment to surgical dental procedures;
    - Trigger point therapy for myofascial pain and dysfunction cases;
    - Advanced upper and mid-face procedures for esthetic and therapeutic maxillofacial and neck treatment;
    - Ability to test and treat hyperactive lower face muscles for dental/facial esthetics, orthodontic retention and removable prosthodontics retention with neuromodulators;
    - Advanced indications and contraindications of facial esthetics and therapeutics use in dentistry;
    - Neuromodulator therapeutic treatments for chronic migraine and facial pain; and

- Alternative methods of treatment through differential diagnosis and offering patients all available options for oral and maxillofacial esthetics and therapeutics, including referrals to other qualified health care professionals.

- Treatment Planning and Delivery
  - Avoidance and management of complications;
  - Neuromodulator therapeutic treatment of myofascial pain and dysfunction, facial pain, bruxism cases, hypertrophic masticatory musculature, etc.;
  - Integrating neuromodulators into a comprehensive treatment plan for treating definitively diagnosed myofascial pain;
  - Continued assessment of treatment and therapeutic outcomes and standardized patient photography; and
  - Limitations of Level 3 treatments and recognizing need for higher level treatments and referral to qualified health care professionals.

- Advanced Practice Management
  - Understanding of advanced team training in facial esthetics; and
  - Enhanced informed consent procedures for facial esthetics treatment.

A Level 3 certificate can only be obtained with successful completion of a documented examination process. A dentist must submit a letter of confirmation and/or certificate of completion as well as maintaining, for their personal records, a listing of the patient identifiers of their 20 different patient treatments at Level 2 cases and start/end dates for the treatment. Upon receipt of this documentation, the Alberta Dental Association and College will issue a Level 3 certificate authorizing the dentist to provide Level 3 treatment to their patients. A certificate must be granted by the Alberta Dental Association and College and in the dentist's possession before providing Level 3 treatment to the dentist's own patients.

The dentist will need to demonstrate proficiency in Level 3 treatment for a minimum of one-year before progressing to the next level.

The dentist may, after the minimum one-year period, submit an application to proceed to the Level 4a and/or 4N training. The dentist must have at least 20 documented treatments on different patients, including pre- and post-treatment photographs, during the minimum one-year period of providing Level 3 treatment to demonstrate substantial experience and competency within the level. Multiple treatments on the same patient do not count towards the 20 patient minimum.

This application must be approved by the Alberta Dental Association and College **before** commencing Level 4a and/or 4N training.

Level 4: 4a - Dermal Fillers: Basic Facial Dermal Fillers
4b – Dermal Fillers: Advanced Facial Dermal Fillers
4N- Neuromodulators for Deep Muscles of Mastication

A dentist wishing to take an approved Level 4 educational program must submit an application to the Alberta Dental Association and College **before** commencing Level 4a or 4N training. A dentist may choose to take a level 4a or 4N course, or both.

The dentist may, after the minimum one-year period, submit an application to proceed to the Level 4b training. The dentist must have at least 20 documented treatments on different patients, including pre and post-treatment photographs, during the minimum one-year period of providing Level 4a treatment to demonstrate substantial experience and competency within the level. Multiple treatments on the same patient do not count towards the 20 patient minimum.

These education levels will introduce the dentist to:

- 4a – Basic Facial Dermal Fillers
- 4b – Advanced Facial Dermal Fillers
- 4N - Neuromodulator treatment for deep muscles of mastication

These levels of education represent an advanced level of clinical competency in safety and clinical use of injected facial pharmaceuticals in oral and maxillofacial esthetics and therapeutics. The curriculum for Level 4 education in facial dermal fillers and neuromodulators for deep muscles of mastication includes specific instructions with demonstrated proficiency in didactic knowledge and live patient hands-on treatment. Live patient hands-on instruction includes demonstration and clinical treatment in the oral and maxillofacial areas on a model patient and must meet participation course guidelines. Practitioners must demonstrate competency in the safety aspects of facial esthetics pharmaceuticals use prior to using these pharmaceuticals on patients. These are the core competencies that define the Standard of Practice.

Each Level 4 educational level must include a minimum of at least 8 didactic hours and at least 8 hours involving direct participation in live treatment on a minimum of 6 patients. Clinical observation of treatment being rendered by others is insufficient for the requirements of this Standard.

In addition to all Level 1, 2 and 3 core competencies, successful completion of a Level 4 educational program requires the understanding and application of the following enhanced core competencies:

Level 4a core competencies:

- **Patient Assessment and Evaluation**
    - Diagnosis, documentation, treatment planning and proper dosing and delivery of dermal fillers;
    - Indications for other treatment;
    - Advanced oral and maxillofacial anatomy and injected facial pharmaceuticals (hands-on review of peri-oral facial anatomy and skin is recommended);
    - Advanced facial skeletal anatomical considerations, review of aging of the face; and
    - Comprehensive patient assessment for more advanced combination treatment with neuromodulators and dermal filler pharmaceuticals for oral and maxillofacial esthetic

and therapeutic cases.

- Advanced Facial Esthetics Treatment Planning and Delivery
    - Facial esthetic procedures in the oral and maxillofacial areas with injected facial pharmaceuticals in association with dental, prosthodontic, orthodontic, periodontal and maxillofacial reconstructive treatment;
    - Conservative lip enhancement procedures and avoidance of potential complications, enhancing the natural lip anatomy to create esthetic lip structures and proper smile lines;
    - Treating the nasolabial fold;
    - Adding volume to the interdental papilla and residual dental ridges using dermal fillers;
    - Limitations of Level 4a treatments and recognizing need for Level 5/6 treatments and referral to qualified health care professional; and
    - Understanding facial functional anatomy, aging and skin care to enhance treatment procedures.
    - Advanced dermal filler injection techniques including cross-hatching, scaffolding and bulk-filling;
    - treating the nasolabial fold, the lips, and the interdental papillae for dental and maxillofacial esthetics and therapeutics;
    - Continued assessment of treatment and therapeutic outcomes and standardized patient photography; and
    - Understanding advanced facial esthetic skin treatments.

- Comprehensive Treatment Objective and Non-surgical Techniques
    - Advanced indications and contraindications of facial esthetics and therapeutics use in oral and maxillofacial areas and their related structures;
    - Alternative methods of treatment through differential diagnosis and offering patients all available options for oral and maxillofacial esthetics and therapeutics;
    - Treatment sequence, patient management, post-operative instructions; and
    - Avoidance and management of complications.

- Advanced Practice Management
    - Enhanced office forms and/or documentation with appropriate informed consent needed to begin treating patients;
    - Understanding of advanced team training in facial esthetics; and
    - Enhanced patient education in facial esthetics in dentistry.

Level 4b core competencies

- Patient Assessment and Evaluation
    - Diagnosis, documentation, treatment planning and proper dosing and delivery of dermal fillers;
    - Indications for other treatment;
    - Advanced oral and maxillofacial anatomy and injected facial pharmaceuticals (hands-on review of peri-oral facial anatomy and skin is recommended);
    - Advanced facial skeletal anatomical considerations, review of aging of the face; and
    - Comprehensive patient assessment for more advanced combination treatment with neuromodulators and dermal filler pharmaceuticals for oral and maxillofacial

esthetic and therapeutic cases.

- Advanced Facial Esthetics Treatment Planning and Delivery
    - Facial esthetic procedures in the oral and maxillofacial areas with injected facial pharmaceuticals in association with dental, prosthodontic, orthodontic, periodontal and maxillofacial reconstructive treatment;
    - Smoothing lip lines and eliminating radial lip lines;
    - Enhancing the upper, mid and lower face using anatomical landmarks;
    - Limitations of Level 4b treatments and recognizing need for Level 5/6 treatments and referral to qualified health care professional; and
    - Understanding facial functional anatomy, aging and skin care to enhance treatment procedures.
    - Advanced dermal filler injection techniques including cross-hatching, scaffolding and bulk-filling;
    - Comprehensively treating the upper, mid, lower face and related structures for dental and maxillofacial esthetics and therapeutics;
    - Creating proper oral and maxillofacial contours with advanced lip sculpting, malar and sub-malar enhancements and glabellar treatment;
    - Continued assessment of treatment and therapeutic outcomes and standardized patient photography; and
    - Understanding advanced facial esthetic skin treatments.

- Comprehensive Treatment Objective and Non-surgical Techniques
    - Advanced indications and contraindications of facial esthetics and therapeutics use in oral and maxillofacial areas and their related structures;
    - Alternative methods of treatment through differential diagnosis and offering patients all available options for oral and maxillofacial esthetics and therapeutics;
    - Treatment sequence, patient management, post-operative instructions; and
    - Avoidance and management of complications.

- Advanced Practice Management
    - Enhanced office forms and/or documentation with appropriate informed consent needed to begin treating patients;
    - Understanding of advanced team training in facial esthetics; and
    - Enhanced patient education in facial esthetics in dentistry.

Level 4N core competencies:

- Patient Assessment and Evaluation
    - Diagnosis, documentation, treatment planning and proper dosing and advanced neuromodulator treatment;
    - Indications for other treatment;
    - Advanced oral and maxillofacial anatomy and injected facial pharmaceuticals (hands-on review of peri-oral facial anatomy and skin is recommended);
    - Advanced facial skeletal anatomical considerations, review of aging of the face; and
    - Comprehensive patient assessment for more advanced combination treatment with neuromodulators and dermal filler pharmaceuticals for oral and maxillofacial esthetic and therapeutic cases.

- Advanced Therapeutic Neuromodulator Treatment Planning and Delivery
    - Avoidance and management of complications;
    - Neuromodulator therapeutic treatment of myofascial pain and dysfunction, facial pain, bruxism cases, hypertrophic masticatory musculature, etc., with specific focus on the deep muscles of mastication
    - Integrating neuromodulators into a comprehensive treatment plan for treating definitively diagnosed myofascial pain;
    - Continued assessment of treatment and therapeutic outcomes and standardized patient photography; and
    - Limitations of Level 4b treatments and recognizing need for higher level treatments and referral to qualified health care professionals.

- Comprehensive Treatment Objective and Non-surgical Techniques
    - Advanced indications and contraindications of facial esthetics and therapeutics use in oral and maxillofacial areas and their related structures;
    - Alternative methods of treatment through differential diagnosis and offering patients all available options for oral and maxillofacial esthetics and therapeutics;
    - Treatment sequence, patient management, post-operative instructions; and
    - Avoidance and management of complications.

- Advanced Practice Management
    - Enhanced office forms and/or documentation with appropriate informed consent needed to begin treating patients;
    - Understanding of advanced team training in facial esthetics; and
    - Enhanced patient education in facial esthetics in dentistry.

A Level 4a and/or 4N certificate can only be obtained with successful completion of a documented examination process. A dentist must submit a letter of confirmation and/or certificate of completion of the Level 4a and/or 4N education program as well as maintaining, for their personal records, a listing of the patient identifiers of their 20 treatments on different Level 3 case patients and start/end dates for the treatment. Upon receipt of this documentation, the Alberta Dental Association and College will issue a Level 4a and/or 4N certificate authorizing the dentist to provide Level 4a and/or 4N treatment to their patients. A certificate must be granted by the Alberta Dental Association and College and in the dentist's possession before providing Level 4a and/or 4N treatment to the dentist's own patients.

A Level 4b certificate can only be obtained with successful completion of a documented examination process. A dentist must submit a letter of confirmation and/or certificate of completion of the Level 4b education program as well as maintaining, for their personal records, a listing of the patient identifiers of their 20 treatments on different Level 4a case patients and start/end dates for the treatment. Upon receipt of this documentation, the Alberta Dental Association and College will issue a Level 4b certificate authorizing the dentist to provide Level 4b treatment to their patients. A certificate must be granted by the Alberta Dental Association and College and in the dentist's possession before providing Level 4b treatment to the dentist's own patients.

The 4a/b and 4Nstreams are distinct and complex entities. Thus, dentists must only provide treatments specific to their training and expertise, in either 4a/b or 4N or both, and specific to their Alberta Dental Association and College certification.

Level 5: Advanced Non-Surgical Esthetic Procedures

This level covers advanced non-surgical esthetic procedures for qualified Oral and Maxillofacial Surgeons only.

This level may include but is not limited to: lasers, intense pulsed light (IPL) dermal therapies, dermabrasion, chemical peels, hair removal, injectable fat dissolving agents (eg. Deoxycholic acid) and eyelash growth stimulating agents.

Oral and Maxillofacial Surgeons must have suitable training and experience for any such Level 5 procedure they seek to provide.

In addition to all Level 1, 2, 3 and 4 core competencies, successful completion of a Level 5 educational program requires the understanding and application of the following enhanced core competencies:

- **Patient Assessment and Evaluation**
  - Diagnosis, documentation, treatment planning and proper dosing and delivery of Advanced Non-Surgical Esthetic Procedures;
  - Indications for other treatment;
  - Comprehensive patient assessment for Advanced Non-Surgical Esthetic Procedures; and
  - Advanced head and neck applied anatomical considerations.

- **Advanced Facial Esthetics Treatment Planning and Delivery**
  - Facial esthetic procedures in the oral and maxillofacial areas and related structures;
  - Limitations of Level 5 treatments and recognizing need for Level 6 treatments and referral to qualified health care professionals;
  - Understanding advanced facial functional anatomy, aging and skin care to enhance treatment procedures; and
  - Continued assessment of treatment and therapeutic outcomes and standardized patient photography.

- **Comprehensive Treatment Objective and Non-surgical Techniques**
  - Advanced indications and contraindications of facial esthetics and therapeutics use in oral and maxillofacial areas and their related structures;
  - Alternate methods of treatment through differential diagnosis and offering patients all available options for oral and maxillofacial esthetics and therapeutics;
  - Treatment sequence, patient management and postoperative instructions;
  - Avoidance and management of complications; and
  - Continued assessment of treatment and therapeutic outcomes and standardized patient photography.

- **Advanced Practice Management**
  - Enhanced office forms and/or documentation with appropriate informed consent needed to begin treating patients;
  - Understanding of advanced team training in facial esthetics; and
  - Enhanced patient education in facial esthetics.

Level 6: Advanced Surgical Esthetic Procedures

This level covers advanced surgical esthetic procedures for qualified Oral and Maxillofacial Surgeons only.

This level may include but is not limited to: soft tissue/hard tissue esthetic procedures for the head and neck region, hair transplants, rhinoplasty, blepharoplasty, face lifts, liposuction, and fat and blood product transfers.

Oral and Maxillofacial Surgeons must have suitable training and experience for any such Level 6 procedure they seek to provide. Successful completion of a Level 6 educational program requires the understanding and application of specific procedural core competencies relative to each applying dentist.

The core competencies at this level will be evaluated on an individual basis. This level includes but is not limited to: soft tissue/hard tissue esthetic procedures for the head and neck region, hair transplants, rhinoplasty, blepharoplasty, face lifts, liposuction and fat and blood product transfers.

Approved Education Programs

Level 1: Applied Anatomy Review and Introduction to Neuromodulators	
Approved Provider	*Course Name*
Pacific Training Institute *for* Facial Aesthetics Vancouver, BC	Level 1A - Applied Anatomy Review & Introduction to Botox® *(Online)* Level 1B - Anatomical & Functional Cadaver Laboratory* *Prerequisite: completion of Level 1A
University of Alberta Edmonton, AB	Level 1: Applied Anatomy Review and Introduction to Botulinum Toxin Type A
Vancouver Laser & Skin Care Centre Vancouver, BC	Level One: Applied Anatomy Review and Introduction to Neuromodulators

Level 2: Basic Neuromodulators: Upper Face and Bruxism Treatment	
Approved Provider	*Course Name*
Pacific Training Institute *for* Facial Aesthetics Vancouver, BC	Level 2 - Basic Botox®: Upper Face & Bruxism Treatment
University of Alberta Edmonton, AB	Level 2: Basic Neuromodulators: Upper Face and Bruxism Treatment
Vancouver Laser & Skin Care Centre Vancouver, BC	Level Two: Basic Neuromodulators: Upper Face and Bruxism Treatment

Level 3: Advanced Neuromodulators: Mid-Face and Lower Face/Neck Regions and Myofascial Pain and Dysfunction Treatment	
Approved Provider	*Course Name*
Pacific Training Institute *for* Facial Aesthetics Vancouver, BC	Level 3: Advanced Botox®: Mid-Face, Lower Face/Neck Region & Myofascial Pain & Dysfunction Treatment
University of Alberta Edmonton, AB	Level3: Advanced Neuromodulators: Mid-Face and Lower Face/Neck Regions and Myofacial Pain and Dysfunction Treatment

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OTHER ISSUES

From: Hooper, Marjorie G. <hooperm@ada.org>
Sent: Thursday, March 10, 2022 12:25 PM
Cc: Tooks, Sherin <tookss@ada.org>
Subject: CODA Winter 2022 Accreditation Actions - Notice

National, Regional, and Specialized Accreditors and State Boards of Dentistry:

In accordance with established policy of the Commission on Dental Accreditation and regulations of the United States Department of Education, please consider this notification that as a result of action taken by the Commission at its February 10-11, 2022 meeting, the following education programs have been notified of the Commission's "intent to withdraw accreditation" at its next regularly scheduled meeting on August 4-5, 2022 if these programs do not achieve compliance with accreditation standards or policy by that date:

Dental Hygiene
Mt. Hood Community College, Gresham, OR

Dental Laboratory Technology
McFatter Technical College, Davie, FL

Endodontics
Marquette University, Milwaukee, WI

Pediatric Dentistry
University of Mississippi Medical Center/Blair Batson Children's Hospital, Jackson MS

Predoctoral Dental Education
University of North Carolina at Chapel Hill, Chapel Hill, NC

In addition, the Commission recognized that the following programs have voluntarily discontinued their participation in the Commission's accreditation program:

Dental Assisting
Metropolitan Community College, Omaha, NE
Amarillo College, Amarillo, TX

Dental Hygiene
University of Southern California, Los Angeles, CA

General Practice Residency – 12 Months
Ellis Hospital, Schenectady, NY

Oral and Maxillofacial Surgery Clinical Fellowship - Craniofacial
University of Pittsburgh, Pittsburgh, PA

Oral and Maxillofacial Surgery Clinical Fellowship - Oncology
North Memorial Medical Center, Robbinsdale, MN

Oral and Maxillofacial Surgery Residency
Mount Sinai Hospital Medical Center, New York, NY

The following new programs have been granted accreditation:

Advanced Education in General Dentistry – 12 Months

University of Pennsylvania, Philadelphia, PA

Dental Hygiene
Hodges University, Fort Myers, FL
Salina Area Technical College, Salina, KS
MedQuest College, Louisville, KY
Germanna Community College, Locust Grove, VA

Dental Public Health
Jacobi Medical Center, Bronx, NY

General Practice Residency – 12 Months
Providence St. Peter Hospital, Olympia, WA

Orthodontics and Dentofacial Orthopedics
Hudson Regional Hospital, Secaucus, NJ (d.b.a. CTOR Academy, Hoboken, NJ)

Pediatric Dentistry
Cooper University Hospital, Camden, NJ

Predoctoral Dental Education
Kansas City University, Joplin, MO

The accreditation statuses of programs reviewed by the Commission on Dental Accreditation at its Winter 2022 meeting can be found at https://coda.ada.org/en/accreditation/accreditation-news/accreditation-notices

The accreditation statuses of all programs accredited by the Commission on Dental Accreditation can be found at https://coda.ada.org/en/find-a-program

You can also access the CODA-accredited program annual survey results at: https://coda.ada.org/en/find-a-program/program-surveys

If you have further questions regarding this information, please contact the Commission on Dental Accreditation. Thank you.

Marjorie Hooper hooperm@ada.org
Coordinator, CODA Operations
Office of the Director
Commission on Dental Accreditation (CODA)
312.440.4653 (office)
312.587.5107 (fax)

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

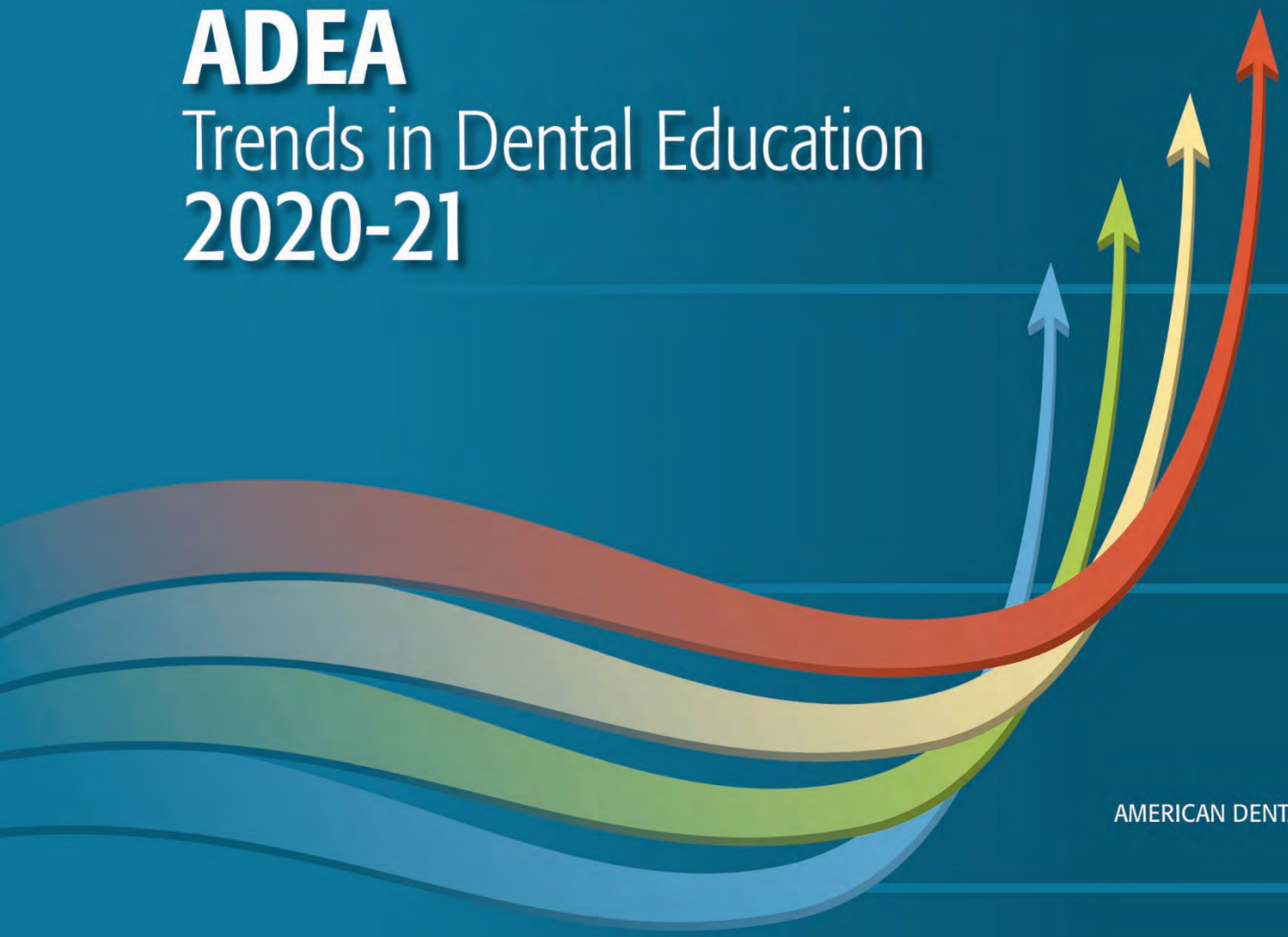
Disclaimer:

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.

NEWSLETTERS & ARTICLES OF INTEREST

ADEA | THE VOICE OF DENTAL EDUCATION

ADEA Trends in Dental Education 2020-21



AMERICAN DENTAL EDUCATION ASSOCIATION
adea.org/DentEdTrends

ADEA Is The Voice of Dental Education

ADEA's vision is a well-prepared and diverse oral health workforce improving the health of all individuals and communities. We lead and support the health professions community in preparing future-ready oral health professionals.

ADEA Trends in Dental Education 2020-21

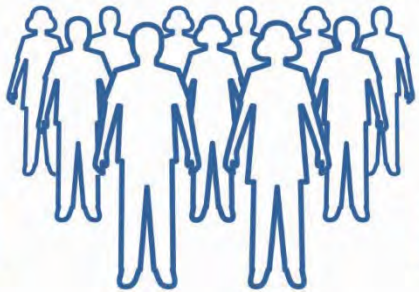
Our community encompasses:

- **78** U.S. and Canadian dental schools
- **800+** allied and advanced dental education programs
- **50+** corporations
- **18,000** individuals

ADEA is committed to:

- Research
- Recruitment
- Inclusion
- Diversity
- Advocacy
- Collaboration
- Innovation
- Leadership Development

…to benefit:



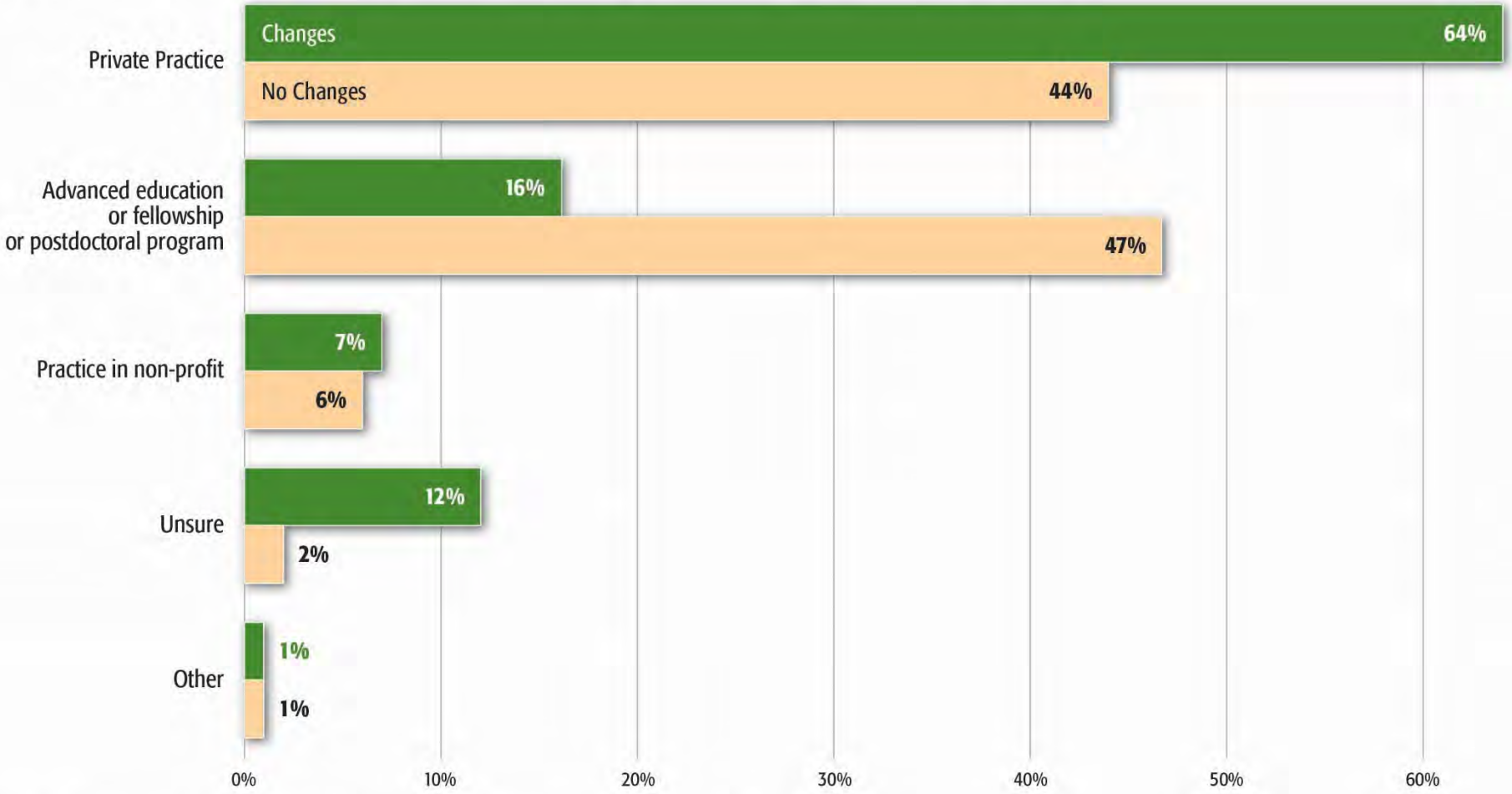
- Deans
- Program Directors
- Faculty and Students
- Corporate Community
- Administrators
- The Public

The Impact of a Global Pandemic on Dental Students' Professional Plans

ADEA Trends in Dental Education 2020-21

2020 was an unusual year. On March 11, 2020, the World Health Organization declared the novel coronavirus disease, COVID-19, a pandemic. Two days later, the United States declared a national emergency. In these uncertain times, dental education institutions stood steady in their mission to prepare the next generation of oral health professionals. When questioned about whether the pandemic influenced their plans, almost two thirds of seniors in the Class of 2020 who reported changes to their immediate post-graduation plans intended to go into private practice (changes could be within a category or to another category).

Percent of *2020* Respondents by Plans Upon Graduation and Changes to Professional Plans due to the COVID-19 Pandemic



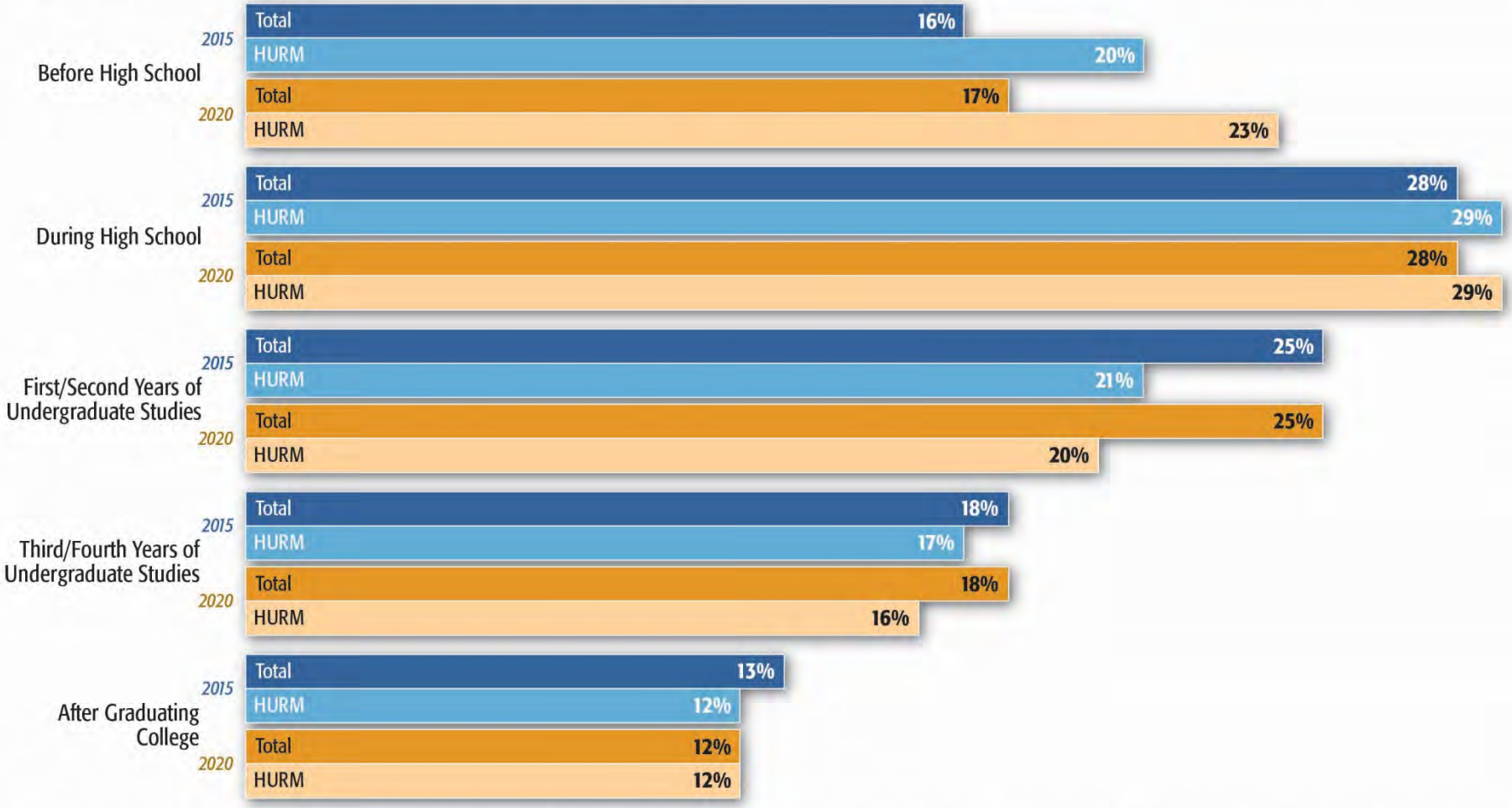
Note: "Other" category includes plans to teach in a dental program, other position in dentistry or a position not related to dentistry.
Source: American Dental Education Association, Survey of U.S. Dental School Seniors, *2020* Graduating Class.

More Students Decide Before College to Pursue Careers in Dentistry

ADEA Trends in Dental Education 2020-21

Almost half of the predoctoral senior students in the Class of 2020 who responded to the ADEA Survey of U.S. Dental School Seniors decided to become a dentist before going to college, more than in 2015. Historically underrepresented and marginalized (HURM) graduating students are even more likely to decide early to go to dental school. College was decision time for a future career in dentistry for a smaller proportion of students than those deciding before college.

Percent of Respondents by Timing of Decision to Pursue a Career in Dentistry, Total and HURM, *2015* and *2020*



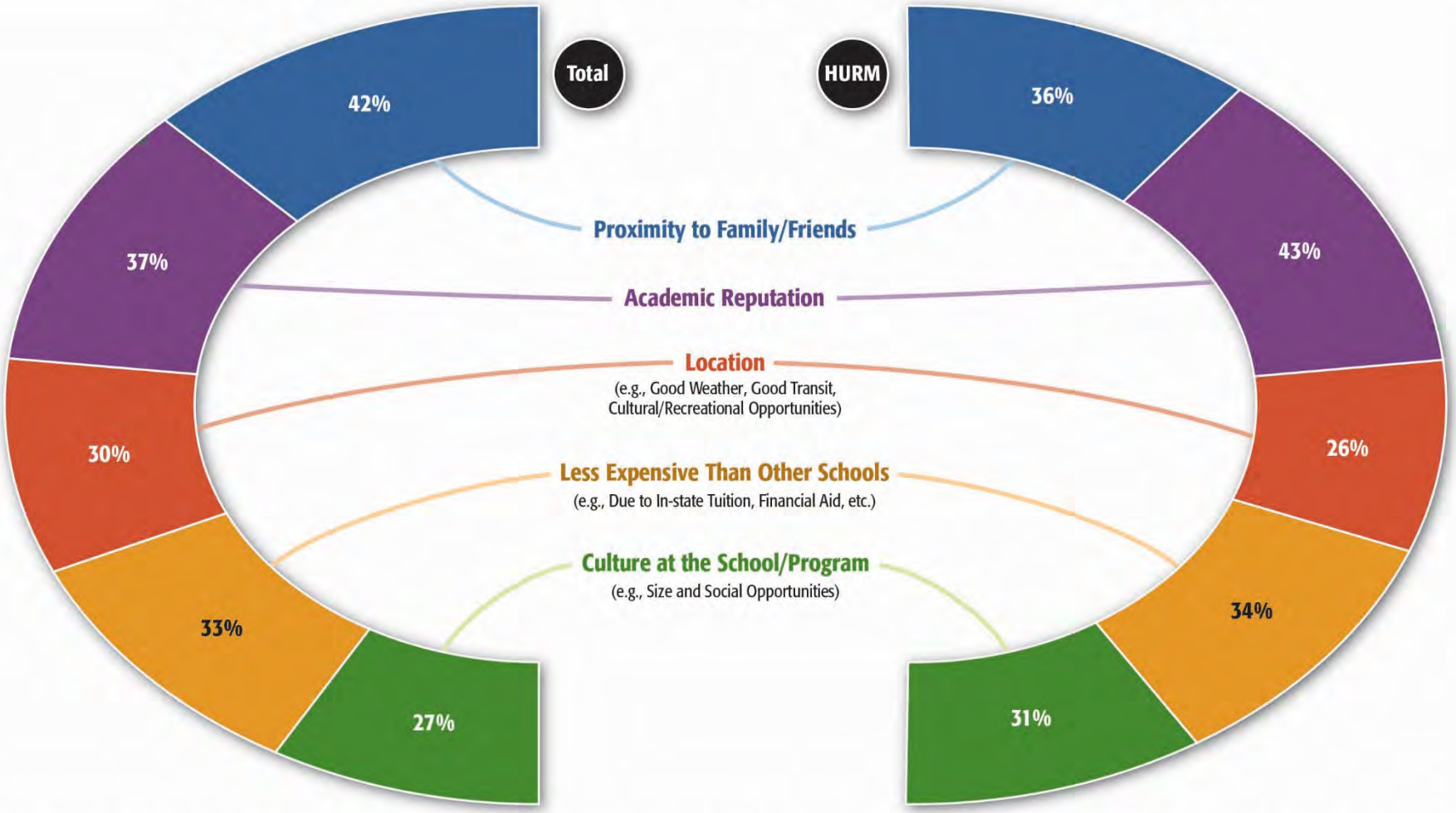
Note: HURM students include the following four race and ethnicity categories: African American, Hispanic or Latino, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander. These four race and ethnicity categories are defined by the U.S. Department of Education for reporting data from higher education institutions.
Source: American Dental Education Association, Surveys of U.S. Dental School Seniors, *2015* and *2020* Graduating Classes.

Top Five Reasons to Choose a Dental School

Either being close to family and friends or in a place with good weather, good transit and cultural/recreational opportunities, dental school location features prominently among the top three reasons predoctoral students choose a specific institution. Academic reputation is cited as a choice factor more often by historically underrepresented and marginalized (HURM) predoctoral senior students.

ADEA Trends in Dental Education 2020-21

Percent of Respondents Indicating the Reason as One of Their Top Three Selection Criteria, Total and HURM Students, *2020*



Note: HURM students include the following four race and ethnicity categories: African American, Hispanic or Latino, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander. These four race and ethnicity categories are defined by the U.S. Department of Education for reporting data from higher education institutions. Percentages add to more than 100% because respondents could select more than one answer choice.
Source: American Dental Education Association, Survey of U.S. Dental School Seniors, *2020* Graduating Class.

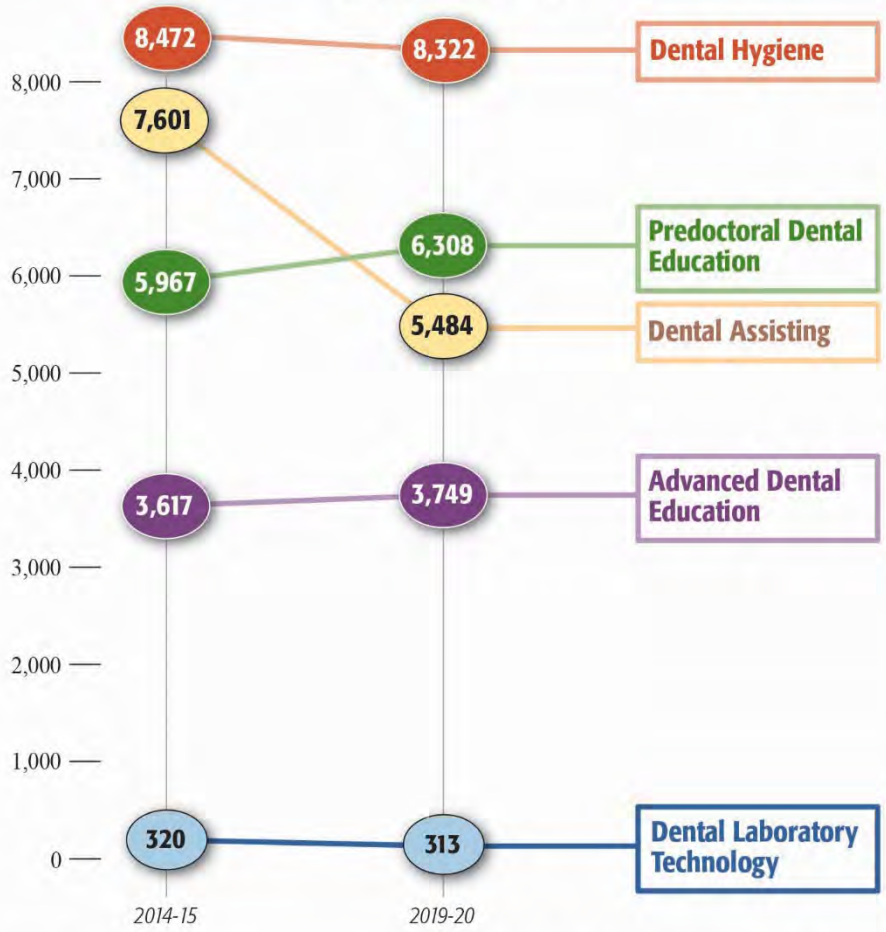
First-year Enrollments Vary by Dental Profession

Accredited predoctoral dental programs and advanced dental education programs have seen an increase in their first-year classes between 2014 and 2019. During the same period, the number of first-time enrollees at accredited allied dental education programs declined during the same period, mainly because of the drop in the number of accredited dental assisting programs and dental laboratory technology programs.

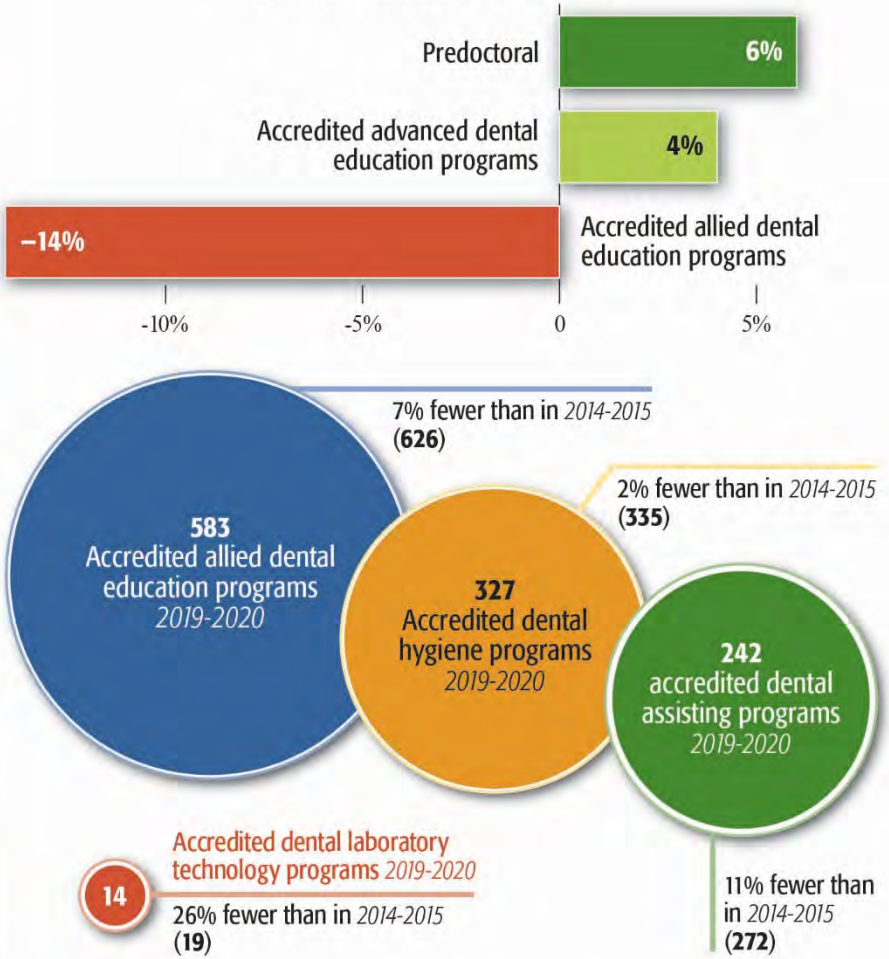
ADEA Trends in Dental Education 2020-21

Number of First-year Enrollees by Type of Dental Education

2014-2019 Entering Classes



5-year enrollment trend, *2014-2019*



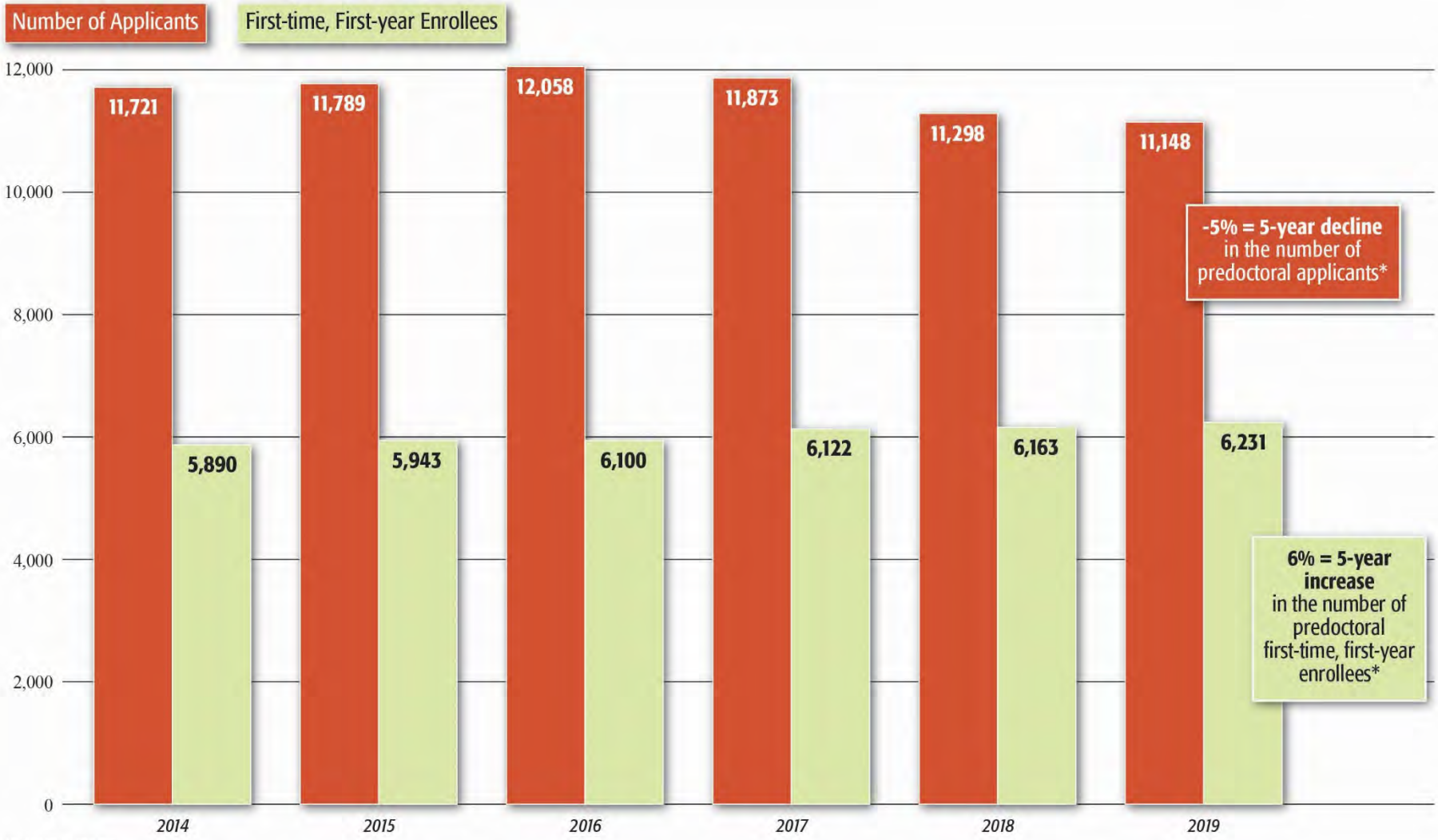
Notes: First-year enrollment for predoctoral students does not include repeaters. The American Dental Association does not specify if the first-year enrollment in allied dental education programs and advanced dental education programs represents only first-time enrollees or includes repeaters. A dental therapy program was accredited in October *2020*.

Source: Analysis of American Dental Association, Health Policy Institute, Surveys of Dental Education, Survey of Advanced Dental Education, Surveys of Dental Hygiene Education Programs, Surveys of Dental Assisting Education Programs, Survey of Dental Laboratory Technology Education Programs, *2014-15* to *2019-20*.

First-year Enrollments in Predoctoral Dental Programs Increase While Number of Applicants Declines

ADEA Trends in Dental Education 2020-21

First-time, first-year enrollment increased steadily between 2014 and 2019. Meanwhile, the number of applicants to predoctoral dental schools declined by 5% during the same period. As a result, the applicant to first-time, first-year enrollee ratio reached 1.79 in 2019, a level not seen since the 2000s.



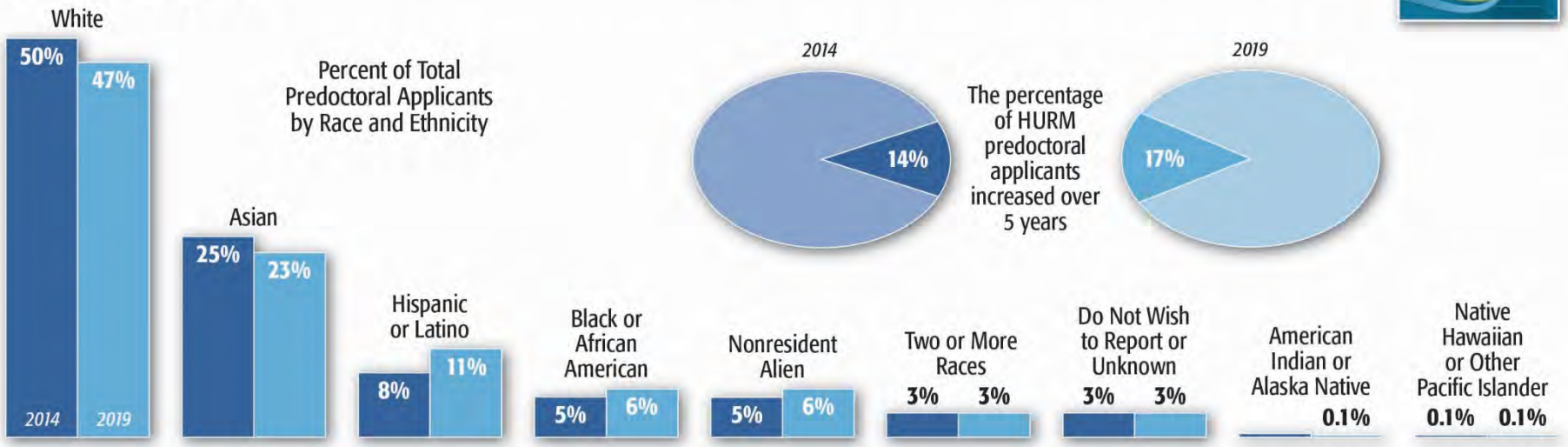
*between 2014-2019.

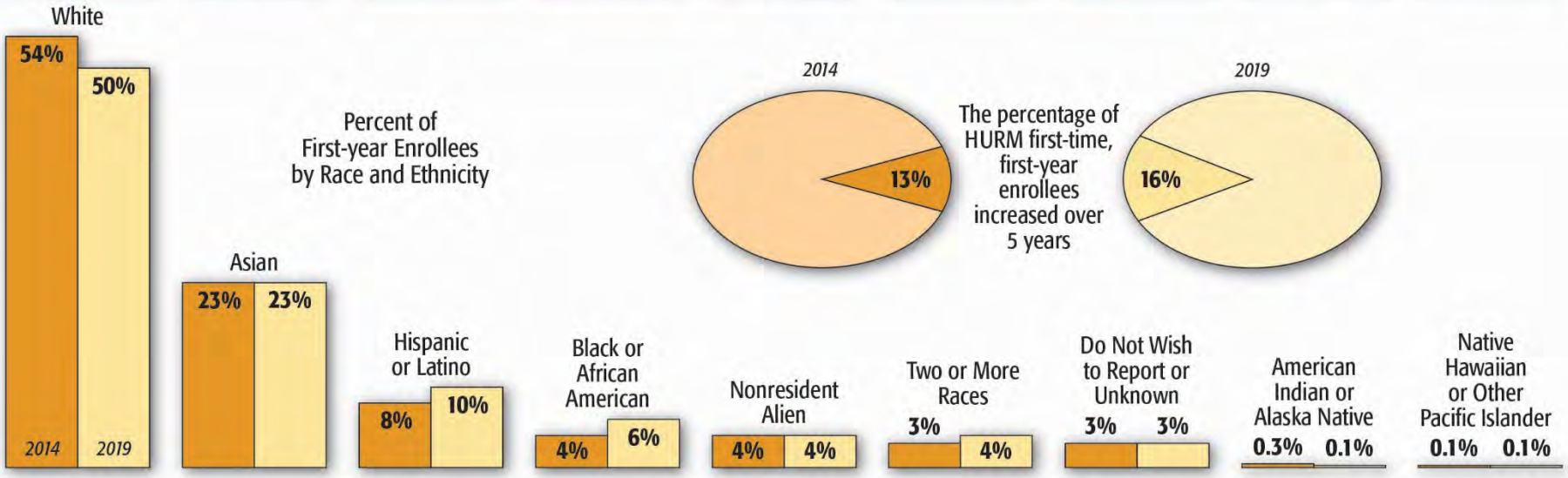
Source: American Dental Education Association, U.S. Dental School Applicants and Enrollees, 2014-2019.

Diversity Increases Among Applicants and First-year Enrollments

ADEA Trends in Dental Education 2020-21

Between 2014 and 2019, a larger share of the predoctoral applicant pool and first-year class was comprised of Hispanic, African American, two or more races and nonresident alien individuals. Historically underrepresented and marginalized (HURM) students are increasingly represented among applicants and in predoctoral first-year classes.





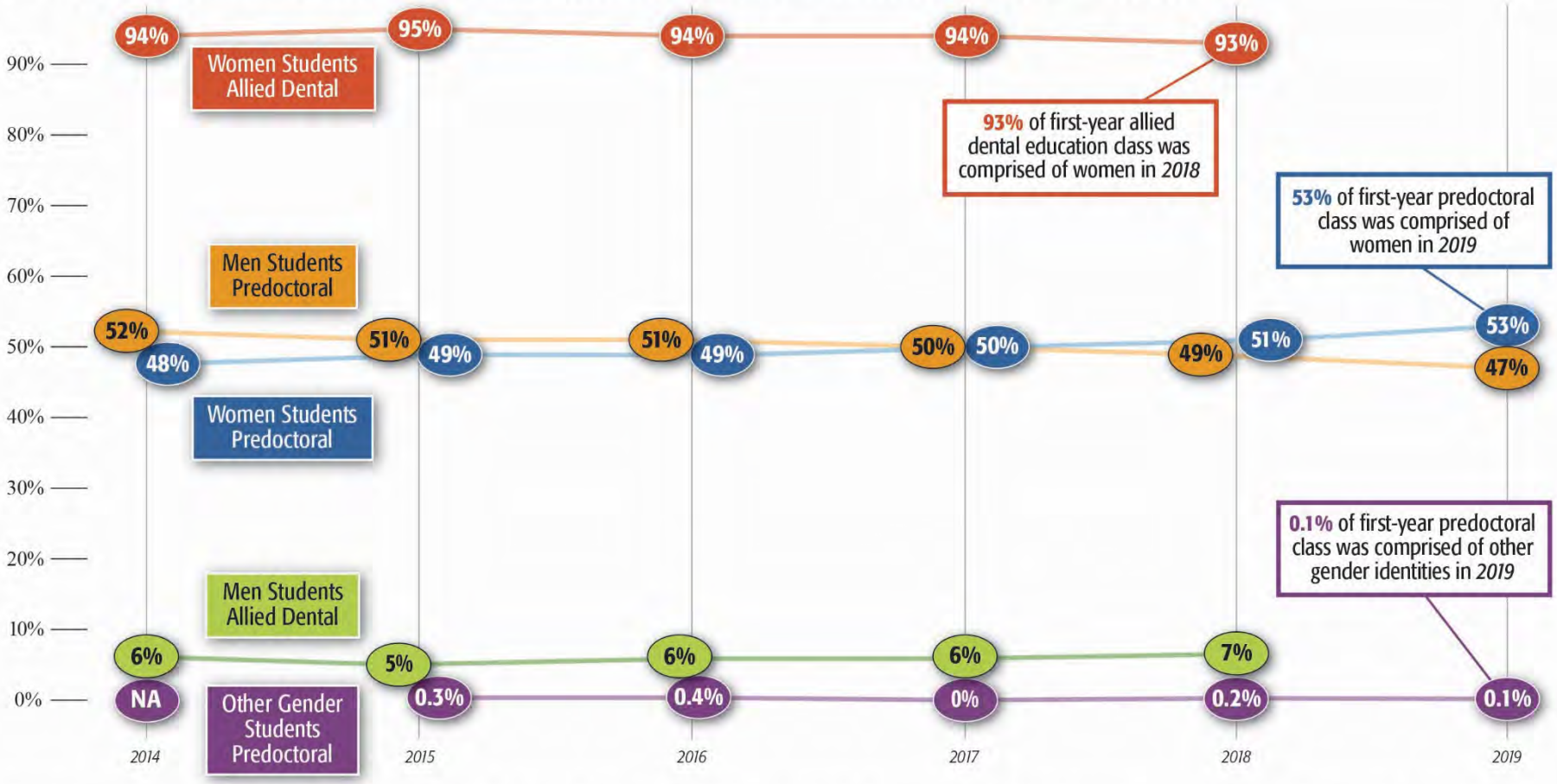
Note: HURM students include the following four race and ethnicity categories: African American, Hispanic or Latino, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander. These four race and ethnicity categories are defined by the U.S. Department of Education for reporting data from higher education institutions. Note: Percentages may not add up to 100% due to rounding.
Source: American Dental Education Association, U.S. Dental School Applicants and Enrollees, *2014-2019*.

Women Make up Majority of First-year Predoctoral and Allied Dental Students

ADEA Trends in Dental Education 2020-21

Women comprise the majority of the first-year class at predoctoral and accredited allied dental education programs. The proportion of women predoctoral dental students surpassed 50% of the entering class in 2018-19. Allied dental education programs continued to enroll mainly women in the first-year class over the past five years.

Percent of First-year Enrollment at Predoctoral Programs and at Accredited Allied Dental Education Programs by Gender, *2014-2019*



Notes: First-year enrollment for predoctoral students does not include repeaters. The American Dental Association (ADA) does not specify if the first-year enrollment in allied dental education programs represents only first-time enrollees or includes repeaters. In *2015-16* ADA introduced an "Other" gender category for predoctoral students who prefer not to report gender, do not identify as either male or female, or whose gender is not available. ADA reports only "male" and "female" for gender categories for first-year enrollment in allied dental education programs. At the time of the analysis, first-year class by gender for allied dental education programs was not available.

Source: Analysis of American Dental Association, Health Policy Institute, Surveys of Dental Education, *2014-2015* to *2019-20*. Surveys of Dental Hygiene Education Programs, Surveys of Dental Assisting Education Programs, Survey of Dental Laboratory Technology Education Programs, *2014-2015* to *2018-19*.

The Share of Women Faculty in Academic Dentistry Grows Slightly

Women are increasingly a larger proportion of faculty in dental schools and accredited allied dental education programs. At dental schools, the trend has been toward more women and a persistent share of faculty not wishing to report their gender or not identifying as either male or female. The faculty at accredited allied dental programs is overwhelmingly comprised of women and the proportion increased slightly in five years.

ADEA Trends in Dental Education 2020-21

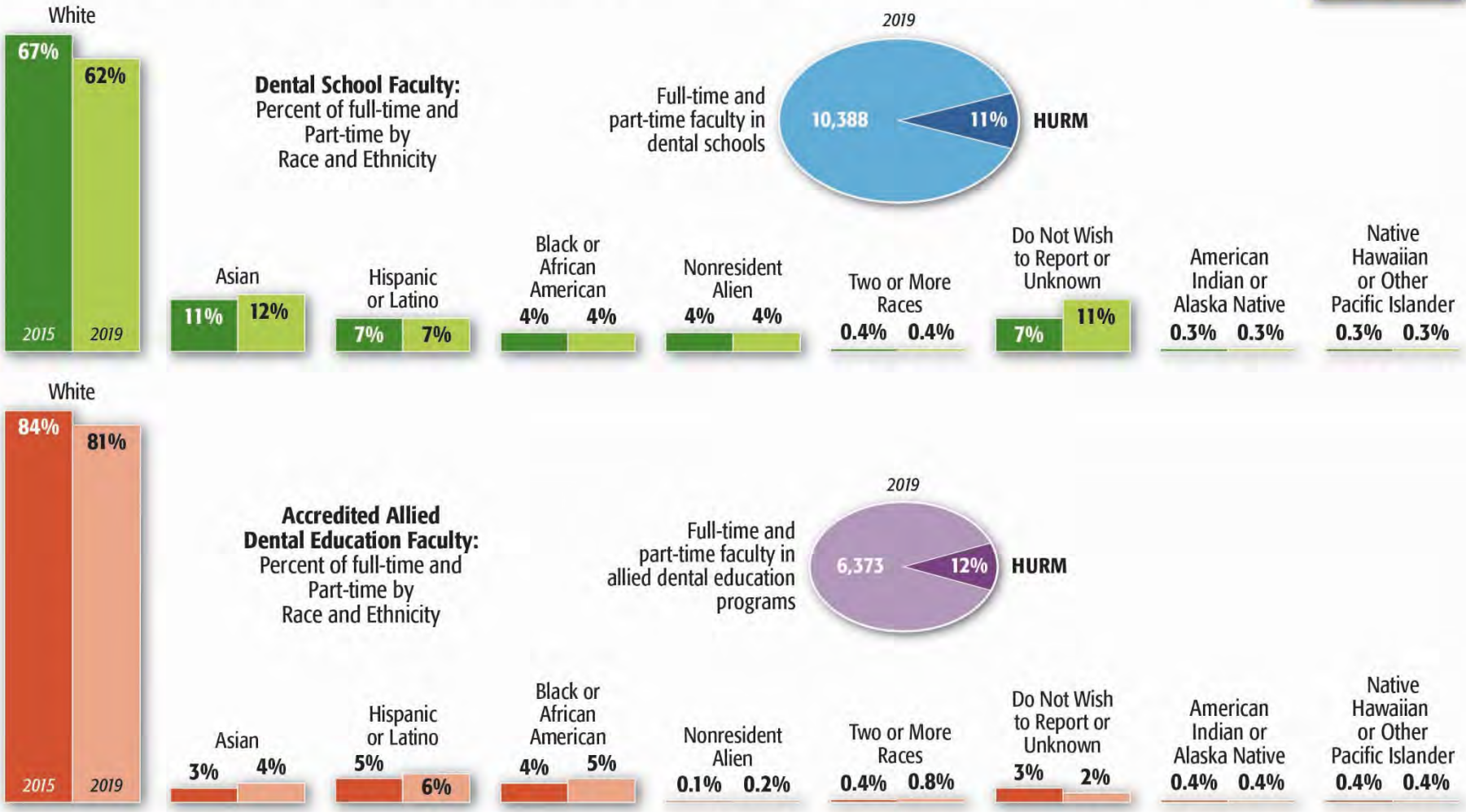
Percent of Full-time and Part-time Dental School and Accredited Allied Dental Education Faculty by Gender, *2014-15* to *2018-19* Academic Years

Notes: Dental school faculty includes faculty teaching predoctoral, allied dental and advanced dental education students at accredited U.S. dental schools. Therefore, there might be an overlap between the counts of dental school and allied dental education faculty. ADA reports only "male" and "female" gender categories for faculty at allied dental education programs. In *2015-16*, ADEA introduced an "other" gender category for faculty at dental schools who prefer not to report gender, do not identify as either male or female, or whose gender is not available.

Source: Analysis of American Dental Association, Health Policy Institute, Surveys of Dental Education, *2014-2015* to *2019-20*. Surveys of Dental Hygiene Education Programs, Surveys of Dental Assisting Education Programs, Surveys of Dental Laboratory Technology Education Programs, *2014-2015* to *2018-19*.

Diversity in Academic Dental Faculty Progressing Slowly

Between 2015 and 2019, the share of historically underrepresented and marginalized (HURM) faculty stayed relatively steady at dental schools, while it increased at accredited allied dental education programs. The number of Hispanics and African Americans increased in accredited allied dental school faculty. Dental schools saw an increase in the percentage of faculty not wishing to report race and ethnicity.



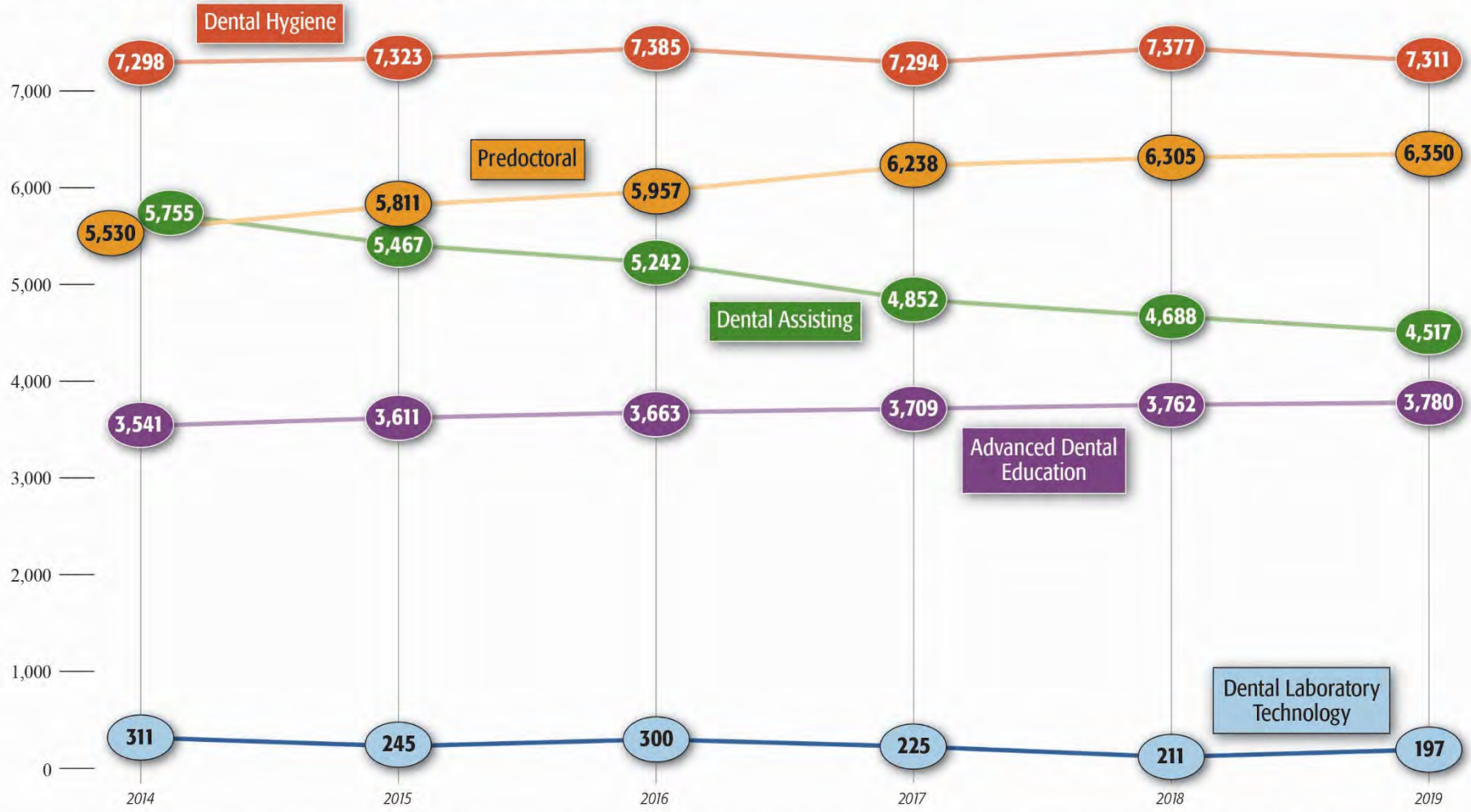
Notes: Dental school faculty includes faculty teaching predoctoral, allied dental and advanced dental education students at accredited dental schools in the United States. Therefore, there might be an overlap between the counts of dental school faculty and allied dental education faculty. HURM includes the following four race and ethnicity categories: African American, Hispanic or Latino, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander. These four race and ethnicity categories are defined by the U.S. Department of Education for reporting data from higher education institutions.

Sources: American Dental Education Association (ADEA) Survey of U.S. Dental School Faculty, *2014* and *2019*; Analysis of American Dental Association (ADA), Health Policy Institute, Surveys of Dental Hygiene Education Programs, Surveys of Dental Assisting Education Programs, Survey of Dental Laboratory Technology Education Programs, *2014-15* to *2018-19*.

Graduation Trends Vary Across Accredited Dental Education Programs

Accredited predoctoral dental education programs and advanced dental education programs saw rises in the number of graduates between 2014 and 2019. Meanwhile, the number of graduates at accredited allied dental education programs declined significantly between 2014 and 2019, mirroring the drop in the number of accredited dental assisting programs.

Number of Graduates by Type of Dental Education, *2014-2019* Graduating Classes



Source: Analysis of American Dental Association, Health Policy Institute, Surveys of Dental Education, Survey of Advanced Dental Education, Surveys of Dental Hygiene Education Programs, Surveys of Dental Assisting Education Programs, Survey of Dental Laboratory Technology Education Programs, *2014-15* to *2019-20*.

More Dental School Graduates Are Pursuing Advanced Education

ADEA Trends in Dental Education 2020-21

More dental schools seniors are planning to attend an advanced dental education program upon graduation, even though entering private practice remained the top professional choice in 2020. Historically underrepresented and marginalized (HURM) students are even more likely to attend advanced education, with private practice as the second most popular choice. Meanwhile, over the past five years, serving in the federal government has declined in popularity for predoctoral graduates.

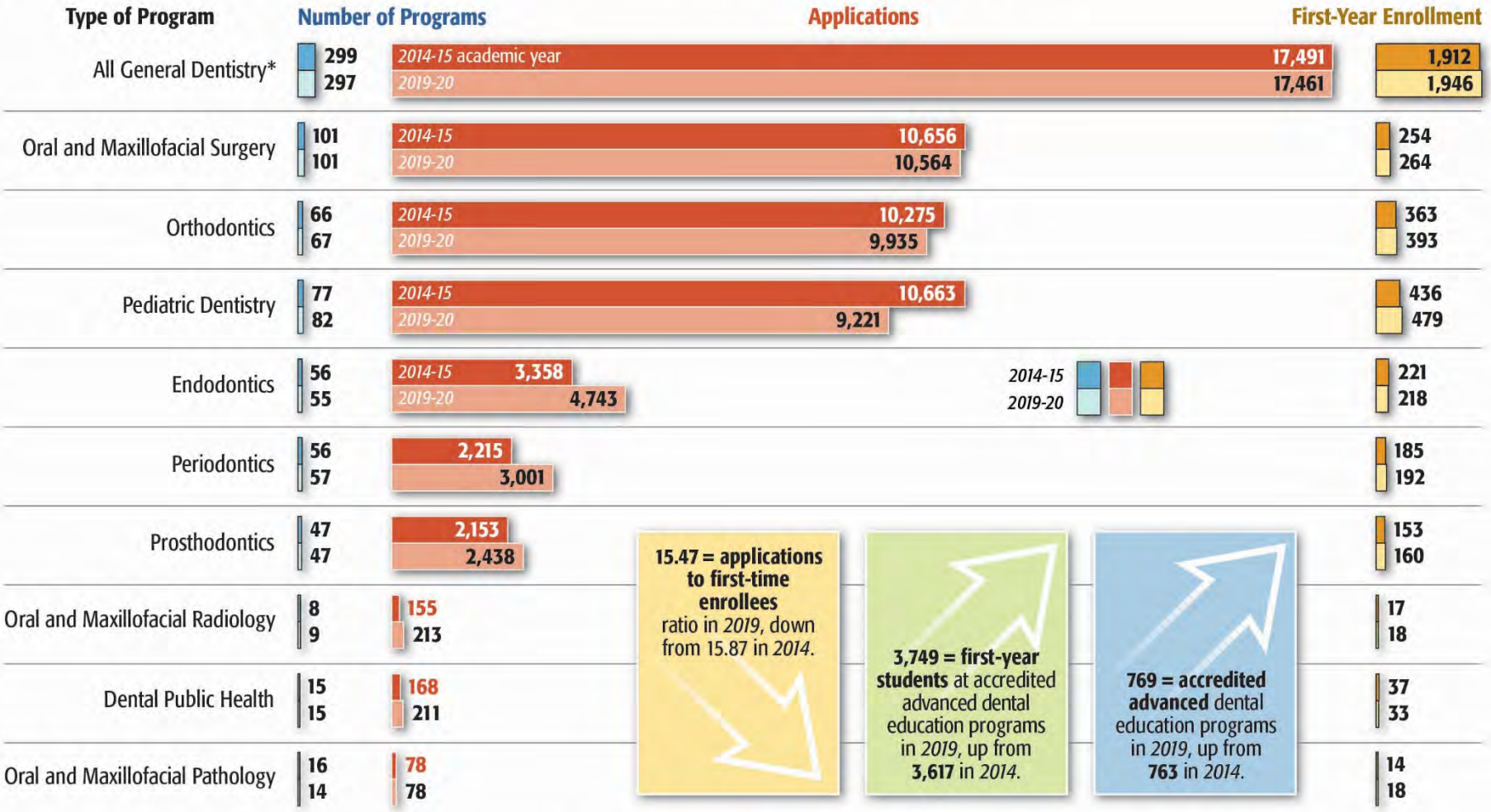
Percentage of Survey Respondents by Immediate Professional Plans Upon Graduation, *2015* and *2020*

Notes: "Dentist in a federal service" includes serving as a dentist in the military, U.S. Public Health Service Commissioned Corps, Federally Qualified Health Centers, U.S. Veteran Affairs and other federal institutions. "Other" includes Dentist in Other Not-for-profit clinic, Other position in dentistry, Dentist in state/local government, Teach in a dental program, and Other position not related to dentistry. HURM students include the following four race and ethnicity categories: African American, Hispanic or Latino, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander. These four race and ethnicity categories are defined by the U.S. Department of Education for reporting data from higher education institutions.
Source: American Dental Education Association, Surveys of U.S. Dental School Seniors, *2015* and *2020* Graduating Classes.

Applications to Accredited Advanced Dental Education Programs Are Increasing

ADEA Trends in Dental Education 2020-21

Oral and maxillofacial surgery continued to receive the largest number of applications per number of first-year enrollees between 2014 and 2019. Endodontics rounded the top three in 2019, an increase from five years before. Overall, the application to first-year enrollee ratio for accredited advanced dental education programs declined over the five-year period due to the number of first-year enrollees growing faster than the number of applications.



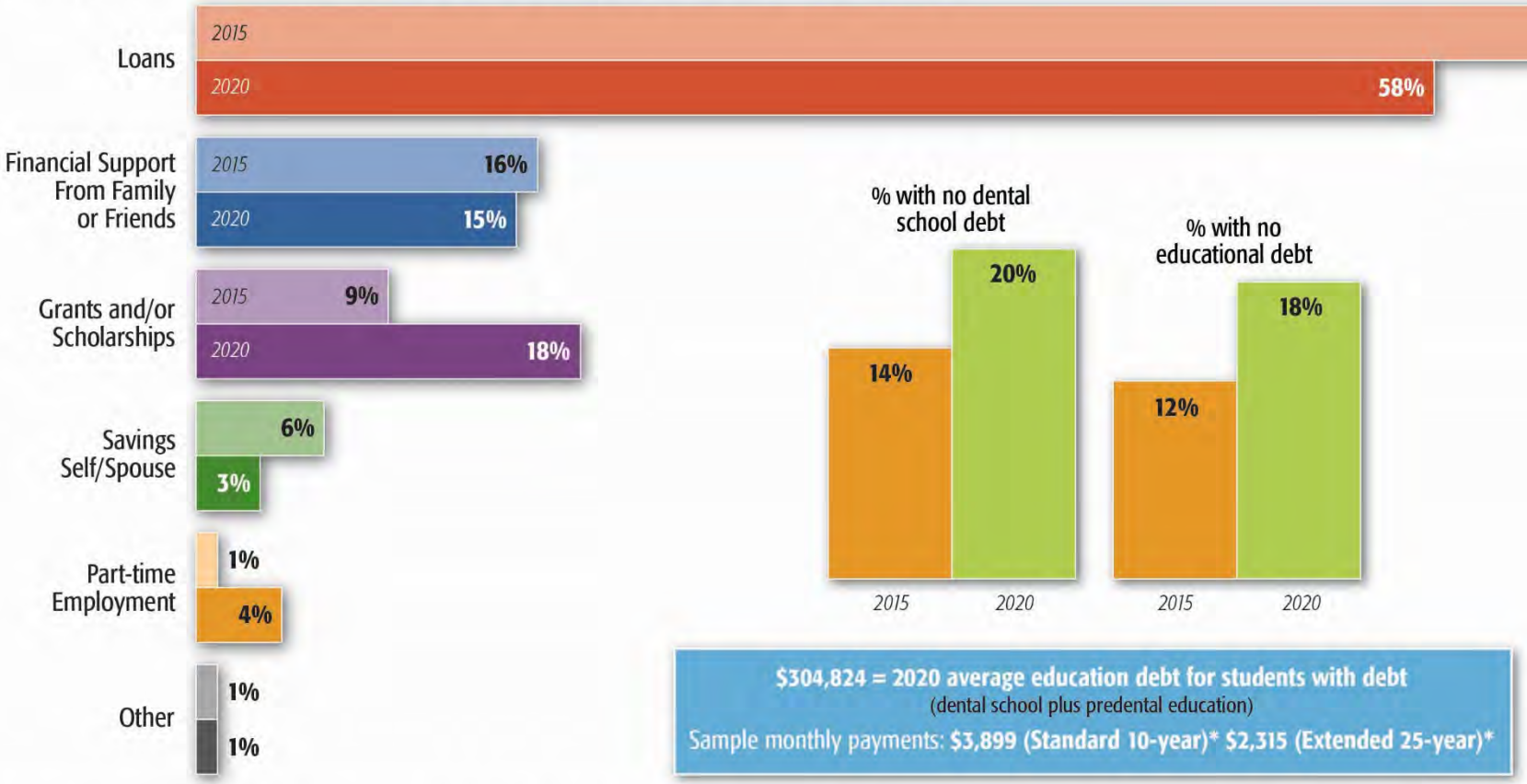
*All General Dentistry includes General Practice Residency, Advanced Education in General Dentistry, Dental Anesthesiology, Oral Medicine, and Orofacial Pain.
Source: American Dental Association, Health Policy Institute, 2014-15 and 2019-20 Surveys of Advanced Dental Education
Note: Application figures represent the total number of applications examined by all programs, and counts applicants more than once if they applied to multiple programs.

Dental Students Are Using More Grants and Scholarships to Fund Dental School

ADEA Trends in Dental Education 2020-21

Graduating dental school seniors in the Class of 2020 are funding their dental education with fewer/less loans and using more grants and scholarships than did the Class of 2015. Federal loans persisted as the top source of financing dental school. The average educational debt (dental school plus predental education) has increased slowly over the past five years. However, a higher proportion of dental school seniors in the Class of 2020 graduated with no dental school debt or educational debt when compared with the Class of 2015.

Funding Sources for Doctoral Dental Education, Average Percentage of Funding, *2015* and *2020*



Note: Educational debt is the sum of dental school debt and predental school debt, including loans for college. This indicator, also called "graduating debt," shows the amount a dental school doctoral graduate must repay. Percentages may add up to more than 100% due to rounding.

*Assumptions: Sample payments based on $304,824 total debt on a Standard 10-year repayment plan (120 level payments) and a 25-year time- driven plan • $162,000 direct unsubsidized, remainder direct PLUS (Grad PLUS) • Repayment begins six months after graduation • No voluntary or aggressive payments, and loans "held to term" (entire repayment period used) • Appropriate interest rates used based on disbursement dates • Repayment numbers run with AAMC/ADEA Dental Loan Organizer and Calculator.

Source: American Dental Education Association, Surveys of U.S. Dental School Seniors, *2015* and *2020* Graduating Classes.

A Career in the Dental Professions Is Rewarding

There's a reason the dental professions have consistently ranked at or near the top of the U.S. News & World Report 100 Best Jobs list for the past several years.

ADEA Trends in Dental Education 2020-21

Dental careers offer:

Professional **autonomy**

Flexible work hours

Financial and **job security**

Opportunities to work as part of a **health care team**

The U.S. Bureau of Labor Statistics predicts:

Employment growth of 7.6%, equating to 10,400 new dentist jobs through the year *2028*

Employment of dental hygienists is projected to grow 6% from *2019* to *2029*, faster than the average for all occupations

U.S. News & World Report 2020 Best Jobs:

Best of all: Dentists and dental hygienists make a difference in the lives of their patients and in their communities.

Sources: U.S. News & World Report. 100 Best Jobs. Bureau of Labor Statistics, U.S. Department of Labor, Occupational Outlook Handbook, Dentists and Dental Hygienists. American Dental Association, Health Policy Institute, Income and Gross Billings.

ADEA | THE VOICE OF DENTAL EDUCATION

adea.org/DentEdTrends

The CRDTS Report

Over 50 Years of Testing Excellence

Central Regional Dental Testing Service, Inc. Spring 2022

President's Message

Sam Jacoby, DDS
President

CRDTS. A WORK IN PROGRESS?

To most who hear the phrase "a work in progress" it means that something is missing, lacking, or incomplete. So, is CRDTS a work in progress? Most definitely it is, but not for those reasons. Our work at CRDTS is just unfinished. Over the more than fifty years that CRDTS has been involved in licensure testing we have always been deeply involved in test development and data collection. Much time has been spent in cooperation with other organizations and testing agencies using input from us to improve the way dental professionals are evaluated. This quest for improvement has never been about strengthening our agency. It has been about strengthening State Boards of Dentistry by giving them a product they can count on to achieve their mission of protecting the public. Additionally, as we continue to do this, our efforts are always guided by the principals of professionalism, honesty, and accuracy.

Over the past year, I have witnessed the CRDTS Leadership Team, Professional and Central Office Staff and Committees cultivate a renewed enthusiasm to become an even greater "work in progress". Both Dental and Dental Hygiene Exam Review Committees continue to recommend innovative modifications to our examinations, and adjunctive support for schools and Boards. The Strategic Planning Committee has recently formulated an updated strategic plan. The Bylaws and Governance Committee completed a thorough review and made recommendations for revisions of our Bylaws, Membership Agreement and Committee Charters. The Executive Committee has responded to the needs of CRDTS Professional & Office Staff reorganization appropriately and the Steering Committee has approved expenditure of funds to make everything work. Our Executive Director, Professional and Office Staff have worked tirelessly to monitor and participate in State Board meetings, develop contacts across the country, renew relationships with Schools and Boards, streamline the process of supporting our exams with both technology and materials and promote our organization as the most trustworthy, ethical, and professional agent for licensure testing.

What has been the result of all this hard work and motivation? Recently CRDTS has grown to include three new member States. Modifications to our examinations have made them more cost and time effective yet increased the level of fidelity and validity for the simulated patient exams. We have fielded multiple requests for School and State Board presentations and have seen increased interest from students. The establishment of CRDTS independent test sites is a concept that has been implemented, successful and appreciated. The continuing exploration of virtual haptic technology coupled with our recent partnership with SIMtoCARE, the premier developer of this technology, holds immense potential to expand our services.

So, in answer to my original question, YES, CRDTS is a work in progress, but only because our work is unfinished. It never has been and never will be, because our organization thrives on constant improvement of our products based on feedback from examiners and individual Member States. All these recent accomplishments have been achieved while maintaining a positive attitude and a core belief in professionalism, honesty, and integrity. No money has changed hands to open doors and no roadblocks have been placed to close others. The progress we make is made with our values intact. What would the world of dental professions licensure testing be like without CRDTS? It's hard to imagine.

Sam Jacoby, DDS
CRDTS President

Volume 18, Issue 1

CENTRAL REGIONAL DENTAL TESTING SERVICE, INC.

Sheli Cobler, Executive Director

After a year since starting as Executive Director of CRDTS, I am very happy to report that CRDTS continues to make great strides toward the goals we have set. CRDTS has an excellent team that is continually working to overcome challenges and find new ways to grow.

To that end, I am happy to announce that Texas, Utah and Idaho have all joined CRDTS since the last newsletter and we are proud to welcome them. Full Members have a voting seat on the CRDTS Steering Committee, thus each state board that is a Member, has a voice in the development and enhancement of the CRDTS examinations. Collaborating with our Members, CRDTS is able to ensure that the examinations are meeting the needs of the state boards and the candidates who will be taking them.

I am also pleased to announce our newest Central Office staff employees, Amelia Hursey, Materials Coordinator, and Ashley Holaday, Facilities Coordinator. Please help us welcome them if you call the office and speak with one of them.

Due to the changing environment in regional testing as a pathway toward licensure, CRDTS is in a position to grow in ways it has not for many years. We have the best professionals in dental and dental hygiene, we have a support staff that is second to none, and we have strategies in place to help us meet the goals before us. We are prepared for the challenges ahead and know that the efforts will culminate in growth.

Over the years, I have worked with many industrious folks yet, none as hard-working and dedicated to the mission and vision of an organization as what I am experiencing with CRDTS. The teamwork and integrity that is a constant is truly inspirational. Along with those characteristics comes the commitment to excellence that CRDTS has continued for over 50 years.

Don't be surprised if you find Dr. Jacoby, President of CRDTS, Dr. Edwards, Director of Dental Examinations, Ms. Gaskill, Director of Dental Hygiene Examinations, Ms. Laudenslager, Director of Communication and Education, or myself ringing your phone or even knocking at your door, as we expand our outreach efforts and tap into the resources we have. Together with our board members, committee chairs, central office staff and examiners, we are reaching out more often and, in more ways, to get the word out about CRDTS.

What we have learned is that there is a lack of knowledge about CRDTS at the state board level, in dental and dental hygiene education, and with the candidates themselves. CRDTS' leadership is working overtime to eliminate misinformation and ensure that those involved in the dental and dental hygiene licensure have the information they need to make informed decisions regarding initial licensure.

Additionally, CRDTS is invested in the future of dental and dental hygiene licensure and with the support of our board members, we are continually researching innovative technology and ways to enhance our exam portfolio. With the forward-thinking that is taking place, CRDTS will be able to assist the state boards even more effectively in their mission to ensure the safety and well-being of the public.

If you didn't already know, these are just a few things that makes CRDTS what it is -

A Model of Excellence and Integrity in National Testing Toward Dental and Dental Hygiene Licensure.

- ▶ National Dental and Dental Hygiene Exam
- ▶ Patient Based Exam Options
- ▶ Simulated Patient Exam Options
- ▶ Dental Therapy Exam
- ▶ Local Anesthesia Exam
- ▶ Restorative Auxiliary Exam
- ▶ Exam Location Flexibility
- ▶ Exam Scheduling Flexibility
- ▶ Same Day Results
- ▶ OSCE Administered On-Site
- ▶ Complimentary On-Site Retakes
- ▶ Virtual Haptic Options
- ▶ Remediation Assessment

As we continue to move forward in our mission and vision, we hope that if you find you have questions or wish to learn more about CRDTS, you will contact us. We are always interested in hearing from anyone who may like to know more about what we are doing to continue the legacy of CRDTS.

Sheli Cobler
CRDTS Executive Director

See You In Kansas City
August 25-27

At a Glance
Schedule on Page 4

ITS THE PEOPLE!

Otto Dohm, DDS
President Elect

Why bother?

Why bother essentially volunteering to be an examiner, to serve on committees. Why bother to expend time and effort trying to deliver an ethical, fair examination to the State Boards, and dental professionals seeking licensure?

For me the answer is I would like to give back to a profession that has provided an excellent career for myself and my family.

Everyone reading this has their own answer and reasons for their commitment to a similar goal. The broader question is why CRDTS?

Why have we chosen to throw in with this organization?

The exciting travel to faraway places like Wahpeton ND? The outstanding BBQ at the KC Hilton? The advanced technology of the ESD tablets or the "Tooth"

I would invite each of you to consider what it is that makes CRDTS worthy of your time and effort.

I had to ponder this last summer when I was approached about serving as an officer in this organization. I do care about the mission, but why would I want to bother doing more. Why would I choose to have more things on the perpetual "to do list"? I talked with my wife and pondered this for some time last summer before deciding to go "all in". I've had the opportunity to work with other testing agencies and have dealt with many of the officers and management of these groups over the years. Their goals are similar to CRDTS, and they provide a good product. Why CRDTS?

As I considered these things last summer and I to only one conclusion.The answer to why CRDTS for me is the people!

I feel much more comfortable working with people that I admire, and respect and this organization is made up of those people. Every agency has technology, psychometrics, calibration etc. Every agency does not have a central staff that is dedicated and committed to achieving the goals of the agency. They don't have state membership in the organization and examiners/committee members that are dedicated and committed to integrity and improvement of the process. CRDTS has these people and more. It's the people that set CRDTS apart.

Otto Dohm, DDS

LET'S CELEBRATE 50 YEARS!

Nancy Kearn, RDH
Vice President

Spring Fever has arrived at my house and I am ready to travel and examine with my testing friends!

CRDTS Staff and Officers have worked nonstop to prepare for this testing year.

We are so excited for the new opportunities that face us each day.

You will hear more about these happenings as you read this newsletter but did you know…

We are celebrating our 50th year of Dental and Dental Hygiene examinations!

To celebrate,

We will gather Friday, August 26 and Saturday the 27th for our Annual Meeting. We have reservations at the Loews Kansas City Hotel that is within walking distance to the Power & Light District.

You will want to arrive early on Friday as we will have our Presidents dinner and special program on Friday night.

We hope many of our past leaders will be joining us to celebrate this milestone in our history.

Saturday we will hold our necessary business meeting, which we will try to keep brief and to the point!

Breakout Sessions for Educators, Examiners and State Board Members were a favorite at last year's annual session. We will be using a similar format for our meeting agenda. From the feedback we received most everyone enjoyed having time to connect, network or just relax with our community.

Mark your calendars and watch for an email/invitation.

I would like to thank you for the opportunity to serve as your Vice President these past four years.

The pandemic pushed us into new uncharted waters, but we have become stronger and better because we had to!

Special thanks to our Executive Director, Richael Cobler and President, Dr. Sam Jacoby for their leadership and perseverance. Who knew Zoom calls could be so fun!

Thank you to our Central Office family,

You truly are the best!

Thank you and Happy Testing!

Nancy Kearn, RDH

NICE TO MEET YOU

Andrew Johnston, RDH
CRDTS Secretary/Treasurer

I am grateful for the opportunity to address our CRDTS family for the first time via the newsletter having recently taken on the role of Secretary/Treasurer. While I am fortunate enough to call many of you friends, there are still many who I do not know, but look forward to serving you as time goes on. The message I bring to you today is an encouraging one. We are in a wonderful position financially based on the decisions of the leaders in years gone by. They have built up the needed funds for us to weather COVID successfully and also enough to carry out the Steering Committee's directive to build out the next chapter of what CRDTS will be for the future. While other agencies struggle with their direction and voice, CRDTS continues to have incredible members and leaders who have the uncanny ability to see what is coming our way in dentistry and act quickly to adapt and be ahead of the curve. Our recent meetings are evidence of this. We have several directives coming from our January Steering Committee meeting that will help us to grow both our dental and dental hygiene exams, without overextending our financial position. I am excited to see the next phases of CRDTS!

Looking forward to meeting you all,

Andrew Johnston, RDH
CRDTS Secretary/Treasurer

An email with instructions for registration and travel will be sent in April

THURSDAY, AUGUST 25

7:30 AM - 1:00 PM	Examiner Evaluation & Assignment Committee
Noon - 3:00 PM	Dental Exam Review Committee
3:00 PM - 6:00 PM	Strategic Planning Committee

FRIDAY, AUGUST 26

7:30 AM - 11:00 AM	Executive Committee
Noon - 4:00 PM	Steeting Committee
5:00 PM - 6:00 PM	Happy Hour (Cash Bar)
6:00 PM - 8:30 PM	President's Dinner - CRDTS Alumni in Attendance Retiree Plaques Presented

SATURDAY, AUGUST 27

7:45 AM - 9:00 AM	Meet & Greet Breakfast CRDTS Presentations
9:00 AM - 9:15 AM	Break
9:15 AM - 10:30 AM	Presentations Continued
10:30 AM - Noon	Business Meeting
Noon - 1:00 PM	Luncheon
1:15 PM - 3:00 PM	Dental Exam Changes 2023 Dental Hygiene Changes 2023
3:00 PM - 5:00 PM	Dental Educator's Meeting Dental Hygiene Educator's Meeting

NEWS FROM DENTAL

Rod Hill, DDS
Executive Chair, Dental Examinations

We hope 2022 is off to a safe and strong start for all. CRDTS Dental ERC has been busy modifying simulated patient examination typodonts as well as simulated patient content, criteria, and policy. Restorative simulated patient procedures have been reduced from six procedures to four. These include an anterior Class III preparation on tooth #9DL, an anterior Class III restoration on tooth #23DL, a Class II posterior preparation on tooth #4DO OR #14MO (candidate chooses) and a posterior Class II restoration on tooth #18MO or #29DO (candidate chooses). In analysis of examination results, the additional Class II preparation and restoration procedures were non-discriminatory regarding pass/fail rates. Time limits for Part IV Periodontal simulated patient were reduced from 3 to 2 hours, and time limits for Part V Restorative simulated patient were reduced from 6 to 5 hours.

Mark Edwards, DDS, Director of Dental Examinations

CRDTS independent testing site located above CRDTS central office in Topeka, KS is set to open in April 2022, and will allow candidates the opportunity to schedule simulated patient examinations seven days/ week. Additional independent testing sites in Decatur, AL. and Hastings, NE. allow candidates the opportunity to take patient based, simulated patient or hybrid examination formats outside of the school setting.

CRDTS continues to embrace and explore new avenues and the impact of technology in dental and dental hygiene licensure assessment, education and remediation. CRDTS has begun a collaborative relationship with SimToCare to develop and refine virtual haptic technology to be used in education and remediation at the independent testing site in Topeka, KS. Particularly relevant due to COVID and the disruption in patient-based care, CRDTS Steering Committee sees an opportunity for altruistically impacting the learning experience for students who have fallen behind. Skill refinement courses are currently in development to allow students an environment to practice and improve their skill set prior to taking a licensure examination.

CRDTS dental leadership in February attended the American Student Dental Association (ASDA) meeting in Louisville, KY and the American Dental Education Association meeting in Philadelphia, PA on March 19-22. These are excellent opportunities to share the CRDTS vision and mission with both students and educators as we strive to tell our story as opposed to our competitors sharing what is many times misinformation.

As always, CRDTS greatly appreciates all feedback as to how CRDTS dental can once again become relevant by improving models for testing by licensure to protect the mission of State Dental Boards but also positively impact Dental schools and students.

Mark Edwards, DDS
Director of Dental Examinations

Rod Hill, DDS
CRDTS Dental ERC Chair

Cindy Gaskill, RDH, MAE
Director of Dental Hygiene Examinations

NEWS FROM DENTAL HYGIENE

The last six months of my life has been full of learning and adjusting to working for our testing organization CRDTS. It seems like there is never enough time in the day to do all that I want to do – I honestly do not know how Kim did it! I am enjoying working with the other great team members, our Executive Director Sheli, our President Sam, my counterpart Mark, and the many wonderful dental hygiene program contacts that Kim has developed over the last 25 years. Of course, I couldn't do my job without almost daily input from our DH Exam Review Committee Chair Janine – I am so lucky to have her and Kim to serve as mentors and guides in my new journey. Their knowledge of CRDTS and Dental Hygiene Testing is truly incredible.

One of our main goals is to continue the relationships with the over 200 schools who administer our CRDTS Dental Hygiene Exam (both live patient and simulated), Anesthesia Exam, Auxiliary Restorative Exam, and Dental Therapy Exams. I am enjoying working with the Program Directors, Faculty, and students as they prepare for their exams. I am gratified and full of respect for the way that our organization has maintained our integrity, validity, and ethical principles through the years despite many curveballs thrown in our path.

It has been a pleasure to meet with new Program Directors and new faculty members that want to learn more about our exams. It has been eye-opening to observe their excitement about the onsite grading, immediate scores release, complimentary exam retakes, and the on-site OSCE. It is exciting to receive calls from schools who want to be placed on our exam schedule for 2023 due to the changes happening in the examining world now. We have already started a list and are looking forward to working with the new programs and sites.

We have less than a month until the beginning of our busy Exam Season. I am ready to gear up for the many successful exams and working with our committed and dedicated examiners. We will miss the following examiners who have decided to hang up their examining explorers this year: Lisa Herder, Laura Jacob, Pat Lepp, Jane Stratman, Deb Palacioz, Nancy Stewart, and Valinda Parsons. These individuals have our deepest gratitude and sincere thanks for their years of service to CRDTS.

The C-CAP (Clinical Calibration and Assessment Program) kicked off our initial pilot session with 10 dental hygiene faculty members from UNMC in Lincoln, Nebraska. The team of C-CAP presenters are Kim, Janine, Penny, and me. We have three more pilot sessions scheduled for 2023 and will be using the statistics that Kim is gathering to access the program and possible expansion next year. Almost every program wanted to participate this year so the future of C-CAP is exhilarating!

It is an impressive time to be part of CRDTS as we are growing and also celebrating 50 Years of Examining Excellence. I hope to see you in KC this fall for our annual meeting and celebration, if not before!

Cindy Gaskill, RDH, MAE
Director of Dental Hygiene Examinations

Janine Sasse-Englert, RDH, MS
Executive Chair, Dental Hygiene Examinations

Greetings from the dental hygiene side of CRDTS. The 2022 exam season is upon us, and we kicked it off with a written local anesthesia exam in Washington. The season gets very busy in the coming months with restorative, local anesthesia, patient-based and simulated patient hygiene examinations. We are utilizing our 3rd generation typodont for the 2022 exam season, and though we were pleased with the 2nd generation model used in 2021, we are excited about the improvements in the teeth and calculus that resulted from work with the research and development team at Acadental. As always, the CRDTS independent third-party assessments exist to serve our state boards' needs and the number of exams we have ready to administer upon request is impressive.

The Clinical Calibration and Assessment Program (CCAP) kicked off in Lincoln, NE this month. We will learn a lot from our pilot programs at four sites throughout this season and will be ready to offer this module to all programs in 2023. It is an exciting opportunity for faculty calibration for both our dental hygiene programs and our CRDTS dental hygiene branch.

The newest member of the dental hygiene team is Cindy Gaskill, who hit the ground running last fall and is busy developing exam materials, meeting with state boards, program directors/faculty and dental hygiene exam candidates. Her knowledge and expertise in all aspects of our exams has been an immeasurable asset to CRDTS.

CRDTS is an innovator in the examining arena. New technologies, new ideas, and a newly designed and constructed independent testing site are explained in other areas of this newsletter. Though covid-19 presented its challenges, we were able to meet them with futuristic thinking visionaries. What an exciting time to be in healthcare and licensure in the United States!

Janine Sasse-Englert, RDH, MS
Chair, Hygiene Examination Review Committee

EEAC Chair, Dr. Steve Holcomb recognizing retiring examiner, Dr. Karen Jahimiak

EEAC Chair, Dr. Steve Holcomb recognizing retiring examiner, Laura Jacob, RDH

Outgoing President, Dr. Tom Willis

2021 ANNUAL MEETING HIGHLIGHTS

Nashville

Outgoing Secretary/Treasurer, Ermelinda Baca, RDH

Executive Chair, Dental Hygiene Examinations, Janine Sasse-Englert, RDH

Executive Chair, Dental Examinations, Dr. Rod Hill & Director of Dental Examinations, Dr. Mark Edwards

Incoming President, Dr. Sam Jacoby

CRDTS
1725 SW Gage Blvd
Topeka, KS 66604

ANNUAL MEETING - POWER & LIGHT DISTRICT

All Annual Meeting attendees are invited to the

"CRDTS Meet & Greet Breakfast" on Saturday, August 27th from 7:45-9:00 am.

We are excited to share what is happening in CRDTS and for you to meet the Executive Committee and Staff.

There are no CRDTS sponsored group events scheduled this year as we wanted everyone to have the opportunity to go out and enjoy Power & Light and what KC has to offer.
Power & Light is the reborn Downtown Kansas City that opened in 2008. A nine-block neighborhood featuring a variety of local, regional and national restaurants, shops, entertainment venues, nightlife and lifestyle amenities. The neighborhood is surrounded by landmarks and entertainment icons like Sprint Center, the Kauffman Center for the Performing Arts, the Crossroads Arts District and more.
Check out Power & Light's website for a directory and list of events closer to date.
www.powerandlightdistrict.com

From: Information <info@crdts.org>
Sent: Thursday, February 24, 2022 12:08 PM
Subject: CRDTS News Update

CRDTS WELCOMES IDAHO AND UTAH AS NEW MEMBER STATES

The CRDTS Steering Committee approved and welcomed Idaho and Utah as new Member States at their most recent meetings.

While the CRDTS Dental and Dental Hygiene Examinations are widely accepted for initial licensure in all but a few states across the country, it is the CRDTS Member States (Alabama, Arkansas, California (DH), Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, New Mexico, North Dakota, South Carolina, South Dakota, Texas, Utah, Washington, West Virginia, Wisconsin, and Wyoming) that govern and make decisions regarding the development (content, scoring and criteria) and administration of all CRDTS Dental and Dental Hygiene Examinations.

According to CRDTS President, Dr. Sam Jacoby; "Given the increased communication we are receiving, it appears recent changes and shifts in dental and dental hygiene licensure exam options have spurred more State Boards to get involved with the exam development process which is a path that leads them directly to our door because, with CRDTS, every Member State has a voice and vote in the process."

CRDTS welcomes Idaho and Utah as their newest Member States and CRDTS wants to remind all State Dental Boards that it is CRDTS' goal to provide and administer nationally accepted Dental and Dental Hygiene Clinical Licensure Examinations that demonstrate fairness, integrity, reliability, validity and fidelity in order to serve and assist each State Board with their mission to protect the health, safety and welfare of the public by assuring that only competent and qualified individuals are eligible to practice dentistry and dental hygiene.

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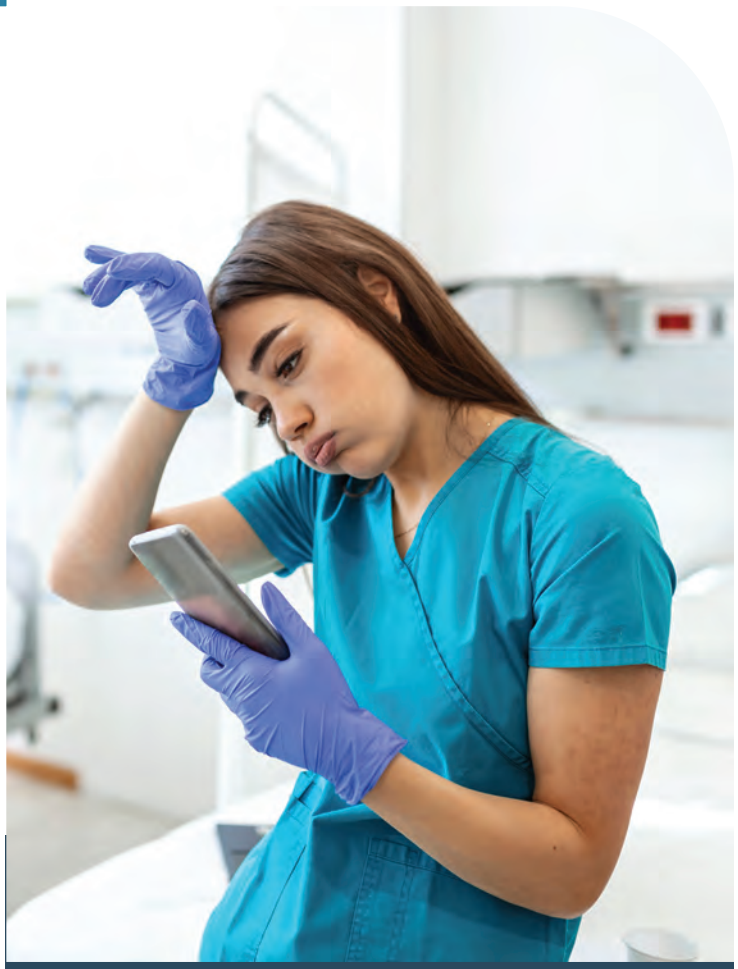
HealthProChoices

February 2022

A newsletter for participants in the Health Professionals' Services Program (HPSP)

Self-Care: Who Has Time for That?

We all know that we should take care of ourselves. We all probably even know the old adage about putting on our own oxygen mask first so that we can care for others. BUT, that doesn't make it any easier to actually find the time or the means to take care of ourselves, especially during a pandemic. The MARC (Maryland Addiction Recovery Center) Clinical Team has some suggestions. Read them here: https://www.marylandaddictionrecovery.com/self-care-during-covid/



After Hours Phone Number

Don't forget to save the Monitoring after-hours line (503.802.9818) in your phone. The Monitoring after-hours line is available for collection site emergencies. During business hours, you should continue to use our regular line (888.802.2843) or your agreement monitor's direct extension.

Family Involvement

Serenity Lane, an Oregon based treatment program, reminds us that substance use disorder "recovery is most successful with the participation of family and friends." Read this blog about HOW to involve your family in your recovery journey: https://serenitylane.org/blog/recovery-for-the-whole-family/

Health Professionals' Services Program

hpspmonitoring.com

888-802-2843

uprisehealth

Guideline Changes

Each quarter, the Advisory Committee meets and, along with many other tasks, reviews a selection of guidelines that inform the program. Revisions are made as needed such that the program can remain in alignment with current best practices. Two guidelines were recently updated and approved by participating Boards (via the Advisory Committee). Navigate to the guideline tab from https://www.hpspmonitoring.com/resources OR click on the links below to read the newly revised guidelines:

- Guideline for Community Recovery Support Attendance
- Guideline for Criminal Background Checks for Self-Referred Licensees

Please keep in mind these key points of the revised guidelines:

- Documentation of attendance at community support ("self-help") meetings may be required. This will be specified in each licensee's individualized Monitoring Agreement Addendum.
- Licensees who are self-referred into HPSP are required to complete a criminal background check six months prior to program completion.

As always, if you have any questions about these changes, please reach out to your Agreement Monitor.

You Are Not Alone

If you are participating in HPSP as part of your recovery from a **substance use disorder** (SUD), you are NOT alone. In fact, more than 9% of adults in the US are in recovery from a SUD. That's 22.3 million Americans. Further, of all of those who do face a SUD, 75% go on to recover. You can do this and we are here to help you! To read or listen to more about these studies, check out the article "There is life after addiction. Most people recover." on NPR at https://www.npr.org/2022/01/15/1071282194/addiction-substance-recovery-treatment

If you are participating in HPSP as part of your recovery from a **mental health disorder**, you too are NOT alone. More than 20% of adults experienced a mental illness in 2019. Check out https://www.nami.org/mhstats for more details. During the pandemic, the story has been even more concerning with 4 in 10 adults exhibiting symptoms of anxiety and depression (https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/). But as you know, with help, recovery is within grasp.

Support Group Options

Many support groups meet online as a result of the pandemic. In addition to local meetings, here are some meeting options you may want to consider:

- Minnesota Nurses Peer Support Network: https://www.npsnetwork-mn.org/meetings.html
- The Luckiest Club: https://www.theluckiestclub.com/join-community
- Caduceus meetings:
  - Pennsylvania: These meetings are on zoom and open to our Oregon licensees. Reach out to your agreement monitor for the schedule if you are interested.
  - Oregon: Reach out to your agreement monitor to find a local meeting that may work for you.
- Oregon AA: https://www.aa-oregon.org/
- NAMI Support: Many of their groups are hosted on zoom and accessible statewide for those living with mental illness: https://namimarionpolk.org/project/nami-oregon-online-support-groups/
- Oregon Recovery Network: Information on support group meetings for a wide-range of topics state wide: https://oregonrecoverynetwork.org/support/
- Professional Recovery Network: This association supports licensed healthcare professionals and offers targeted support group meetings: http://www.prnoforegon.org/
- And here are a few recommendations from our Medical Director: https://shantipdx.com/our-4-favorite-addiction-recovery-support-groups-in-portland-oregon/

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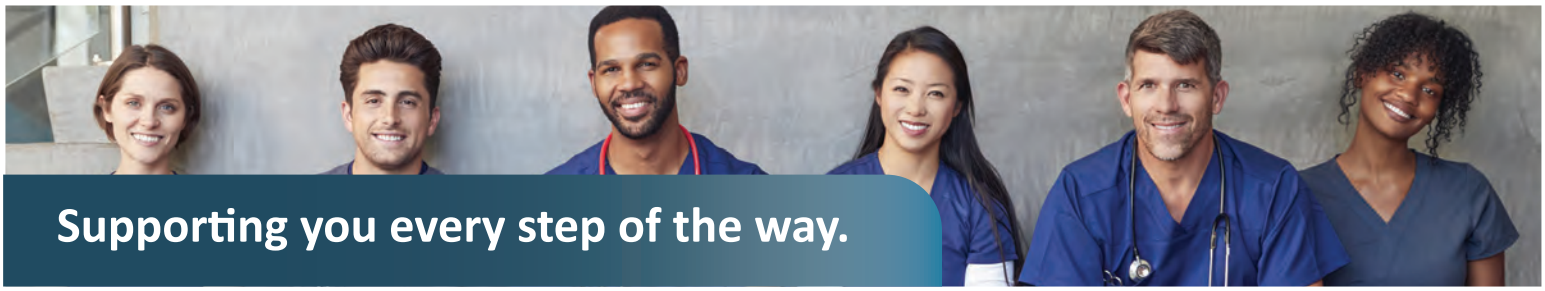


HPSP January 2021 Satisfaction Survey

Thank you to all of those who participated in the January 2022 Health Professionals' Services Program (HPSP) Satisfaction Survey. We know that this is a difficult time in the healthcare field and we appreciate you squeezing in the time to respond to the survey. Unfortunately, only 16% of licensees surveyed this period provided responses. We will repeat the survey in July and hope that you will all respond then!
Surveys are sent out to all licensees who have been enrolled for at least 4 months, as well as to all workplace monitors, GMC/PMC providers, evaluators, and related Healthcare Professional Associations. The survey serves as an ongoing quality improvement tool and provides a feedback loop for participants. Survey results are reviewed by the internal HPSP Policy Advisory Committee (PAC) comprised of the HPSP Medical Director, Consulting Psychiatrist, Program Manager, and two Agreement Monitors. A few survey highlights follow:

- 96% of licensee-respondents endorse understanding the program's statutory monitoring requirements.
- A "significant amount" of structure and accountability is provided by the program according to the largest group of licensee-respondents.
- 96% of licensee-respondents feel their agreement monitor is knowledgeable about their case.
- 88% of licensee-respondents endorsed that "information is communicated clearly and professionally."
- 100% of workplace monitors were satisfied with Uprise Health's support.
- 100% of workplace monitors also endorsed Uprise Health's ability to ensure safety in the workplace, with 60% rating this as "excellent."
- All workplace monitors who rated response timeframe, staff knowledge of a licensee, staff's ability to respond to questions regarding program administration, frequency of feedback, gave a rating of "excellent" or "above average."
- 100% of workplace monitors provided an overall rating of "excellent" or "above average" for the services received and their overall experience working with Uprise Health.
- 100% of providers "agree" or "strongly agree" that their questions/concerns are responded to promptly, that information is communicated clearly and professionally and that they had all the information they needed when they saw the licensee.
- All providers who gave an overall rating of their experience working with Uprise Health indicated it was "excellent" or "above average."

In addition to the data, the PAC reviews each and every comment provided by respondents. After reviewing these comments, the PAC would like to respond to 3 issues:

1. **Collection Sites:** HPSP appreciates the concerns that were shared about the proximity of the location of collection sites that are assigned, especially for travel. This issue will be reviewed carefully with the goal of providing more convenient and practical options for collections.
2. **Exemption Days:** Concern was raised about the number of exemption days that are provided. HPSP's allowance of up to 21 exemption days per 12-month period is well within the standard across other monitoring programs. Uprise Health also provides the monitoring program for Delaware; in that program, the Boards only allow five exemption days. It is our goal to work with you such that you can travel and that on the chance you are called to test during that time, you can visit a convenient site and quickly go back to your vacation.
3. **Rewarding Compliance / Customizing the Program:** A few comments indicated that licensees felt that the program should be more customized for them or that the requirements should be substantially lifted as a "reward" for compliance. Please remember that the structure of the program is dictated by Oregon State law. HPSP's ability to customize the program is therefore limited by these regulations. However, compliance does result in a reduction in testing from the initial levels. This reduction should save time and money as the program progresses.

DANB and OSAP Launch Certified in Dental Infection Prevention and Control (CDIPC) Certification

The Dental Assisting National Board (DANB) in collaboration with the Organization for Safety, Asepsis and Prevention (OSAP) have officially launched the Certified in Dental Infection Prevention and Control (CDIPC) certification program.

The CDIPC certification is the first clinically focused dental infection control certification in the U.S. The exam is rigorous and requires demonstrating not only knowledge of infection control guidelines and standards, but also the analytical and critical-thinking skills to apply them in a variety of scenarios. Maintaining CDIPC certification requires a commitment to lifelong learning and staying up to date on infection prevention and control knowledge.

Earning CDIPC certification is a professional achievement that also benefits dental practices and their patients by ensuring precautions are taken to keep providers and patients safe. The CDIPC certification mark is a signal to patients, employers, and colleagues of a commitment to ensuring safety in the dental practice.

“Already, more than 125 dental professionals have earned CDIPC certification,” said DANB CEO Laura Skarnulis. “This distinction indicates that you are a leader in the field, with the most up-to-date knowledge in dental infection control, and can oversee and implement necessary protocols to protect your team and patients.”

“By earning CDIPC certification, dental professionals are positioned to maintain safety in the dental practice – both today and in the future, as new threats may emerge and policies and guidelines continue to evolve,” said Michelle Lee, OSAP Executive Director.

Learn more about CDIPC certification.

About DANB

The Dental Assisting National Board (DANB) is the national certification board for dental assistants. DANB’s mission centers on public protection, which it fulfills by developing and administering credentials for oral health professionals. DANB exams and certifications are recognized or required by 37 states, the District of Columbia, the U.S. Air Force and the Department of Veterans Affairs.

About OSAP

The Organization for Safety, Asepsis and Prevention (OSAP) is the only nonprofit membership association for oral healthcare professionals that focuses exclusively on infection prevention and patient and provider safety. OSAP helps operationalize dental infection control and safety laws, regulations, guidelines, standards, and best practices to ensure every dental visit is a safe visit.

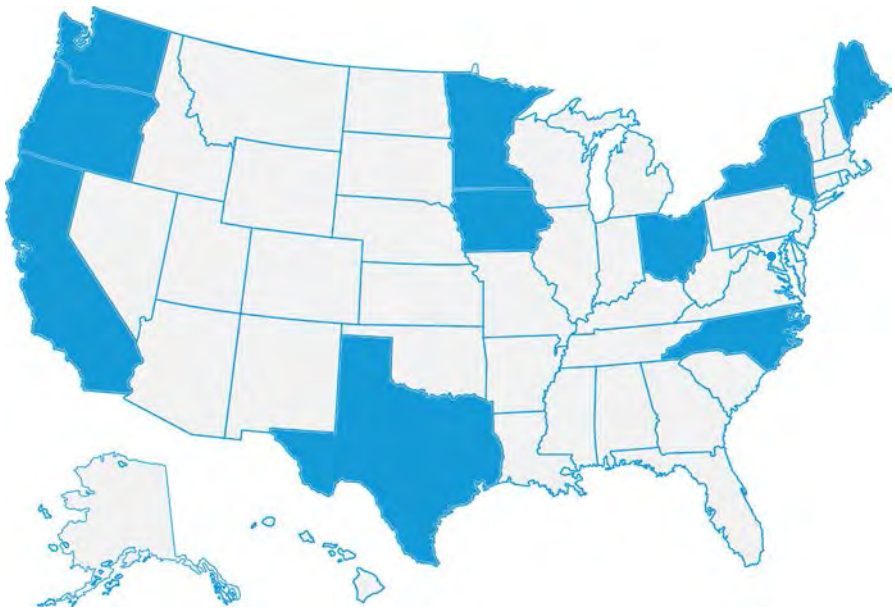
STATE OF THE STATES

August 2021-March 2022

DANB's compilation of state dental assisting requirements — on its website and in its state publications — is one of the most comprehensive resources available on this topic. The updates below highlight recent state legislative and regulatory changes that may be of interest to stakeholders of DANB and the DALE Foundation.

California

Effective Sep. 28, 2021, Senate Bill 607 repealed the clinical and practical exam requirement for dental assistants to receive the California's Registered Dental Assistant in Extended Functions (RDAEF) credential. RDAEF candidates must continue to meet the other existing requirements to perform extended functions.



District of Columbia

Effective Aug. 6, 2021, the District of Columbia Board of Dentistry made amendments to its dental assisting rules that:

- Limit eligibility to perform radiography to Level II Dental Assistants (formerly, both Level I and Level II dental assistants could qualify in radiography)
- Specify that a Board-approved radiography training program must consist of "at least twenty-four (24) hours of coursework in radiology, radiation safety, biology, and physics" and that candidates must pass the any examinations required for successful completion of the program
- Clarify that Level II Dental Assistants may perform radiography procedures only if they have completed a Board-approved program or passed DANB's RHS or CDA exams

The new rule also amends one pathway to registration as a Level II Dental Assistant: Existing requirements allowed for completion of a CODA-accredited dental assisting program or current DANB CDA certification; the new rule specifies that, for the certification pathway, an applicant may hold DANB's CDA certification or "other dental assisting certification approved by the Board."

Iowa

Effective Aug. 18, 2021, new subrules added to the Iowa Administrative Code establish procedures for "registration by verification" for dental assistants licensed or registered for at least a year in another jurisdiction with a scope of practice similar to Iowa. Applicants must establish residency in Iowa or be the spouse of an active-duty military member permanently stationed in the state to be eligible for such registration. Applicants for registration by verification must submit a verification form from the licensing authority in the jurisdiction that issued their existing license and information about the scope of practice in the state of origin and disciplinary actions taken, if any, along with other required information. Applicants may receive a temporary registration for three months (with a one-time extension of three additional months) if they have not yet passed the jurisprudence exam but have met all other requirements.

Maine

The Maine Board of Dental Practice amended its rules, effective Dec. 15, 2021, to expand its recognition of out-of-state credentials for certain purposes, such as faculty licensure and licensure by endorsement. Under the new rule, the Board now accepts credentials from other jurisdictions, including another state, a U.S. territory, a foreign nation or a foreign administrative division that issues licenses in the

dental profession, in situations in which it formerly recognized only credentials from other U.S. states and Canada. The new rule affects some Maine Expanded Function Dental Assistant (EFDA) licensure applicants, because individuals applying for the EFDA license through the pathway requiring licensure as a dental hygienist may now use a dental hygiene license from another U.S. state, a U.S. territory, a foreign nation, or a foreign administrative division to qualify. In addition, those applying for EFDA licensure by endorsement may now use a substantially equivalent license from another jurisdiction to qualify, subject to review by the Board.

Minnesota

Effective Feb. 14, 2022, the Minnesota Board of Dentistry adopted a series of rule amendments affecting dental assistants. Most importantly, the new rule provides an avenue for unlicensed dental assistants to qualify to perform radiography procedures.

Prior to the rule change, state rules specified that only a Licensed Dental Assistant could perform radiography procedures and allowed a narrow exception for individuals licensed or qualified in Minnesota in an allied health profession (such as registered nurses) to earn a *limited-license permit* in dental radiography. The new rule changes the name of this credential to *limited radiology registration* and eliminates the requirement that the applicant be qualified in an allied health profession by virtue of academic achievement greater than that required for a Licensed Dental Assistant, making dental radiography qualification in Minnesota available to a broader population of dental assistants.

To earn the limited radiology registration, a dental assistant must have completed a Board-approved course in radiography through a CODA-accredited program, have passed DANB's RHS exam within the past five years, have passed the Board's jurisprudence exam within the past five years, hold current CPR certification, submit a completed application and required fee, and undergo a criminal background check.

Additionally, a limited radiology registrant must complete two hours of infection control education every two years and comply with the most current infection control guidelines for dental settings.

The new rule also:

- Defines requirements for oral healthcare professionals licensed in other states to receive a guest license or a guest volunteer license in Minnesota
- Adjusts license reinstatement requirements for oral healthcare professionals, including dental assistants
- Reorganizes sedation rules, including those related to nitrous oxide administration, and clarifies that an LDA who graduated from a Minnesota dental assisting program after Sep. 2, 2004, does not need to meet any additional educational or administrative requirements to administer nitrous oxide analgesia; those who graduated prior to this date must take an additional course in this function
- Adjusts and clarifies biennial professional development requirements for oral healthcare professionals, including LDAs, who must complete 25 hours of continuing education, with at least 15 hours in "fundamental activities" and no more than 10 hours in "elective activities." HIPAA training, formerly an elective, has been reclassified as a fundamental activity
- Updates sections addressing procedures delegable to unlicensed and licensed dental assistants to remove outdated and non-relevant language, without substantive changes
- Updates and clarifies language related to conduct unbecoming a licensee

New York

At its May 14, 2021, meeting, the New York State Board for Dentistry determined that the application of bleach must be performed by a dentist and is not within the scope of practice of registered dental assistants or hygienists.

North Carolina

Effective Nov. 1, 2021, the North Carolina State Board of Dental Examiners amended its rule setting forth course requirements for dental assistants to qualify to assist a dentist in nitrous oxide sedation monitoring. The amendment specifies that course instructors must be dentists holding an unrestricted license or an instructor's license, or dental hygienists or dental assistants who themselves serve under the direction of the aforementioned licensees. The amendment further specifies that courses shall be reviewed at any Board meeting and approved by a majority of the Board.

STATE OF THE STATES

August 2021-March 2022

Ohio

In February 2021, the Ohio State Dental Board voted that it will temporarily recognize DANB's NELDA certification as meeting the state's requirements for Certified Assistant status through the end of 2021. At its meeting on March 9, 2022, the Ohio Dental Board voted to extend its acceptance of DANB's NELDA certification for Certified Assistant status through June 30, 2023, and to review and consider inclusion of this exam via its rulemaking process.

Oregon

Effective Sep. 25, 2021, House Bill 2528 enacted a series of statutes authorizing and governing the practice of dental therapy. Under the new law, dental therapists may supervise both dental assistants and expanded function dental assistants, provided that such supervision does not exceed two individuals and that the dental therapists are themselves authorized to perform the relevant services.

Texas

Effective Sep. 30, 2021, the Texas State Board of Dental Examiners adopted an amendment to the requirements for initial dental assisting registration. Specifically, the amended rule now requires that RDA applicants must complete a human trafficking prevention course approved by the Texas Health and Human Services Commission. This amendment continues a trend by states to increase education and training in human trafficking prevention for dental team members. It also expands upon an existing Texas requirement that dental assistants earn CE in human trafficking prevention, which began in December 2020.

Washington

Effective Aug. 18, 2021, the Washington State Dental Quality Assurance Commission made permanent an emergency rule adopted in December 2020 allowing dentists to delegate the administration of COVID-19 screening tests (swab tests) to registered dental assistants, licensed EFDAs and licensed dental hygienists.

LICENSE RATIFICATION

16 . RATIFICATION OF LICENSES

As authorized by the Board, licenses to practice dentistry and dental hygiene were issued to applicants who fulfilled all routine licensure requirements. It is recommended the Board ratify issuance of the following licenses. Complete application files will be available for review during the Board meeting.

DENTAL HYGIENISTS

H8388	2/16/2022	LINSTAD	MEGAN	R.D.H.
H8389	2/16/2022	MCEVOY	MACKENZIE	R.D.H.
H8390	2/16/2022	JUBEA	DIANA	R.D.H.
H8391	2/16/2022	BROWN	JENNY	R.D.H.
H8392	3/4/2022	DIAZ	NATALIA	R.D.H.
H8393	3/4/2022	PONCE FLORES	CECILIA	R.D.H.
H8394	3/4/2022	BROWN	CHRISTOPHER	R.D.H.
H8395	3/4/2022	PROULX	SARA	R.D.H.
H8396	3/9/2022	GAWLICK	KIMBERLY	R.D.H.
H8397	3/18/2022	RAMIREZ	ALEJANDRA	R.D.H.
H8398	3/24/2022	SOLOVYEVA	MARINA	R.D.H.
H8399	3/31/2022	HORVAT	JENNA MAE ROLLAND	R.D.H.
H8400	4/1/2022	EGLIAN	CHEYENNE	R.D.H.
H8401	4/1/2022	RIOS	ADRIANNA JULISSA	R.D.H.
H8402	4/8/2022	COLMENERO	NOELLE	R.D.H.
H8403	4/8/2022	HITZ	LEAH	R.D.H.

DENTISTS

D11578	2/16/2022	HUNT	BRANDON	D.D.S.
D11579	2/16/2022	NORDEEN	JEANINE	D.D.S.
D11580	2/17/2022	LOW	ANGELA	D.D.S.
D11581	2/23/2022	PROULX	GABRIEL	D.M.D.
D11582	3/4/2022	NGUYEN	MINHHUY	D.M.D.
D11583	3/9/2022	KHORSANDI	JAY	D.D.S.
D11584	3/9/2022	KARIYA	CASEY	D.D.S.
D11585	3/15/2022	HAYEK	GABRIEL MATTHEW	D.M.D.
D11586	3/18/2022	BOUNEFF	ALEXANDER	D.M.D.
D11587	3/18/2022	BELLO RIVERA	ANGEL	D.M.D.
D11588	3/24/2022	GONZALEZ	PETER	D.D.S.
D11589	3/24/2022	MEHR	SOFIA	D.M.D.
D11590	3/31/2022	CHANG	NAI-YUAN	D.D.S.

D11591	4/1/2022	MIRCHEL	THOMAS K.L.	D.D.S.
D11592	4/1/2022	FUGARO	ORLANDO	D.D.S.
D11593	4/8/2022	CHAO	LAUREN	D.M.D.
D11594	4/8/2022	WU	YING	D.D.S.

LICENSE, PERMIT & CERTIFICATION

Nothing to report under this tab