Certification Page
Regular and Emergency Rules
Revised June 2020

☐ Emergency Rules *(Complete Sections 1-3 and 5-6)* ■ Regular Rules

1. General Information

a. Agency/Board Name*	Dental Examiners, Board of		
b. Agency/Board Address	2001 Capitol Ave, Room 127	c. City: Cheyenne	d. Zip Code: 82002
e. Name of Agency Liaison	Emily Cronbaugh	f. Agency Liaison Telephone Number	307-777-6529
g. Agency Liaison Email Address	emily.cronbaugh@wyo.gov	h. Adoption Date	November 12, 2021
i. Program	Dental Examiners, Board of		
☐ Amended Program Name (*if applicable*):			

* ☐ *By checking this box, the agency is indicating it is exempt from certain sections of the Administrative Procedure Act including public comment period requirements. Please contact the agency for details regarding these rules.*

2. Legislative Enactment

For purposes of this Section 2, "new" only applies to regular (non-emergency) rules promulgated in response to a Wyoming legislative enactment not previously addressed in whole or in part by prior rulemaking and does not include rules adopted in response to a federal mandate.

a. Are these non-emergency or regular rules new as per the above description and the definition of "new" in Chapter 1 of the Rules on Rules?

☐ No. ■ Yes. If the rules are new, please provide the Legislative Chapter Numbers and Years Enacted (e.g. 2015 Session Laws Chapter 154): 2021 Session Laws Chapter 107

3. Rule Type and Information

For purposes of this Section 3, "New" means an emergency or regular rule that has never been previously created.

a. Provide the Chapter Number, Title* and Proposed Action for Each Chapter. *Please use the "Additional Rule Information" form to identify additional rule chapters.*

Chapter Number:	Chapter Name:			
1	General Provisions	☐ New	■ Amended	☐ Repealed
	Amended Chapter Name (*if applicable*):			
3	Requirements for Licensure and Renewal	■ New	■ Amended	☐ Repealed
	Amended Chapter Name (*if applicable*):			
4	Dental Practice	☐ New	■ Amended	☐ Repealed
	Amended Chapter Name (*if applicable*):			
5	Anesthesia Administration and Sedation Permit Procedures	☐ New	■ Amended	☐ Repealed
	Amended Chapter Name (*if applicable*):			
7	Dental Auxiliaries	■ New	■ Amended	☐ Repealed
	Amended Chapter Name (*if applicable*):			
9	Practice and Procedures for Disciplinary, Application, and Licensure Matters	☐ New	■ Amended	☐ Repealed
	Amended Chapter Name (*if applicable*):			

Additional Rule Information

Revised June 2020

Include this page only if needed.

1. General Information			
a. Agency/Board Name* Dental Examiners, Board of			
b. Agency/Board Address 2001 Capitol Ave, Room 127	c. City Cheyenne	d. Zip Code 82002	
e. Name of Agency Liaison Emily Cronbaugh	f. Agency Liaison Telephone Number 307-777-6529		
g. Agency Liaison Email Address emily.cronbaugh@wyo.gov			
h. Program Dental Examiners, Board of			
Amended Program Name (*if applicable*):			

2. Rule Type and Information, Cont.		
a. Provide the Chapter Number, Title, and Proposed Action for Each Chapter.		
Chapter Number: 10	Chapter Name: Fees	☒ New ☒ Amended ☐ Repealed
	Amended Chapter Name (*if applicable*):	
Chapter Number:	Chapter Name:	☐ New ☐ Amended ☐ Repealed
	Amended Chapter Name (*if applicable*):	
Chapter Number:	Chapter Name:	☐ New ☐ Amended ☐ Repealed
	Amended Chapter Name (*if applicable*):	
Chapter Number:	Chapter Name:	☐ New ☐ Amended ☐ Repealed
	Amended Chapter Name (*if applicable*):	
Chapter Number:	Chapter Name:	☐ New ☐ Amended ☐ Repealed
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	Amended Chapter Name (*if applicable*):	
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	Amended Chapter Name (*if applicable*):	
Chapter Number:	Chapter Name:	☐ New ☐ Amended ☐ Repealed
	Amended Chapter Name (*if applicable*):	
Chapter Number:	Chapter Name:	☐ New ☐ Amended ☐ Repealed
	Amended Chapter Name (*if applicable*):	

4. Public Notice of Intended Rulemaking

a. Notice was mailed 45 days in advance to all persons who made a timely request for advance notice. ☐ No. ☑ Yes. ☐ N/A

b. A public hearing was held on the proposed rules. ■ No. ☐ Yes. Please complete the boxes below.

Date:	Time:	City:	Location:

5. Checklist

a. ☑ For regular rules, the Statement of Principal Reasons is attached to this Certification and, in compliance with Tri-State Generation and Transmission Association, Inc. v. Environmental Quality Council, 590 P.2d 1324 (Wyo. 1979), includes a brief statement of the substance or terms of the rule and the basis and purpose of the rule

b. ☐ For emergency rules, the Memorandum to the Governor documenting the emergency, which requires promulgation of these rules without providing notice or an opportunity for a public hearing, is attached to this Certification.

6. Agency/Board Certification

The undersigned certifies that the foregoing information is correct. By electronically submitting the emergency or regular rules into the Wyoming Administrative Rules System, the undersigned acknowledges that the Registrar of Rules will review the rules as to form and, if approved, the electronic filing system will electronically notify the Governor's Office, Attorney General's Office, and Legislative Service Office of the approval and electronically provide them with a copy of the complete rule packet on the date approved by the Registrar of Rules. The complete rules packet includes this signed certification page; the Statement of Principal Reasons or, if emergency rules, the Memorandum to the Governor documenting the emergency; and a strike and underscore copy and clean copy of each chapter of rules.

Signature of Authorized Individual	Emily Cronbaugh
Printed Name of Signatory	Emily Cronbaugh
Signatory Title	Executive Director
Date of Signature	November 22, 2021

7. Governor's Certification

I have reviewed these rules and determined that they:

1. Are within the scope of the statutory authority delegated to the adopting agency;
2. Appear to be within the scope of the legislative purpose of the statutory authority; and, if emergency rules,
3. Are necessary and that I concur in the finding that they are an emergency.

Therefore, I approve the same.

Governor's Signature	
Date of Signature	

STATEMENT OF PRINCIPAL REASONS

FOR FORMAL ADOPTION OF REGULAR RULES

The Wyoming Board of Dental Examiners (Board) is authorized to adopt rules and regulations to implement the Board's practice act. The Board regularly reviews its rules to correct inconsistences, eliminate any repetition with its practice act, correct grammatical errors, and update the rules' requirements. Furthermore, recent amendments to the Board's Practice Act as a result of 2021 Senate Enrolled Act 43 have necessitated additional rules changes. Specifically, these Act revisions changed the license expiration date from an annual renewal to a biennial renewal and updated the name of the national written examination for dentists. As a result, the Board is proposing changes to nearly every chapter of its rules.

Following public comment, the Board made three (3) changes, which are identified in blue text under both Chapter 4 and Chapter 7.

Chapter 1: General Provisions

- Section 3:
  - Corrected a typographical error in the definition of ADHA.
  - Removed the definitions of CDCA, CITA, CRDTS, SRTA, and WREB as these specific exam companies are no longer referenced in rule. Instead, the Board will only list required exam criteria instead of specific examinations.
  - Removed the definition of "CPR" as all references to the required life support training have been changed to "BLS" for basic life support.
  - Updated NBDE definition to INDBE to reflect new examination name. This change is now permitted pursuant to 2021 SEA No. 0043.
  - Removed the requirement for a PBIS report for dental endorsement candidates as PBIS is no longer in business effective December 31, 2020.
  - Added a definition for teledentistry using resources from the American Dental Association, American Association of Dental Boards, and other state dental boards as related requirements were added into Chapter 4. Although teledentistry is already permitted, the Board seeks to make those requirements clearer to better ensure patient safety.
  - Renumbered section accordingly.
- Section 6:
  - Updated the Board's Rules webpage link to all references by incorporation.
  - Updated ADA Code of Ethics, the American Dental Hygienists' Association (ADHA) Code of Ethics, the Dental Assisting National Board (DANB) Code of Ethics, the Summary of Infection Prevention Practices in Dental Settings, and OAH Rules to the newest versions.
  - Added the CDC Guideline for Prescribing Opioids for Chronic Pain reference. This is intended to better define appropriate opioid prescribing standards for licensees. It is the Board's hope that this will alleviate prescriptive related complaints.

Chapter 3: Requirements for Licensure and Renewal

- General Changes:
  - Added authority section as required by Wyo. Stat. Ann. § 16-3-104(a).
  - Renumbered chapter sections accordingly.

    - Made some grammatical revisions.
- New Section 5:
    - Removed the requirement for the ARC to recommend eligibility to test. This will allow applicants to complete the jurisprudence examination prior to application review and remove additional delay from application to licensure.
    - Changed the exam pass rate from 75% to 80% as the exam has evolved to now be offered "open book" and the Board has determined a higher pass rate is appropriate.
    - Added a requirement that applicants who fail the exam must wait 1 week to re-test to encourage applicants to study prior to the examination.
- New Section 6 (Dentist by Examination):
    - Added a broad eligibility description to account for individuals not licensed elsewhere that have graduated more than 1 year prior to application. Current eligibility requirements do not offer a licensure path for these individuals.
    - Added BLS and transcripts as application requirements in rule to clearly reflect materials required by the application form.
    - Updated prosthodontics requirements to support current testing procedures.
    - Removed "and root planing" because it is no longer a skill assessed at clinical examinations.
    - Updated restorative dentistry requirement to support current testing procedures.
    - Added a competency section to ensure that the updated eligibility definition ensures those out of clinical practice can adequately demonstrate competency. Added requirement for continuing education to be earned from an accredited dental program or pre-approved by the Application Review Committee.
- New Section 7 (Dentist by Endorsement):
    - Clarified eligibility language.
    - Removed the requirement for a PBIS report for dental endorsement candidates as PBIS is no longer in business effective December 31, 2020. (Currently addressed via existing emergency rules)
    - Incorporated application requirements in rule that were previously collected by PBIS, including: BLS, verification of an active license in another jurisdiction, and a copy of the applicant's dental diploma.
    - Clarified regional examination requirements.
    - Changed CE competency hours from ten (10) hours to eight (8) hours annually. As the Board previously determined sixteen (16) hours every two years adequate CE competency for renewal, eight (8) would be the appropriate requirement annually.
    - Clarified competency CE must be earned from an accredited dental program or pre-approved.
- New Section 8 (Dental Hygiene by Examination):
    - Added a broad eligibility description to account for individuals not licensed elsewhere that have graduated more than 1 year prior. Current eligibility requirements do not offer a path for these individuals.
    - Added BLS and transcripts as application requirements in rule to clearly reflect materials required by the application form.
    - Clarified that dental hygiene exams must be performed on a patient and not a simulated patient or manikin. The Board has concluded that patient care and safety cannot be similarly identified or managed on a simulated patient as on actual patients.

    - Added a competency section to ensure that the updated eligibility definition ensures those out of clinical practice can adequately demonstrate competency. Added requirement for continuing education to be earned from an accredited dental hygiene program or pre-approved by the Application Review Committee.
- New Section 9 (Dental Hygiene by Endorsement):
    - Clarified eligibility language.
    - Removed the requirement for a PBIS report for dental endorsement candidates as PBIS is no longer in business effective December 31, 2020.
    - Incorporated application requirements in rule that were previously collected by PBIS, including: BLS, verification of an active license in another jurisdiction, a copy of the applicant's diploma, and exam scores.
    - Clarified regional examination requirements to address competency and not specify an examination company. This better matches how the dental examination requirements are listed.
    - Changed CE competency hours from ten (10) hours to eight (8) hours annually. As the Board previously determined sixteen (16) hours every two years adequate CE competency for renewal, eight (8) would be the appropriate requirement annually.
    - Clarified competency CE must be earned from an accredited dental program or pre-approved.
- New Section 10:
    - Updated license expiration references pursuant to 2021 SEA No. 0043 that require licenses be renewed every two years instead of annually.
    - Added requirement that licensees verify active clinical practice. This is required by W.S. 33-15-109(b) and has always been on the renewal form, but now added to rule to further clarify renewal requirements.
    - Clarified exam requirement for those out of clinical practice and removed the requirement to apply for a non-clinical license. The Board is striking the non-clinical license as explained in Section 15 below.
- New Section 12:
    - Updated license expiration references pursuant to 2021 SEA No. 0043 that require licenses be renewed every two years instead of annually.
    - Clarified that late renewals must also provide evidence of CE completion.
- New Section 14:
    - Clarified applicants must provide eight (8) hours of CE for each year the license has been lapsed. While this is the same requirement as sixteen (16) hours every two (2) years, this wording is clearer for licenses that have been lapsed three (3) years instead of two (2).
    - Changed CE competency hours from ten (10) hours to eight (8) hours annually. As the Board previously determined sixteen (16) hours every two years adequate CE competency for renewal, eight (8) would be the appropriate requirement annually.
    - Clarified competency CE must be earned from an accredited dental program or pre-approved.
- Section 15:
    - Removed the non-clinical licensure method. It was determined the non-clinical license was initially created based on W.S. 33-15-109(b), but upon review, the Board did not believe it was necessary.

Chapter 4: Dental Practice

- General Changes:
  - Added authority as required by Wyo. Stat. Ann. § 16-3-104(a).
  - Renumbered chapter sections accordingly.
  - Made some grammatical revisions.
- New Section 3:
  - Added requirements for performing teledentistry using resources from the American Dental Association and American Association of Dental Boards. Although teledentistry is already permitted, the Board seeks to make those requirements clearer to better ensure patient safety.
  - Pursuant to public comment, the Board changed "practitioner-patient relationship" to "dentist-patient relationship", as "dentist-patient relationship" is already defined in Chapter 1.
  - The Board removed the proposed Chapter 4, Section 3(b)(vi) which required a licensee to "Obtain patient consent to forward patient identifiable information to a third party" prior to treating the patient. The Board determined this requirement was not necessary prior to providing teledentistry services.
- New Section 4:
  - Clarified that licensees using satellite offices must adhere to the same standard of care in the satellite office as the main office.
- New Section 5:
  - Updated requirements for radiograph use by dentists. The Board used provisions in place by the Colorado Department of Public Health and Environment, the Minnesota Department of Health, and the Utah Department of Environmental Quality in addition to a technical white paper by the Conference of Radiation Control Program Directors Task Force on Cone Beam Computed Tomography. The revisions in this section will no longer require licensees to document their machine inspections to the Board office, but instead allow licensees to attest to compliance with these requirements periodically as determined in this section. This will alleviate board administrative time for a business process that occurs between an inspector and dentist, but also ensure machines are appropriately inspected.

Chapter 5: Anesthesia Administration and Sedation Permit Procedures

This chapter was significantly revised to make requirements easier for licensees to adhere to and for board staff to administer. The significant changes are:

- Removing the operating dentist sedation permit. This permit allowed individuals already licensed as dentists to perform the same function the dental license allows for. This is being removed to avoid redundancy and alleviate an unnecessary permitting process for licensees and staff.
- Better clarification of the facility permit process. This change includes clearly identifying a responsible dentist accountable for the facility permit. This allows the Board to monitor where sedation is being performed while ensuring an individual license holder is responsible for that sedation procedure.
- Reorganization to move requirements for administration, office inspection requirements, patient monitoring and documentation requirements, and personnel requirements under each respective anesthesia level. This will allow a permit holder to find all practice requirements for their specific permit level in one section instead of spread throughout the chapter.

- General Changes:
  - Added authority as required by Wyo. Stat. Ann. § 16-3-104(a).
  - Renumbered chapter sections accordingly.
  - Made some grammatical revisions.
- New Section 3 (Old Section 2):
  - Changed definition of "anxiolysis" to mean minimal sedation. Minimal sedation is further defined in this section and this change reduces redundancy and confusion.
  - Removed definition of dentist as this is defined in statute.
  - Clarified the "facility permit" is tied to one specific facility.
  - Added definition of "facility permit holder" to require a licensed dentist as accountable for this permit.
  - Updated "minimal sedation" to incorporate anxiolysis administration.
  - Removed "operating dentist" as this is no longer required. As explained above, this permit allows individuals already licensed as dentists to perform the same function the dental license already allows. This is being removed to avoid the redundancy and alleviate an unnecessary permitting process for licensees and staff.
  - Removed "permit holder" definition. There were multiple permits being issued as a result of this chapter and this term was confusing when used within the chapter. It has been either stricken or clarified as used in the rest of this chapter.
  - Defined a responsible dentist to support other facility permit changes.
  - Defined a sedation inspector. The requirement for a board approved inspector was already within this chapter, but not clearly defined. As the Board currently requires x-ray machine inspectors the lack of clarification was confusing.
- New Section 4 (Old Section 3)::
  - Removed operating dentist from this section.
  - Clarified "permit holder" was a "sedation permit holder" in this section.
- Old Section 4:
  - Deleted section and incorporated requirements for anxiolysis into the following minimal sedation section (section 5).
- Section 5:
  - Removed operating dentist from this section.
  - Moved deleted Section 4 content into subsection (c).
  - Moved deleted Section 12(a) content into subsection (d).
  - Moved deleted Section 13(a) and (b) content into subsection (e).
  - Moved deleted Section 14(a) and (b) content into subsection (f).
  - Changed anxiolysis to administration.
- Section 6:
  - Moved deleted Section 12(b) and (c) content into subsection (b).
  - Moved deleted Section 13(a) and (c) content into subsection (c).
  - Moved deleted Section 14(a),(c) and (d) content into subsection (d).
  - Removed operating dentist from this section.
  - Clarified "permit holder" was a "sedation permit holder" in this section
  - Deleted new subsection(e)(v) as grounds for discipline in Chapter 9 would address this violation
  - Deleted subsection (d). This definition would allow an individual to be sedated past moderate and was inaccurate.

- Section 7:
    - Removed requirement for the ARC to approve applicants for a site inspection. Many applicants can obtain a site inspection prior to application completion and ARC review. This is anticipated to help speed up the time from application to a sedation permit.
    - Moved deleted Section 11(b)(ii)(B) content into subsection (c).
    - Moved deleted Section 11(b)(ii)(C) content into subsection (d). Also included simulated emergencies listing that has been used in the inspector's checklists.
    - Moved deleted Section 11(b)(ii)(D) content into subsection (e).
    - Deleted requirement for applicants to pay inspectors a fee. It was determined the Board could not set fees for services provided by private individuals.
- Section 8:
    - Removed requirement for the ARC to approve applicants for a site inspection. Many applicants can obtain a site inspection prior to application completion and ARC review. This is anticipated to help speed up the time from application to a sedation permit.
    - Moved deleted Section 11(b)(ii)(B) content into subsection (c).
    - Moved deleted Section 11(b)(ii)(C) content into subsection (d). Also included simulated emergencies listing that has been used in the inspector's checklists.
    - Moved deleted Section 11(b)(ii)(D) content into subsection (e).
    - Deleted requirement for applicants to pay inspectors a fee. It was determined the Board could not set fees for services provided by private individuals.
- Old Section 9:
    - Deleted section. Temporary permits were necessary while applicants waited for their facilities to be inspected. Now that this inspection can occur upon application, this waiting period is no more and the temporary permit was removed accordingly.
- New Section 9:
    - Incorporated content deleted from Section 16. This was created in new Section 9 as the renewal requirement appeared to be the logical section to follow application requirements. Licensees are more likely to comply when requirements are more easily located.
    - Updated renewal expiration date to "every second year" to match recent Practice Act revisions pursuant to 2021 Senate Enrolled Act 43.
- New Section 10:
    - Incorporated content deleted from Section 17. This was created in new Section 10 as the reinstatement requirement appeared to be the logical section to follow renewal requirements.
- New Section 11 (Old Section 10):
    - Clarified the inspector is a sedation inspector. The Board currently requires x-ray machine inspectors and the lack of clarification was confusing.
    - Removed requirement for a sedation inspector to hold a sedation permit. This requirement conflicted with the ability to have an anesthesiologist or certified nurse anesthetist conduct sedation inspections, as they are not licensed by this board and unable to hold a sedation permit issued by this board.
    - Changed "dental specialist" to "oral maxillofacial surgeon". Not all dental specialists have equal sedation training, so the Board changed this requirement to an oral maxillofacial surgeon who has the appropriate training and education.

    - Moved requirement for a sedation inspector to be considered an agent for the Board to the top of the list.
    - Changed clinical locations to sedation facilities to better match wording for a facility permit.
    - Added requirement for an inspector to review a sedation permit applicant's surgical techniques.
- Old Section 11:
    - Deleted section. Inspection requirements moved to New Section 12, inspection review, surgical/anesthetic techniques, simulated emergencies, and discussion period moved to Sections 7 and 8. Inspection and reinspection processes moved to New Section 13.
- New Section 12:
    - Incorporated initial inspection requirements for facilities from Old Section 11 and facility renewal permit language from Old Section 16.
    - Updated renewal expiration date to "every second year" to match recent Practice Act revisions pursuant to 2021 Senate Enrolled Act 43.
- New Section 13:
    - The sedation facility inspection process and reinspection process were moved here from Old Section 11.
- Old Section 12:
    - Office faculties and equipment requirements were moved to Section 5 for minimal sedation and Section 6 for moderate and deep sedation.
- Old Section 13:
    - Patient monitoring and documentation requirements were moved to Section 5 for minimal sedation and Section 6 for moderate and deep sedation.
- Old Section 14:
    - Dental Personnel requirements were moved to Section 5 for minimal sedation and Section 6 for moderate and deep sedation.
- Old Section 15:
    - The application process for facility permits was moved to New Section 12 and the operating permit requirements were deleted.
- Old Section 16:
    - This renewal of sedation permits section was moved to New Section 10. This change more logically follows a permit procedure through rule - from the application requirements, to the application process, to renewal requirements, etc.
- Old Section 17:
    - This reinstatement of expired and revoked sedation permits was moved to New Section 10. This change more logically follows a permit procedure through rule - from the application requirements, to the application process, to renewal requirements, to reinstatement requirements.
- Old Section 18:
    - The requirement for sedation permit holders to report any morbidity, mortality, or other incident resulting in injury requiring hospitalization was moved to Chapter 6 on Ethics in the rules effective December 9, 2019. This is now a requirement for all licensees to report these outcomes to the Board.

<u>Chapter 7: Dental Auxiliaries</u>

- General Changes:

    - Added authority as required by Wyo. Stat. Ann. § 16-3-104(a).
    - Renumbered chapter sections accordingly.
    - Made some grammatical revisions.
    - Changed "functions" to "duties" throughout Chapter to comply with wording in the Board's Practice Act.
- New Section 5:
    - Defined community dental health activities. This expanded definition will allow any hygienist to perform these duties under general supervision and will remove the special expanded duty of the Public Health Hygienist. Now hygienists need no longer apply for a special permit to perform public health services and can do so under general supervision instead of direct supervision.
    - Added silver diamine fluoride to acceptable duties. This will alleviate many questions licensees have posed to the Board.
- New Section 6:
    - Deleted public health hygiene from the expanded duties as this is now allowed without the expanded functions permit as described under New Section 5 above.
- New Section 7:
    - Moved placing and exposing x-ray image receptors, added need for a dentist's order to do so, and placed under general supervision instead of indirect supervision. This allows permitted assistants to begin x-rays for a patient with a dentist's order and not their physical presence.
    - Clarified polishing should be done on coronal surfaces of teeth and removed prohibition for prophylaxis procedures as already listed in subsection (e).
    - Clarified use of high and low speed hand pieces is prohibited by assistants except for the coronal polishing. This is intended to alleviate frequent questions received and ensure only those appropriately trained are using such equipment. Pursuant to public comment, the Board clarified the prohibited use to be "intraorally".
- New Section 8:
    - Updated application competency requirement to specify training must be completed in the year prior to application and added option to demonstrate competency through a similar credential in another jurisdiction.
    - Added late renewal process.
- New Section 9:
    - Clarified training must be completed in the year prior to application.
    - Added late renewal process.

Chapter 9: Practice and Procedures for Disciplinary, Application, and Licensure Matters

The Board is revising its chapter governing investigations and contested cases for discipline and license applications. The changes bring the Board's discipline chapter in line with the procedures other professional licensing boards use to clarify the investigation process and protect the due process rights of licensees.

Chapter 10: Fees

- General Changes:
    - Added authority as required by Wyo. Stat. Ann. § 16-3-104(a).
    - Renumbered chapter sections and subsections accordingly.
    - Made some grammatical revisions.
- New Section 3:

    - Removed payment methods which will allow the Board to transition to online credit card payments in the future.
    - Added requirement for fees related to public records to be assessed pursuant to the corresponding A&I Rules.
- New Section 4:
    - Removed non-clinical application and renewal fees from the dental and dental hygiene fee subsections as the non-clinical license was removed.
    - Removed Operating Dentist Permit Application and Renewal fees as this permit was removed from Chapter 5.
    - Removed office inspector fee. The requirement for applicants to pay inspectors a fee was removed from Chapter 5 as it was determined the Board could not set fees for services provided by private individuals.
    - Lowered renewal fees as follows:
        - Dentist Renewal from $185 annually (or $370 biennially) to $350 biennially
        - Sedation Permit Renewal from $250 annually (or $500 biennially) to $475 biennially
        - Hygiene Renewal from $95 annually (or $190 biennially) to $170 biennially
    - Clarified permit reinstatement was for a sedation permit reinstatement.
    - Separated radiograph permit renewal fee from the pit and fissure permit renewal fee and created a pit and fissure permit renewal fee, as some individuals may now hold a pit and fissure permit without also holding a radiograph permit. Lowered the permit renewal fee from $15 annually (or $30 biennially) to $20 biennially.
    - Added fee for late permit renewal. The Board presently assesses a $15 fee for each year the permit has been expired. This would instead be a single late fee payment of $15.
    - Removed roster fee as this information is provided free of charge.

COMMENT SUMMARY AND CHANGES BASED UPON PUBLIC COMMENT

The Wyoming Board of Dental Examiners proposed changes to Chapters 1, 3, 4, 5, 7, 9, and 10. The Board held a public comment period from September 10, 2021 through October 29, 2021, and received eleven (11) public comments.

Based on several public comments, the Board made three (3) non-substantive amendments to the rules. Some comments were in regards to rules not included in the proposed rules package and some would necessitate additional consideration and public comment. The Board elected to further consider these comments in future rulemaking discussions.

Comment #1: Damon Jensen commented:

I hope the Dental Board will serve the citizens of Wyoming and not dentists by limiting competition. We should encourage dentists to practice in Wyoming. Any dentist who has graduated from an accredited dental school and passed any regional board exam and passed the jurisprudence exam should be considered eligible for a Wyoming license. This was Wyoming law pre 2007. The board changed part 3 section 65 limiting the number of potential dentists who could practice in Wyoming. This proposed change continues the trend. The proposed changes basically exclude WREB dentists (largest regional exam with nearly 30% of graduates taking it.) Having more dentists improves access, and with more dental supply drives down consumer cost.

Please serve the citizens and patients of Wyoming and restore licensing language to accept any regional exam. The board has no roll in stating what the regional exam is composed of. This decision should be up to the regional exams themselves.

As a profession we have a duty to put our patients above our financial well being. Limiting potential competition by dictating what a regional board should consist of hurts patients. The testing boards know what a safe dentist is. Let them decide what a regional exam board should be and accept unconditionally all regional exams.

Very respectfully,

Damon Jensen
License 1180

Response: *The Board thanks Dr. Jensen for commenting. Regional examination requirements are driven by state board members and all regional examinations, including WREB, are able to provide examinations that comply with Wyoming's rules. The ultimate responsibility of the Board is to safeguard the health, safety and welfare of the citizens of Wyoming by ensuring that those individuals licensed to provide dental services in the state are duly qualified. The Board does not believe any changes are necessary because every regional examination company offers examinations that can comply with the Board's Rules.*

Comment #2: Callie Holwegner, DDS commented:

I would like to propose an addition to the current proposed changes:

Chapter 7
Dental Auxiliaries

Section 7. Dental Assistants. The Following applies to all dental assistants:

(d) Direct Supervision. The following procedures require direct supervision:
(ix) Take impressions either digital or conventional for clear aligner orthodontic therapy of any type;

As an orthodontist who uses invisalign treatment, I would feel comfortable having my assistants take a PVS impression for treatment and I can check the impression before it is sent off to invisalign. If this impressions is not quality, invisalign rejects it and you have to retake the impression anyway. I would like to place it under direct supervision because I do think it is important for the doctor to check the impression before it is sent to invisalign.

Thanks,
Callie Holwegner, DDS, MS

Response: *The Board thanks Dr. Holwegner for commenting. The current and proposed language already allow for these impressions to be taken under direct supervision, specifically, Chapter 7(d)(x) "Take impressions for orthodontic procedures, i.e. retainers and removable appliances."*

Comment #3: Sean Ellis, DDS commented:

Emily, I have several comments regarding some of the proposed Rules changes. If this is not the correct path let me know.

Chapter 3 Changes to the Jurisprudence exam I disagree with the idea to force a candidate who fails the exam to wait a week to re take the exam. I have provided the exam to one dentist candidate and a number of hygiene candidates. Many of them travel to take the exam, several have chosen my Casper office because they can fly to Casper. Making a candidate make other travel arrangements to re-take the exam is unfair. I have not had anyone fail the exam but it will eventually happen. My plan is to tell them to go drink a cup of coffee, review the Rules and I will provide another version of the exam that same day. The point of the jurisprudence exam is to impress upon the candidate the need be aware of the Rules and to practice within the Rules. To that point changing the passing grade to 80% from the current 75% is a poor idea. The current tests are not professionally written and the questions leave room for disagreement to specific answers. Again the idea is to force the candidate to review/study the Rules and be familiar with them and how to apply them to practicing in Wyoming.

Regarding inspection of x-ray machines. I hope that the Board will not make the requirements to be an inspector for Wyoming dental offices too stringent. It is already pretty difficult to find and arrange for the in-office inspection. Creating requirements for inspectors that will make inspections more difficult to arrange and likely more expensive and have no effect on patient safety are counter productive.

Chapter 7 typo (B) (ii) duties for "dental assistant" should read "hygienist"

Thanks, Sean Ellis, DDS

Response: *The Board thanks Dr. Ellis for commenting. The Board will no longer require candidates to appear in person to test when these new rules go into effect. The Board chose to keep the one (1) week requirement to allow applicants an appropriate time to study materials should they fail their previous attempt. The jurisprudence examination question will be reviewed and rewritten by a committee of the Board. Regarding x-ray machine inspections, the Board presently and will continue to allow x-ray machine installation companies to perform x-ray machine inspections. At their November 12, 2021 meeting, the Board became aware that two such companies, Henry Schein and Patterson, were able to perform these inspections. The Chapter 7 language is to clarify that dental hygienists can perform any duties authorized for dental assistants.*

Comment #4: Rodney Hill, DDS commented:

Wyoming Board of Dental Examiners,

In reading the proposed rule changes to chapter 3, I see potential problem by just referencing a "Regional Clinical Exam". I understand the reasoning behind removing the reference to any specific testing agency and fully support that. My concern is the interpretation of what is a "Regional Clinical Exam" by a candidate. While we all know what you are meaning, someone may want to push that definition. May I offer a simple suggestion, in definitions you could add Regional Clinical Exam to be defined as a "Independent Third-Party Testing Organization", example: CRDTS, CDCA, WREB, ect.

Thank you for your time in this matter and for serving on the board,
Rod Hill DDS

Response: *The Board thanks Dr. Hill for commenting. The Board believes the existing wording is sufficient.*

Comment #5: Dr. Eric Hillam commented:

Wyoming Dental Board,

My name is Eric Hillam. I am an orthodontic resident at St. Louis University Center for Advanced Dental Education. May I begin by thanking all, in advance, who are taking the time to read and consider the contents of this letter. I am grateful for the thought that has been enlisted into rule changes that have recently been made, it shortened this letter by half and indicates your dedication to dentistry in Wyoming. I appreciate

the communications that I have had with Emily Cronbaugh, who suggested that I write this letter to the board in advance of the November meeting as you consider the by-laws of the state board of dentistry. Hopefully, I can articulate a few points that may be helpful to you as you deliberate.

When I took the WREB exam in 2019 I did not perform the class III restoration portion of the exam. I completed the operative, periodontal, prosthodontic, and endodontic sections of the exam and passed the WREB. As I read chapter 3 of the by-laws I became aware of some questions and possible concerns that may be helpful as you broach the subject of dental licensure for those who specialize in dentistry.

- Section 7(iii) allows for a waiver of the fixed prosthodontic section of the clinical exam if the applicant completes a specialty practice residency. Why does fixed prosthodontics get waived with the completion of a residency? Why not the endodontic section or periodontics section, or class III restoration? May I respectfully suggest a possible change of verbiage that might add balance to the exception (changes are in bold)? "*If applicant successfully passed a regional clinical examination as identified in Section 6(b)(v) which did not include* **ONE of the following;**
  a. Fixed prosthodontics
  b. Endodontics
  c. Periodontics
  d. Class II preparation and restoration
  e. Class III preparation and restoration

  the applicant shall submit evidence of active clinical practice of 5,000 hours in the last five (5) years or verification of completion of a general practice residency (GPR), advanced education in general dentistry (AEGD), or other specialty practice residency as identified in Chapter 6;" This revision will acknowledge the hard work that the applicant has dedicated to the practice of dentistry through either years of experience or continued education.

- Although the above modification could facilitate my successful licensure, I believe the over-arching concern is that of granting specialty licenses. This would include limiting the licenses of specialists, in the state, to the scope of their specialty. One could consider this point of discussion out of concern for the residents of the State of Wyoming and delivery of the best possible care. May I simply offer this example from our friends in medicine. A cardiac surgeon being allowed to replace a knee. Both the cardiac surgeon and orthopedic surgeons are medical doctors, but they are not practicing the same scope of medicine. It could be considered unethical for these surgeons to practice outside of their specialty training. Another example in dentistry might be referring a patient to an oral surgeon that has been practicing many years, for a class II restoration, a root canal, or prepare a tooth for a crown. Obviously, the best care would be rendered by their capable dentist. The example of the oral surgeon would also apply to an orthodontist. So why are specialists given license to perform procedures that many have not done since dental school upon residents of the state?
- Another consideration, if there is a limiting of the scope of practice for specialists in the state, then licensure for dental specialists could be different than that of a general dentist. Below are a couple examples of other states, Idaho and Nevada.

024. LICENSURE OF DENTAL SPECIALISTS.

01. Requirements for Specialty Licensure. Each applicant for specialty licensure must have graduated from a CODA accredited dental school and hold a license to practice general dentistry in the state of Idaho or another state. The Board may grant licensure in specialty areas of dentistry for which a dentist has completed a CODA accredited postdoctoral advanced dental education program of at least two full-time academic years. (7-1-21)T

02. Examination. Specialty licensure in those specialties recognized may be granted solely at the discretion of the Board. An examination covering the applicant's chosen field may be required and, if so, will be conducted by the Board or a testing agent. Applicants who have met the requirements for licensure as a specialist may be required to pass an examination as follows: (7-1-21)T

a. Applicants who have passed a general licensure examination acceptable to the Board may be granted specialty licensure by Board approval. (7-1-21)T

b. Applicants who have passed a general licensure examination not acceptable to the Board may be required to pass a specialty examination. (7-1-21)T

c. Applicants who are certified by the American Board of that particular specialty as of the date of application for specialty licensure may be granted specialty licensure by Board approval. (7-1-21)T

03. Limitation of Practice. No dentist may announce or otherwise hold himself out to the public as a specialist unless he has first complied with the requirements established by the Board for such specialty and has been issued a specialty license authorizing him to do so. Any individual granted a specialty license must limit his practice to the specialty(s) in which he is licensed. (7-1-21)T

NRS 631.255 Issuance of specialist's license to person without required clinical examination; revocation.

1. The Board may, without a clinical examination required by NRS 631.240, issue a specialist's license to a person who:
(a) Presents a current certification as a diplomate from a certifying board approved by the Commission on Dental Accreditation of the American Dental Association; or
(b) Has completed the educational requirements specified for certification in a specialty area by a certifying board approved by the Commission on Dental Accreditation of the A
certification. A person who is licensed as a specialist pursuant to the provisions of this paragraph:
(1) Shall submit to the Board his or her certificate as a diplomate from the certifying board within 6 years after licensure as a specialist; and
(2) Must maintain certification as a diplomate of the certifying board during the period in which the person is licensed as a specialist pursuant to this paragraph.
2. In addition to the requirements set forth in subsection 1, a person applying for a specialist's license:
(a) Must hold an active license to practice dentistry pursuant to the laws of another state or territory of the United States, or the District of Columbia, or pursuant to the laws of this
applying pursuant to paragraph (b) of subsection 1;
(b) Must be a specialist as identified by the Board;
(c) Shall pay the application, examination and renewal fees in the same manner as a person licensed pursuant to NRS 631.240;
(d) Must submit all information required to complete an application for a license; and
(e) Must satisfy the requirements of NRS 631.230.
3. The Board shall not issue a specialist's license to a person:
(a) Whose license to practice dentistry has been revoked or suspended;
(b) Who has been refused a license to practice dentistry; or
(c) Who is involved in or has pending a disciplinary action concerning a license to practice dentistry,
in this State, another state or territory of the United States, or the District of Columbia.
4. The Board shall examine each applicant in writing on the contents and interpretation of this chapter and the regulations of the Board.
5. A person to whom a specialist's license is issued pursuant to this section shall limit his or her practice to the specialty.
6. The Board may revoke a specialist's license at any time if the Board finds, by a preponderance of the evidence, that the holder of the license violated any provision of this chapter
(Added to NRS by 2001, 1607; A 2005, 45, 273, 274, 2719; 2009, 1527; 2015, 712)

Notice, in the above by-laws, the ability to gain licensure if a specialist did not pass a general licensure exam acceptable to the state. They do this through an examination that proves their competency within the scope of practice to which they are specially trained. This would be through American Board certification of their specialty. In orthodontics, the pinnacle of competency is achieved by working through and passing the rigorous American Board of Orthodontics examinations. As of February, 54% of AAO registered orthodontists are board certified, which includes thorough preparation, a written exam, and a clinical exam. Board certification is not required to practice a dental specialty and therefore shows a specialist's dedication to the profession and patients. A visual example of the process is shown below: please see "The ABO Board Certification Process." Another conceivable recommendation, is permitting the specialty board examination to satisfy a portion of the state clinical exam or, allowing this process to fulfill the requirements to practice a specialty in dentistry in Wyoming.

- One last thought. I would like to raise this awareness for contemplation. I wonder about the ethical considerations requiring a specialist to perform a procedure on a live patient when it is outside of their scope of practice. Some who might apply for licensure may not have performed a class II, class III, or periodontal cleaning for several years. This type of service may not be in the best interest of the patient.

I wish to again express my gratitude for your time. I would love to practice orthodontics in Wyoming as my family has been serving Wyoming, practicing orthodontics, for the past 30 years. I hope that I can be a part of the next 30 years of creating beautiful smiles.

Humbly,

Eric Hillam

Response: *The Board thanks Dr. Hillam for commenting. The Board will consider your comments in future rulemaking.*

Comment #6: Scott Williams, DDS commented:

Ms. Cronbaugh,
Can you please forward this letter to the Board for review as it relates to the proposed rule changes.
As outlined on the website, I would appreciate any explanations for overruling that the board may have of these comments.

Dear Board Members,

I want to express my appreciation to each of you for being willing to take the necessary time to safeguard the health, safety, and welfare of the citizens of Wyoming. Ensuring that all those who are providing dental care to our citizens is a thankless job and we appreciate the care that you take in reviewing information related thereto.

I have taken the time to review the proposed rule changes and have a few concerns as it relates to the adjustments in Chapter 7. As I am sure you have expected to hear from many dentists as it relates to the adjustments to the General supervision of the practice of Dental Hygiene, I have a few items of input. However, before I make comment, I would like to state that I have an association with a Dental Hygienist who has obtained a public health license. This Dental Hygienist has done locum work with me, in my office, and I have a great respect for the work that she does here and in the residency clinic she does public health work in. She is a great practitioner. I asked her if there was a great degree of difficulty in obtaining the additional credentialing, she indicated that it was not a problem and presented very little barrier to her ability to practice in that setting.

There are two perspectives that can be taken here. First, one might say that because there is no significant problem in obtaining the public health credentials the need for such credentialing is very limited. Eliminating such will open up public health service opportunities to all dental hygienists. This, at least on the surface, seems to allow greater access to care. I do not wish to debate access to care issues, and will not do so here. The second perspective would be that by requiring credentialing, the regulation of the general supervision clause would be much more controlled and thereby provide a higher level of care. Infact, a more stringent review of applicants may provide an elevation of care that would provide more safeguards for the citizens of Wyoming, not less.

With this in mind, I would like to address several areas of the proposed changes to Chapter 7. In Section 5 (a)(i) of the proposed changes it states:

(i) Community dental health activities; which includes public health services at federally funded health centers and clinics; nursing homes; extended care facilities; home health agencies; group homes for the elderly, disabled and youth; public health offices; Women, Infants, and Children; Head Start programs; child development programs; early intervention programs; migrant work facilities; free clinics; health fairs; public and private schools; state and county correctional institutions; community school-based prevention programs; and public health vans.

With the wording and punctuation of this subsection, the care of women, infants and children is determined to be a community dental health activity. There is no clarification in the rules that dictates that this need be in a specific setting. Therefore, the general supervision rule applies to all dental hygiene prophylaxis procedures except those performed on men. In regards to the treatment of men, it only excludes them if their treatment does not fall under the hat of one of the other provisions in this subsection. The result here is that a hygienist can practice anywhere outside a dental office as long as they have an association agreement with a dentist. I believe that the intention of the proposed changes is to bring more individuals into public health settings, however, as previously mentioned, the barrier is very minimal already. "Basically, all I had to do was pay some money," the locum that works in my office. If there are locations that are needing hygienists, they certainly could offer to pay for this credentialing and actively recruit individuals to work with them.

Chapter 1 Section 3 Subsection (w)(i) defines general supervision as:

i)"General Supervision" of a dental auxiliary means that a dentist has diagnosed and authorized the procedures which are being carried out; however, a dentist need not be present when the authorized procedures are being performed;

Chapter 7 Section 5 Subsections (a)(i)(A) of the proposed rules states:
(A) Public health services solely consist of prophylaxis, topical fluoride applications, oral health education, and dental screenings. These services can be provided by the hygienist without prior authorization of the dentist. All patients seen shall be referred to a dentist annually.
By the definition in the aforementioned Chapter 1 Section 3 Subsection (w)(i) this would not be General supervision, and should require a seperate section within the Dental Practice act. The requirement to have a Public Health expanded function allowed for more oversight from the board thus placing the board at the position of ensuring proper practice and the specific exemption from General Supervision. The blanket approval granted by the proposed verbiage allows much more freedom than I believe is intended by the board or any current practitioners.

The scope of practice has been defined in the proposed rules as Prophylaxis, topical fluoride applications, oral health education, and dental screenings.
The CDT code book defines an adult prophylaxis as the, "Removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. it is intended to control local irrational factors."
As all are aware, procedures in dentistry are to be performed based on a diagnosis. This has not always been followed to the letter in dentistry as it is required to do so in medicine because of our lack of being required to provide ICD 10 coding. I have a background in medical coding and have witnessed how in many dental offices coding is based on preference, patient's wishes, and a myriad of other circumstances, not on diagnosis.
I had an opportunity to talk to a dental hygienist with public health endorsement. She indicated that in the clinic where she works they are doing such good things because they are able to see people who have not had their teeth cleaned in as many as 20 years. While it is possible that they may be the picture of perfection in gingival health, in all likelihood, this individual had gingival condition that would fall under moderate to severe gingivitis or more likely periodontitis. These individuals would fall outside the scope outlined currently in the public hygiene and under the proposed general supervision subset of the practice act.
Additionally, the current and proposed rules require that the individuals be referred to a dentist at least once a year. Referrals, as we all know from sad experience, are often ignored. Seeing a hygienist without doctor examination would potentially create a false sense of security and leave, untreated, problems that could result in much more expensive work as well as other worse problems.

Additionally, the requirement to carry individual liability insurance has been stricken in the proposal. Is there a provision to protect individuals who may be treated by a hygienist in these settings? The lack of liability coverage leaves the citizens receiving treatment in a vulnerable position.

As far as it relates to the practice of dental assistants, there is wording that needs to be clarified as well. While I realize that it should go without saying, The indication that assistants cannot use a high speed or a slow speed handpiece needs to be clarified as "intraorally". For example, the high speed handpiece is used to refine margins and remove flash from a provisional crown. This wording would make this a violation of the dental practice act. Again, I realize this was not the intent of the verbiage, but it is stated this way.

Response: *The Board thanks Dr. Williams for commenting. The Board will consider your comments regarding public health hygiene in future rulemaking. Regarding your comment to add "intraorally" to Chapter 7, New Section 7(e)(v) and (vi), the Board agreed and made the changes accordingly.*

Comment #7: Dr. Peyton Cometti provided a comment in the attached letter: October 6, 2021 Letter

Response: *The Board thanks Dr. Cometti for commenting. The Board believes this requirement to be in keeping with the Board's responsibility to protect the public.*

Comment #8: Susan Greenspon Rammelt. Chief Legal Officer, EVP Business Affairs at SmileDirectClub provided a comment in the attached letter: October 11, 2021 Letter

Response: *The Board thanks Ms. Rammelt for commenting. Regarding Amendment 1: The Board intends to amend Chapter 4 language from "practitioner-patient relationship" to "dentist-patient relationship" to clarify language. The Board does not intend to modify the definition of a "dentist-patient relationship" at this time. Regarding Amendment 2: Digital consent would be considered written consent and the Board concluded no changes were necessary. Regarding Amendment 3: The Board removed Chapter 4, Section 3(b)(vi). Regarding Amendment 4: The Board did not believe any changes were necessary.*

Comment #9: Cole Weaver, DDS on behalf of the Wyoming Association of Orthodontists (WAO) provided a comment and supporting attachments as follows:

- WAO Comment Letter
- AGD Dental Asst Duties
- Dr. Arnold Hill Mayo Clinic
- Idaho Adhesive Removal
- Tufecki et al.

Response: *The Board thanks Dr. Weaver and members of the WAO for commenting.*

Comment 1: "Therefore, we request that non-master/final impressions for orthodontic appliances and retainers be moved from direct/indirect supervision to general supervision. If the board does not feel comfortable allowing this, we request at a minimum that retainer impressions be allowed to be performed under general Supervision." The Board will consider this for future rulemaking.

Comment 2: "We request omission of the proposed rule that restricts usage of slow-speed handpieces by dental assistants." The Board believes dental assistants do not have the appropriate training to use slow speed handpieces and this prohibition is in keeping with the Board's responsibility to protect the public.

Comment #10: Jim Wetzel, DDS commented:

In re to Chapter 7 under section e subsection v and vi dealing with assistants duties that are prohibited the assistants should not be permitted to use any hand piece-slow or high speed for any reason. First most probably have no knowledge re the actual morphology of a tooth and especially what that looks like in a real life setting. True they know the tooth as it sits in the mouth but once the tooth is cut into that they have no knowledge. They have no training using high speed or low speed hand-pieces. Their level of dexterity using these instruments has never been tested. Their spacial perception regarding the thicknesses of enamel and dentin and working within those parameters are untested. Utilizing a mirror while working with the hand pieces would be another entire unknown for them.

As a dental board I believe it's your responsibility to evaluate a person's competency and since assistants are not required to test how can you evaluate their competency? Is not another area of your oversight to protect the public? If so how can you do this if you have no ability to test proficiency?

I personally urge you to keep this section for all the above reasons. Thank you for your time and consideration.

James L Wetzel Jr DDS

Response: *The Board thanks Dr. Wetzel for commenting. The Board agrees with the comment provided.*

Comment #11: David Bingham commented:

To whom it may concern,
My name is David Bingham and I am currently an endodontic resident at Saint Louis University. I graduated from UT Health San Antonio in 2020 and due to COVID restrictions took and passed the manikin WREB exam. As you are aware, many states have made accommodations for students in this difficult situation to get licensed, but no changes have been made in Wyoming.

As a professional board, I can appreciate that your first responsibility is to protect the people of your state, and I would not ask you to make accommodations that you believe would compromise this responsibility. However, I ask that you please consider some options that would allow someone such as myself to become licensed in your state while still safeguarding patients in your state.

After I graduate in June 2022, I would like to practice in the state of Wyoming. I will only be practicing within the scope of practice of an endodontic specialist. The portions of the exam I lack, the live operative and periodontal exam, are not areas of dentistry performed by endodontists. I know the "easy" answer would be for me to retake the live portion of the exam. Unfortunately, at this time retaking the exam is not feasible for the following reasons. First, due to postponement from COVID, I already took time out of residency to take WREB exam the first time, and would not be allowed to take time off again. Second, many locations are still only offering the manikin exam, and many others are only allowing dental students

from their school to participate. Third, being a resident at SLU (not associated a dental school), the pool of patients I would rarely qualify for these portions of the WREB. Even if they did, time does not allow for me screen my patients, that present for endo, for periodontal and operative. Fourth, I have a family to care for, and at present I do not have the finances to pay for another exam, and all the expenses that come with it (equipment rental, plane, hotel, and food for both me and my patients).

I know some state boards have the flexibility to consider special circumstances for licensure. If this is not an option, I would propose allowing my certificate of endodontics to replace the sections of the WREB I would need to retake. If neither of these are options, I would ask that you consider a temporary license until I have had reasonable time to retake the exam following residency. Please consider these options (as if it were you in my situation), or any others that could serve the same purpose. Thank you for your consideration.

Respectfully,
David Bingham
Class of 2022
SLU-Center for Advanced Dental Education
Endodontics Department

Response: *The Board thanks Dr. Bingham for commenting. The Board will consider this for future rulemaking.*

Meyer Dana
orthodontics
Black Hills Orthodontics, Prof. L.L.C.

Chad Meyer D.D.S. • Jesse Dana D.D.S. • Shannon Schober, D.M.D., M.S. • Peyton Cometti, D.D.S., M.S. Practice Limited to Orthodontics

October 4, 2021

Board of Dental Examiners
Attn: Emily Cronbaugh
2001 Capitol Ave, Room 127
Cheyenne, WY 82002

To Whom It May Concern:

The recently published proposed rule changes in Chapter 7, Section 7:3:v-iv seek to specifically prohibit the use of a high-speed handpiece or slow-speed handpiece, except for coronal polishing, by dental assistants. We respectfully request that you provide evidence for the necessity of such regulation and consider alternative actions to address any concerns. If there have been no recent instances of patients experiencing damage to hard or soft tissue as a result of a dental assistant using a handpiece, there is no need to further regulate this matter.

If there are recent instances of hard or soft tissue damage, we propose the language in Chapter 7, Section 7:3:v-iv be modified to prohibit a dental assistant from using a handpiece to perform specific actions such as cutting hard or soft tissue. Additionally, we propose a board-approved course to allow dental assistants to receive certification for expanded function duties not prohibited by Chapter 7, Section 7:3:v-iv. While it is understood that any dental auxiliary who uses a handpiece shall be held to the same standard as a dentist, many states, including South Dakota, have left this to the discretion of each dentist. With proper training and only using fine-fluted finishing burs, dental assistants are able to safely remove adhesive from coronal tooth surfaces. As with any delegated task, the dentist is ultimately responsible for any and all negative consequences.

For reference, our office locations in South Dakota abide by SDCL 20:43:08:10 which states:

> If the supervising dentist exercises full responsibility, a registered dental assistant may perform expanded functions under the direct supervision of a dentist. A registered dental assistant may not perform the following procedures:
>
> (1) Irreversible procedures;
> (2) Cutting of hard or soft tissue;
> (3) Using lasers that are capable of altering, cutting, burning or damaging hard or soft tissue;
> (4) Intraoral placing, finishing, and adjusting of final restorations…

To become a Certified Dental Assistant requires a combination of 1500 hours of chairside experience with 4 months of online and in-person education. We submit this as an alternative action rather than generally prohibiting these duties. In our combined experience at our South Dakota locations, we have found that the ability to delegate such duties to qualified auxiliaries enhances the efficiency of our offices. Ultimately, this allows us to see our patients in a more timely manner and create a more positive overall patient experience.

Thank you for your time and consideration. We look forward to hearing back from you regarding this matter.

Sincerely,

Peyton Cometti, DDS, MS

October 11, 2021

Ms. Emily Cronbaugh
Executive Director
Wyoming Board of Dental Examiners
2001 Capitol Avenue, Room 127
Cheyenne, Wyoming 82002

RE: ***Public comment on proposed changes to rules and regulations to implement the Wyoming Dental Practices Act.***

Dear Ms. Cronbaugh:

I write to you today to provide public comment from SmileDirectClub ("SDC") on the Wyoming Board of Dental Examiners ("Board") proposed changes to rules and regulations to implement the Wyoming Dental Practices Act as published on September 8, 2021. SDC has a keen interest in these rules and regulations because Wyoming licensed dentists and orthodontists use the SDC technology platform to diagnose and treat patients in Wyoming.

SDC is in general support of the Board's proposed changes but requests the Board's favorable consideration on a few "friendly" amendments to correct apparent inconsistencies and provide greater clarity to licensees practicing dentistry in the state.

Amendment #1

Board proposed language:
[Chapter 1, Section 3(l)]

> *"Dentist-Patient Relationship" means a formal inferred relationship between the dentist and a patient of record, which is established once the dentist assumes or undertakes the dental care or treatment of a patient in the state where the patient resides. A dentist-patient relationship is assumed to have been created after there is a physical examination of a patient (e.g., when a patient is seen in a dentist's office), but is not assumed in others (e.g., when a dentist performs a physical examination as a health screening procedure at a health fair event).*

A licensee can be left with the unclear impression from the example provided in this section that an in-office visit is always required in order to establish a valid dentist-patient relationship. Yet, the provision in Chapter 4, Section 3(a) requires that a licensee utilize teledentistry services consistent with the prevailing standard of care to establish a dentist-patient relationship where one is not previously present. Accordingly,

SDC recommends correcting this inconsistency by adding the appropriate teledentistry services language to the example provided, as follows:

Proposed amendment language:
[Chapter 1, Section 3(l)]

> *"Dentist-Patient Relationship" means a formal inferred relationship between the dentist and a patient of record, which is established once the dentist assumes or undertakes the dental care or treatment of a patient in the state where the patient resides. A dentist-patient relationship is assumed to have been created after there is a physical examination of a patient (e.g., when a patient is seen in a dentist's office or through teledentistry services as permitted in this Chapter), but is not assumed in others (e.g., when a dentist performs a physical examination as a health screening procedure at a health fair event).*

Amendment #2

Board proposed language:
[Chapter 4, Section 3(b)(iii)]

> *Before rendering dental advice or care using teledentistry services, the licensee shall:*
> *(iii) Obtain appropriate written treatment consent from the requesting patient.*

This provision, as proposed, requires that a licensee obtain "written" consent from the patient. Obtaining a "written" document from a patient prior to engagement through a remote encounter would be problematic at best and create an artificial barrier to care. Most state address this issue by either simply requiring the treating dentist to obtain "informed consent" of the patient or, in some instances, providing that informed consent can be obtained through oral, written or digital means. For instance, Arizona requires that *"[t}he treating health care provider shall obtain verbal or written informed consent, including by electronic means, from the patient or the patient's health care decision maker. If the informed consent is obtained verbally, the health care provider shall document the consent on the patient's medical record."* Accordingly, SDC recommends correcting this restrictive provision as follows:

Proposed amendment language:
[Chapter 4, Section 3(b)(iii)]

> *Before rendering dental advice or care using teledentistry services, the licensee shall:*
> *(iii) Obtain appropriate written, or digital treatment consent from the requesting patient and document the consent on the patient's medical record.*

Amendment #3

Board proposed language:
[Chapter 4, Section 3(b)(iii)]

> *Before rendering dental advice or care using teledentistry services, the licensee shall:*
> *(vi) Obtain patient consent to forward patient identifiable information to a third party.*

This provision as written makes patient affirmative consent to forward patient identifiable information to a third party a precondition to treatment through teledentistry services. Whether or not a patient wants a treating dentist to share the patient record outside of the dentist-patient relationship has no statutory support to serve as a barrier to access to dental care. SDC believes that the Board's intent is to protect patient personal information and require patient consent before any of that information is shared by the treating dentist rather than to require that consent as a precondition to care. A licensed dentist should request patient consent to forward patient identifiable information to a third party; if the patient does not consent to have

that information shared, then the dentist should still be able to treat the patient. Accordingly, SDC recommends correcting this provision as follows:

Proposed amendment language:
Chapter 4, Section 3(b)(iii)]

Before rendering dental advice or care using teledentistry services, the licensee shall:
(vi) ~~Obtain~~ Request patient consent to forward patient identifiable information to a third party.

Amendment #4

Board proposed language:
[Chapter 4, Section 3(b)(iii)]

Before rendering dental advice or care using teledentistry services, the licensee shall:
(viii) Determine appropriate treatment and follow up care if needed.

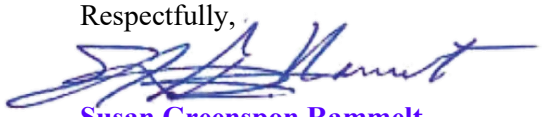
This provision is inappropriate as a pre-condition to the use of teledentistry services by licensed dentist. A licensed dentist, whether in a traditional bricks-and-mortar setting or through remote teledentistry services, cannot determine "appropriate treatment and follow up care" for a patient without first conducting an examination appropriate for the patient condition as presented and then rendering a diagnosis. Both the examination and diagnosis are considered to be within the definition of "dental care." SDC believes that it is not the Board's intent to require a licensed dentist to make an unprofessional guess about the appropriate treatment and follow up care before an appropriate examination and diagnosis and can be made. Accordingly, SDC recommends deleting this provision.

Proposed amendment language:
[Chapter 4, Section 3(b)(iii)]

Before rendering dental advice or care using teledentistry services, the licensee shall:
~~(viii) Determine appropriate treatment and follow up care if needed.~~

SDC thanks the Board for this opportunity to comment on the proposed rules and regulations to implement the Wyoming Dental Practices Act. I remain available to answer any questions you may have about this submission.

Respectfully,



Susan Greenspon Rammelt
Chief Legal Officer, EVP Business Affairs
SmileDirectClub

Attention Wyoming Board of Dental Examiners

Re: Proposed Rule Changes

As the membership of the Wyoming Association of Orthodontists and licensees of the State of Wyoming, we would like to request adjustment and clarification on the proposed rule changes in Section 7 of Chapter 7 for the following:

1) Chapter 7 Section 7 Subsection c item (i) and Subsection d item (x)

We understand that protections need to be in place to prevent treatment without oversight of a licensed dentist. However, we feel that restricting impression (digital or conventional) for orthodontic appliances and retainers is not in the best interest of the patient. Access to timely care is critically important, especially as it relates to orthodontic retention. If a doctor is out of the office, or unavailable, a trained assistant should be trusted to take an impression for a new retainer to protect a patient from alignment relapse. We do not feel the standard, as currently outlined, provides adequate protection to patients, and can cause harm by limiting access to a safe and necessary service. Similar to the proposed rule to allow assistants to place and expose radiographs with verbal or written consent of the orthodontist, we feel this level of oversight would be appropriate for orthodontic impressions without compromising proper treatment oversight. **Therefore, we request that non-master/final impressions for orthodontic appliances and retainers be moved from direct/indirect supervision to general supervision. If the board does not feel comfortable allowing this, we request at a minimum that retainer impressions be allowed to be performed under general supervision.**

2) Chapter 7 Section 7 Subsection e item (vi)

We request omission of the proposed rule that restricts usage of slow-speed handpieces by dental assistants. We understand the Boards' desire to clarify the issue of handpiece use by assistants considering the many questions you receive. This decision should be based on what is best for the people of Wyoming and the practitioners that care for them. We feel the current proposed rule will have a negative impact on the access to care for the people of Wyoming and does not support the goal of evidence based dental practice.

It is important to understand access to care in orthodontics through a historical perspective. A brief search shows that in the 1960's the average cost of a comprehensive orthodontic case was approximately $2,000. In 2021 the cost for comprehensive treatment is typically between $5,000-$6000. According to the Bureau of Labor Statistics, at the time that this letter was written, $1 in January 1960 is equivalent to $9.36 in September of 2021. Adjusting for inflation, the average cost of braces should be 3x higher than it is. Due to the many changes in orthodontic care models and advancements in technology, the cost of orthodontic treatment has

not increased in tandem with inflation. Dentistry has seen similar advancements that have allowed improved access to care without compromising quality. Among these changes is an increased utilization of dental auxiliaries, allowing practitioners to care for a greater number of patients. This has significantly reduced the cost of treatment, allowing patients from many socioeconomic levels to seek appropriate care which has not historically been the case. If we enact regulations that limit the capabilities of dental auxiliaries, without considering the best scientific evidence, then it sets a dangerous precedent and has a negative impact to the residents of our state. It should be the goal of the Wyoming Dental Board to not only enact policies to maintain or improve the standard of care for the people of Wyoming, but to remove barriers when quality can be maintained.

In reference to the proposed rule change on handpieces we are aware that there have been report(s) of enamel damage by assistants using highspeed handpieces. We do not have access to all board disciplinary matters and complaints so we cannot definitively say that there have not been incidents of harm to patients using slow speed handpieces. Based on the hierarchy of evidence, single cases may not be the best basis on which to enact change to dental board regulations. These fall under the case report tier of evidence which is the 2nd lowest form of scientific evidence. In counterpoint, we would like to present evidence of a study performed by Drs. Arnold Hill and Peter Wollan which compared adhesive removal by dentists and dental assistants. 80 patients participated in the study and 10 each were assigned to 4 dentists and 4 dental assistants. Following glue removal using a slow-speed handpiece with a carbide finishing bur, the patients were examined by an evaluator who was not aware of which practitioner worked on which patient. Following this the patients were given a questionnaire to fill out regarding their experience and perceptions. Use of handpieces with appropriate burs will result in the loss of only .13mm^3 of enamel and even less in areas of decalcification .06mm^3 (Tüfecki et al.). According to the author of the Mayo Clinic paper “There was no significant difference after composite removal in the amount of residual composite, enamel surface modification, bleeding or gingival damage.” This confirms that the safety and efficacy of utilizing dental assistants for removal of adhesive with slow-speed handpieces is comparable to that of a dentist. Additionally, “Of the respondents 76% said that it didn’t make any difference who was the provider if competent.” This tells us that the vast majority of patients have the same clinical experience regardless of provider.

The presented study from the Mayo Clinic falls under the Randomized Controlled Trials tier which is only surpassed by Systematic Reviews in strength of evidence. The WAO cannot present evidence to contraindicate the prohibition of highspeed handpiece usage by dental assistants and in this case it may be appropriate to base a regulation change on evidence in a lower tier. However, with evidence presented contrary to the proposed rule change, it would be concerning for the members of the WAO and all licensees of the Wyoming Dental Board, for the Board to make a decision without appropriate scientific backing. It has been a priority of the ADA to aid practitioners in practicing Evidence Based Dentistry. This requires us to make decisions based on our own clinical knowledge, the patient’s needs and preferences and the most current, clinically relevant evidence. If we follow the 3 tenets of Evidence Based Dentistry then we must base regulations on fulfilling as many of these criteria as possible. We have

evidence showing the safety of slow-speed handpiece use by dental assistants. This same paper demonstrates that 76% of patients are comfortable with providers from different levels removing adhesive. Finally, if we trust in the judgement of our licensees then we are able to fulfill all 3 pillars of evidence based dental practice. It may also be helpful to consider that, according to that attached information sheet from the Academy of General Dentistry, in the United States only OK and RI specifically prohibit the removal of adhesive by dental auxiliaries, while ID and MN require certain certifications to do so. The rest of the states leave it to the discretion of the supervising dentist. It is our hope that the evidence presented will allow the members of the board to make a decision based on sound, scientific evidence and not have to unilaterally prohibit handpiece usage based on their clinical expertise alone.

If the board feels that additional training should be required, we have attached a course that the Idaho Dental Board has orthodontists follow for the training and certifying of their dental assistants for adhesive removal. We would encourage the members of the board to thoughtfully consider the evidence presented and hope that we can agree on the best way to care for the people of Wyoming.

Respectfully,

Adam Chorak	Jon Silcox
Austin Ledingham	Joseph Feller
Barak Jones	Lori Tima
Chad Lambourne	Marc Olsen
Chad Meyer	Nathan Moeller
Cole Weaver	Peyton Cometti
Cory Coombs	Page Hudson
Jesse Dana	Sami Jo Webb

Academy of General Dentistry

DENTAL ASSISTANT DUTIES AND FUNCTIONS

The following chart outlines the levels of dental assistants allowed in each state, what the requirements are to reach each level, and the duties dental assistants are allowed or not allowed to perform. Below the chart is a list of dental assistant duties that have been developed by the American Dental Assistant Association/Dental Assisting National Board (ADAA/DANB) Alliance. Dental assistants are allowed to perform these tasks, unless indicated that they are NOT allowed to permit certain functions outlined in the chart. Where available, hyperlinks to state rules and guidelines for dental assistants have been provided. Much information was obtained from DANB (www.danb.org); other information was taken from state dental board web sites. This information is provided for informational purposes only; it is not intended as a legal opinion regarding dental assistance requirements in any state

State	Dental Assistant Levels Allowed in Each State	Requirements for Working at each Level	The following functions are NOT permitted by any level of dental assistant *(all other functions in list below table are allowed)*
AL	Dental Assistant	A **dental assistant** in the state of Alabama may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Laser technology
AK	Dental Assistant (Article 3.A.)	A **dental assistant** in the state of Alaska may perform basic supportive dental procedures specified by the state dental practice act under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Remove calcareous deposits, accretions, and stains from the exposed surfaces of the teeth beginning at the epithelial attachment by scaling and polishing techniques; perform root planing and periodontal soft tissue curettage; diagnosing, treatment, planning, and writing prescriptions for drugs; writing authorizations for restorative, prosthetic, or orthodontic appliances; operative or surgical; procedures on hard or soft tissues; other procedures that require the professional competence and skill of a dentist or licensed dental hygienist.
	Dental Assistant qualified in coronal polishing procedures (Article 3.A.)	To perform **coronal polishing procedures** in the state of Alaska under the direct supervision of a licensed dentist, a dental assistant must hold a certificate in coronal polishing. To qualify, one must: Successfully complete a program of instruction approved by the Alaska Board of Dental Examiners.	
	Dental Assistant qualified in restorative functions (Article 3.A.)	To perform **restorative functions** in the state of Alaska under the direct supervision of a licensed dentist, a dental assistant must hold a certificate in restorative functions. To qualify, one must: Successfully complete a program accredited by the Commission on Dental Accreditation (CODA) or other course of instruction approved by the Alaska Board of Dental Examiners ***AND*** Pass the Western Regional Examining Board's restorative examination or other equivalent examination approved by the board within the five years preceding the dental assistant's certificate application	

		OR Have legal authorization from another state or jurisdiction to perform restorative functions.	
AR	Dental Assistant (Subchapter4)	A **dental assistant** in the state of Arkansas may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the personal supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Scaling, root planing, and curettage; final placement of orthodontic brackets; placement, seating, or removal of any final or permanent restorations; diagnosis and treatment planning; surgical or cutting procedures on hard or soft tissue; prescription, injection, inhalation, and parenteral administration of drugs (except where permitted by the Arkansas Board); any procedure that contributes to or results in irreversible alteration of the oral anatomy; those functions relegated to a dental hygienist.
	Registered Dental Assistant (RDA) (Article XVII, section E.)	A **Registered Dental Assistant (RDA)** in the state of Arkansas is an individual who holds a permit from the Arkansas State Board of Dental Examiners to perform one or more of the **expanded functions** listed on the opposite page. To obtain RDA status, one must: Hold a current national DANB Certified Dental Assistant (CDA) Certification ***OR*** Graduate from a CODA-accredited dental assisting program ***AND*** Apply to the Arkansas State Board of Dental Examiners Dental assistants who do not meet the above qualifications may still earn RDA status by completing the following requirements: *Coronal polishing:* Successfully complete an Arkansas board-approved course in coronal polishing, pass an Arkansas board-approved coronal polishing exam, and apply to the Arkansas State Board of Dental Examiners *Monitor nitrous oxide/oxygen analgesia:* Successfully complete an Arkansas board-approved nitrous oxide administration and monitoring course and submit a copy of the certificate of completion to the Arkansas State Board of Dental Examiners	
AZ	Dental Assistant (Article 7)	A **dental assistant** in the state of Arizona may perform basic supportive dental procedures specified by the state dental practice act under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Taking final impressions for any activating orthodontic appliance, fixed or removable prosthesis; intraoral carvings of dental restorations or prostheses; a procedure which by law only licensed dentists, licensed dental hygienists, or certified denturists can perform; final jaw registrations; activating orthodontic appliances; an irreversible procedure
	Dental Assistant qualified in coronal polishing procedures	To perform coronal polishing procedures in the state of Arizona under the general supervision of a licensed dentist, a **dental assistant** must hold an Arizona Coronal Polishing Certificate. To qualify, one must: Pass the Arizona Coronal Polishing exam (administered by DANB) ***AND*** Submit an Arizona Coronal Polishing Clinical Skills Affidavit (completed by a licensed dentist or a coronal polishing educator/course instructor) to DANB ***AND*** Receive the Arizona Coronal Polishing Certificate, sent upon successful completion of the Arizona Coronal Polishing exam and submission of the	

		Arizona Coronal Polishing Clinical Skills Affidavit to DANB	
	Dental Assistant with certificate in radiologic proficiency (Article 2, Sec. R4-11-204.)	To be eligible for **dental assistant radiography certification by credential**, an applicant shall have a current certificate or other form of approval for taking dental radiographs, issued by a professional licensing agency in another jurisdiction of the United States that required successful completion of written and clinical dental radiography examinations or a single dental radiography examination with written and clinical components.	
CA	Unlicensed Dental Assistant	An **unlicensed dental assistant** in the state of California may perform basic supportive dental procedures under the supervision of a licensed dentist specified by the state dental practice act (see opposite page). A dentist must ensure that dental assistants in continuous employment for 120 days or more have proof of completing all of the following within a year from date of employment: A California Dental Board-approved course in the California Dental Practice Act ***AND*** A California Dental Board-approved course in infection control ***AND*** An AHA or ARC-approved course in Basic Life Support which includes hands-on simulated clinical scenarios All dental assistants must maintain BLS certification.	Placement, condensation, carving, or removal of permanent restorations, including final cementation procedures; oral prophylaxis procedures; tTaking of impressions for prosthodontic appliances, bridges, or any other structures which may be worn in the mouth; diagnosis and treatment planning; surgical or cutting procedures on hard or soft tissue; fitting and adjusting of correctional and prosthodontic appliances; prescription of medicines; irrigation and medication of canals, try-in cones, reaming, filing, or filling of root canals; administration of injectable and/or general anesthesia
	Registered Dental Assistant (RDA)	To be licensed as a **Registered Dental Assistant (RDA)** in the state of California, one must: Graduate from a California Board-approved RDA educational program ***OR*** Complete 15 months of work experience as a dental assistant ***AND*** Successfully complete California Board-approved courses in radiation safety and coronal polishing ***AND*** Successfully complete California Board-approved courses in the California Dental Practice Act and infection control within 5 years prior to application for licensure ***AND*** Successfully complete an AHA or ARC-approved course in Basic Life Support ***AND*** Pass a state written and practical exam ***AND*** Pass a state written exam in law and ethics ***AND*** Apply for licensure as a Registered Dental Assistant to the Dental Board of California	

	Registered Dental Assistant in Extended Functions (RDAEF)	To perform **expanded functions** under the direct supervision of a licensed dentist in the state of California, a dental assistant must be licensed as a **Registered Dental Assistant in Extended Functions (RDAEF).** To register as an RDAEF, one must: Hold a valid license as an RDA (see below) ***OR*** Successfully complete the requirements for licensure as an RDA ***AND*** Successfully complete a California Board-approved course for application of pit and fissure sealants ***AND*** Successfully complete a California Board-approved extended functions educational program ***AND*** Pass a California Board-approved written exam, and a state clinical or practical exam ***AND*** Apply to the Dental Board of California for licensure as a Registered Dental Assistant in Extended Functions	
	Orthodontic Assistant (OA) [effective 2010]	To hold an **Orthodontic Assistant permit** in the state of California, one must: Complete at least 12 months of work experience as a dental assistant ***AND*** Successfully complete California board-approved courses in the California Dental Practice Act and infection control ***AND*** Successfully complete an AHA or ARC-approved course in Basic Life Support, or any other course approved by the California board as equivalent ***AND*** Successfully complete a California board-approved orthodontic assistant course (may begin after six months of work experience as a dental assistant) ***AND THEN*** Pass a state written exam in orthodontic duties ***AND*** Apply for Orthodontic Assistant permit to the Dental Board of California	
	Dental Sedation Assistant [effective 2010]	To hold a **Dental Sedation Assistant permit** in the state of California, one must: Complete at least 12 months of work experience as a dental assistant ***AND*** Successfully complete board-approved courses in the California Dental Practice Act and infection control ***AND*** Successfully complete an AHA or ARC-approved course in Basic Life Support	

		AND Successfully complete a board-approved dental sedation assistant course (may begin after six months of work experience as a dental assistant) ***AND THEN*** Pass a state written exam in dental sedation duties ***AND*** Apply for Dental Sedation Assistant permit to the Dental Board of California	
CO	Dental Assistant	A **dental assistant** in the state of Colorado may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting. **Note:** Dental assistants who render patient care services in a dental setting where anesthesia/sedation and/or nitrous oxide/oxygen is administered must have proof of current basic life support (BLS) knowledge and skills.	Scaling (supra- and sub- gingival), as it pertains to the practice of dental hygiene; diagnosis; treatment planning; prescription of therapeutic measures; any procedure that contributes to or results in an irremediable alteration of the oral anatomy; administration of local anesthesia; rroot planning; soft tissue curettage; periodontal probing; placement of local therapeutic agents.
	Expanded Duties Dental Assistant	Some dental assistants in the state of Colorado may choose to complete an **Expanded Duties Dental Assistant (EDDA)** educational program. The EDDA designation is not recognized by the Colorado State Board of Dental Examiners and does not qualify a dental assistant to perform expanded duties in the state. **Note:** To administer and induce conscious analgesia solely by means of nitrous oxide/oxygen inhalation techniques, a dental assistant must complete a course in a CODA-accredited program or an institution certified by the Colorado Department of Higher Education Division of Private Occupational Schools. The course must have a minimum of 16 hours, including 4 patient contact hours. The dental assistant must submit proof of compliance to the Colorado Board of Dental Examiners.	
CT	Dental Assistant	A **dental assistant** in the state of Connecticut may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	The placing, finishing, and adjustment of temporary or final restorations, capping materials, and cement bases; the taking of any impression of the teeth or jaws or the relationship of the teeth or jaws for the purpose of fabricating any appliance or prosthesis; diagnosis for procedures or treatment; prescribing of drugs or medications which require the written or oral order of a licensed dentist or physician; administration of local, parenteral, inhalation or general anesthetic agents in connection with any dental operative procedure; the cutting or removal of any hard or soft tissue or suturing; practicing of dental hygiene as defined in the Connecticut Dental Practice Act.
DE	Dental Assistant	In the state of Delaware, competency of **Dental Assistants** in specific duties is	Diagnosis and treatment planning; cutting of hard

		determined by the supervising dentist. The dentist is given full responsibility in deciding the scope of work to be allocated to the dental assistant. Adequate training of dental assistants is solely the responsibility of the dentist. In summary, the Delaware Dental Board places full responsibility for the work done by dental assistants directly upon the dentist.	and/or soft tissues; any intra-oral procedure which would lead to the fabrication of an appliance and/or restoration which, when received by the patient, would come in direct contact with hard or soft tissue and which could result in tissue irritation or injury; those procedures allocated by the Dental Code to registered dental hygienists
DC	Dental Auxiliary	A **dental auxiliary** in the District of Columbia may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	The charting of cavities during preliminary examination, prophylaxis, or polishing; the intraoral polishing of a tooth or a restoration; placing, carving, or finishing of amalgam restorations; temporary wire ligation; the instruction of individuals or groups of individuals in oral health care, unless it is in the dental office and done as instructed by the dentist; final positioning of orthodontic bonds and bands; condensing, contouring or adjusting any final, fixed or removable prosthodontic appliance or restoration in the mouth 33. Placing and finishing of composite resin/silicate restorations; application of cavity liners and bases; the application of pit and fissure sealants; placement of temporary restorations; administering or monitoring nitrous oxide; performing final diagnosis and treatment planning; performing surgical or cutting procedures on hard or soft tissue; prescribing or parenterally; administering drugs or medications; administering inhalants or inhalation conscious sedation agents; authorizing work orders for any appliance or prosthetic device or restoration to be inserted into a patient's mouth; operating high speed rotary instruments in the mouth; performing pulp capping procedures; orthodontic arch wire activation with the exception of minor adjustments to eliminate pain or discomfort; taking impressions for master casts to be used for prosthetic restoration of teeth or oral structures; final cementation of crowns, bridges, inlays, onlays, posts and cores, and insertion of final prosthesis; placing sutures; flushing root canals; the performing of a diagnostic screening to identify indications of oral abnormalities; a preliminary dental examination; a complete prophylaxis, including the removal of any
	Dental Auxiliary qualified in designated expanded functions	To perform **designated expanded functions** under the direct supervision of a licensed dentist in the District of Columbia, an auxiliary *must*: Satisfactorily complete training in a CERP-approved program ***OR*** Satisfactorily complete a training program or course recognized by the Commission on Dental Accreditation (CODA) ***OR*** Satisfactorily complete a training program or course recognized by DANB. **Note:** A dentist may delegate designated expanded functions to an auxiliary who does not meet these requirements if the auxiliary had been performing the tasks for at least three (3) months prior to the effective date of these regulations, 1/9/09*, and has demonstrated competency to perform the tasks to the supervising dentist's satisfaction.	

			deposits, diseased crevicular tissue, accretion, or stain from the surface of a tooth or a restoration; administering or monitoring general anesthetics and conscious sedation; administering or monitoring local anesthesia
FL	Dental Assistant	A **dental assistant** in the state of Florida may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the supervision of a licensed dentist. **Note:** On-the-job trained dental assistants in Florida must be trained in the dental office under the supervision of a licensed dentist who assumes full responsibility for assuring that the dental assistant so trained is competent to perform the tasks.	Gingival curettage and root planning; taking impressions for the purpose of fabricating any intraoral restorations or orthodontic appliance; initial access preparation
	Expanded Functions Dental Assistant	**Dental assistants** in the state of Florida must have formal training to perform the **expanded functions** listed on the opposite page. To earn status to perform expanded functions, one must: Graduate from a CODA- accredited dental assisting program, provided that it included appropriate training in the function ***OR*** Successfully complete a Florida Board-approved expanded duties training program	
GA	Dental Assistant (§ 43-11-9.)	A **dental assistant** in the state of Georgia may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Utilize laser equipment and technology; utilize intraorally micro etching and/or air polishing equipment and technologies; any operations catalogued as dental hygiene treatments
	Expanded Duty Dental Assistant	To perform **expanded functions** under the direct supervision of a licensed dentist in the state of Georgia, a dental assistant *must* earn status as an **Expanded Duty Dental Assistant (EDDA)**. To qualify as an EDDA, one must: Hold a high school diploma or its equivalent ***AND*** Hold a current Cardiopulmonary Resuscitation (CPR) certification ***AND*** Provide documentation of successful completion of a Georgia Board-approved course pertaining to the specific expanded duties outlined in that certificate. (A national DANB Certified Dental Assistant [CDA] Certification is one of the ways by which an assistant may qualify to enroll in a Georgia Board-approved course.)	
HI	Dental Assistant (Subchapter 7)	A **dental assistant** in the state of Hawaii may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct supervision of a licensed dentist.	Placing of retractions, cords, or other devices for tissue displacement for crown and bridge impressions; coronal polishing with a rubber cup or

		There are no education or training requirements for this level of dental assisting.	brush; irrigation, medication, or drying of canals; reaming, filing, trying in cones, or filling of root canals; or establish length of tooth; placement, condensation, carving, finishing, or adjustment of final restorations; placement of pulp capping materials and cement bases; or any cementation procedures; any intra-oral procedure which would lead to the fabrication of any appliance or prosthesis which, when worn by the patient, would come in direct contact with hard or soft tissues; test pulp vitality; diagnosis and treatment planning; surgical or cutting procedures on hard or soft tissues, or extraction of teeth; prescription or injection of drugs; administration of injectable or general anesthesia and acupuncture; adjust or attempt to adjust any prosthodontic or correctional appliance to be worn in the mouth; cementation or bonding of any fixed prosthetic or orthodontic appliance; use of ultrasonic equipment to remove cement or calculus; prophylaxis or removal of stains, accretions, or deposits from the teeth; polishing of restorations; any diagnosis of or prescription for treatment of disease, pain, deformity, deficiency, injury, or physical condition of human teeth or jaws or adjacent structure; intra-orally adjust occlusion of inlays, crowns, bridges, or any restoration; intra-orally finish margins of inlays, crowns, or bridges; cement or recement perm- anently any cast restoration or stainless steel crown; elevate soft-tissue flaps; establish occlusal vertical dimension for dentures; try-in of dentures set in wax; curette to sever epithelial attachment; insertion and post-insertion adjustments of dentures; suture; write a prescription for authorization to fabricate restorative prosthodontic or orthodontic appliances
ID	Dental Assistant (Rule 035)	A **dental assistant** in the state of Idaho may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Placement or carving of permanent restorative materials in any manner; definitive diagnosis or treatment planning; any procedure using lasers; administration of any general anesthetic, infiltration anesthetic, or any injectable nerve block procedure; any oral prophylaxis, defined as the removal of plaque, calculus, and stains from the exposed and
	Expanded Functions Dental Assistant (Rule	To perform **expanded functions** under the direct supervision of a licensed dentist in the state of Idaho, a **dental assistant** *must* be Board-qualified in	

	035.03)	expanded functions. To qualify, one must: Hold a current national DANB Certification ***OR*** Successfully complete an Idaho Board-approved course in the fundamentals of dental assisting ***AND*** Successfully complete an Idaho Board-approved competency exam in each of the expanded functions	unexposed surfaces of the teeth by scaling and polishing
IL	Dental Assistant	A **dental assistant** in the state of Illinois may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Removal of calculus from teeth; performing supragingival or subgingival scaling; placing and finishing composite restorations; applying cavity bases; taking of final impressions for the fabricating of prosthetic appliances, crowns, bridges, inlays, onlays, or other restorative or replacement dentistry; performing pulp vitality tests; condensing or carving amalgam restorations; diagnosis of or prescription for treatment of disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws, or adjacent structures; removal of, restoration of, or addition to the hard or soft tissues of the oral cavity; any and all correction of malformation of teeth or of the jaws; administration of anesthetics except for topical anesthetics and monitoring of nitrous oxide, as specified; the operative procedure of dental hygiene consisting of oral prophylactic procedures except for coronal polishing, as specified; making denture adjustments; permanently cementing permanent crowns or bridges; permanently re-cementing permanent crowns or bridges that have come loose; placement of any chemotherapeutic agent for the management of periodontal disease; cementing bands and/or bonding brackets; air polishing
	Dental Assistant qualified in expanded functions	To perform **expanded functions** under the supervision of a licensed dentist in the state of Illinois, a **dental assistant** *must* earn state qualification in each of the desired expanded functions. To qualify, one must: Be at least 18 years of age ***AND*** Complete 1,000 hours of clinical dental assisting experience ***OR*** Complete a CODA-accredited dental assisting program ***OR*** Hold a current national DANB Certified Dental Assistant (CDA) Certification ***AND*** Complete an approved course relative to the expanded function in question, subject to specific didactic and clinical requirements ***OR*** Provide proof of completion of an approved dental assisting program that contained the expanded function in the curriculum **Note:** In order to monitor patients while nitrous oxide is being administered, dental assistants must maintain current Cardiopulmonary Resuscitation (CPR) certification.	
IN	Dental Assistant	A **dental assistant** in the state of Indiana may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting, except for Radiology Requirements.	Diagnosis and treatment planning; cutting of hard or soft tissues; any intraoral impression which would lead to the fabrication of a final prosthetic appliance; removing calcific deposits or accretions from the surfaces of human teeth or cleaning or

	Dental Assistant qualified in coronal polishing and Dental Assistant qualified in fluoride administration	To perform **coronal polishing procedures** in the state of Indiana under the direct supervision of a licensed dentist, a dental assistant must: Successfully complete a board-approved curriculum for polishing the coronal surface of teeth To **administer fluoride** in the state of Indiana under the direct supervision of a licensed dentist, a dental assistant must: Successfully complete a board-approved curriculum for applying medicaments for the control or prevention of dental caries Dental	polishing such teeth (except coronal polishing, as permitted by meeting the requirements); applying and using within the patient's mouth such antiseptic sprays, washes, or medicaments for the control or prevention of dental caries (except for applying medicaments, as permitted by meeting the requirements); treating gum disease; using impressions and x-ray photographs for treatment purposes; administering local dental anesthetics
IA	Dental Assistant Trainee	In order to work as a dental assistant in the state of Iowa, an individual **must be 17 years of age, be a high school graduate or equivalent, and be registered** with the Iowa Dental Board and have received a Certificate of Registration. To qualify as a **Dental Assistant Trainee** in Iowa, one must: Within 12 months of employment, successfully complete an Iowa board-approved course of study and exam in the areas of infection control (the DANB ICE Exam)/ hazardous materials and jurisprudence ***AND*** Apply to the Iowa Dental Board for registration as a Dental Assistant Trainee and receive a Certificate of Registration **Note:** A Dental Assistant Trainee's employer must notify the Iowa Dental Board in writing of such employment within seven days of the initial employment as a dental assistant.	Removal of any plaque, stain, or hard natural or synthetic material except by toothbrush, floss, or rubber cup coronal polish, or removal of any calculus; placement of sealants; diagnosis, examination, treatment planning, or prescription, including prescription for drugs and medicaments or authorization for restorative, prosthodontic or orthodontic appliances; surgical procedures on hard and soft tissues within the oral cavity and any other intraoral procedure that contributes to or results in an irreversible alteration to the oral anatomy; administration of local anesthesia; procedures that require the professional judgement and skill of a dentist
	Registered Dental Assistant (RDA)	To qualify as a **Registered Dental Assistant (RDA)** in Iowa, one must: Work in a dental office for six months as a Dental Assistant Trainee (see requirements listed below). ***OR*** Have had at least six months of prior dental assisting experience under a licensed dentist within the past two years ***OR*** Graduate from a post-secondary dental assisting program ***AND*** Successfully complete an Iowa board-approved course of study and exam in the areas of infection control (the DANB ICE Exam)/ hazardous materials and jurisprudence ***AND*** Apply to the Iowa Dental Board for registration as an RDA and receive a Certificate of Registration	
	Registered Dental	Dentists may delegate an **expanded function** duty (see listing on opposite	

	Assistant with expanded functions training	page) to a **Registered Dental Assistant** (see below) if the assistant has completed Iowa board-approved training in that specific function. Documentation of training must be available, if requested. To qualify for expanded function training, a dental assistant must be DANB Certified or hold a minimum of two years of clinical dental assisting experience as an RDA.	
KS	Dental Assistant	A **dental assistant** in the state of Kansas may perform basic supportive dental procedures (see opposite page) under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Any and all removal of or addition to the hard or soft tissue of the oral cavity; any and all diagnosis of or prescription for treatment for disease, pain, deformity, deficiency, injury, or physical condition of the human teeth or jaws, or adjacent structure; any and all correction of malformation of teeth or of the jaws; any and all administration of general or local anesthesia of any nature in connection with a dental operation; a prophylaxis (except coronal polishing and scaling as defined in "Allowable Functions;" see opposite page)
	Dental Assistant with expanded duties training	To perform **expanded functions** under the direct supervision of a licensed dentist in the state of Kansas, a **dental assistant** must become qualified as follows: *Coronal polishing:* The dental assistant must undergo appropriate training by a licensed dentist. *Coronal scaling:* The dental assistant must successfully complete a Kansas Board-approved course of instruction. *Assisting in the administration and monitoring of nitrous oxide and/or oxygen*: The dental assistant must successfully complete a Kansas Board-approved course of instruction which includes six hours of instruction at a CODA-accredited teaching program.	
KY	Dental Assistant	Dentistry. A **dental assistant** in the state of Kentucky may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting Dental Assistant.	Subgingival and supragingival scaling; the making of final impressions from which casts are made to construct any dental restoration; placement of final impressions; placement and removal of actisite; administering local anesthetic agents by infiltration or block; brush biopsy; diagnosis; general supervision; administering nitrous oxide analgesia; probing; root planning; place sutures; the practice of dental hygiene or the performance of the duties of a licensed dental hygienist that require the use of any instrumentation which may elicit the removal of calcareous deposits or accretions on the crowns and roots of teeth; treatment planning and prescription, including prescriptions for drugs or medicaments, or authorization for restorative, prosthodontic, or orthodontic appliances; surgical procedures on hard or soft tissues of the oral cavity, or any other intraoral procedure that contributes to or results in an irreversible alteration of the oral anatomy
	Dental Assistant qualified in coronal polishing	To perform **coronal polishing procedures** under the direct supervision of a licensed dentist in the state of Kentucky, a **dental assistant** must successfully complete an eight-hour course developed by the Kentucky Board of Dentistry.	
LA	Dental Assistant (Ch. 5)	A **dental assistant** in the state of Louisiana may perform basic supportive dental procedures specified by the state dental practice act (see opposite	The removal of calculus, deposits, or accretions from the natural and restored surfaces of teeth or

		page) under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	dental implants in the human mouth using hand, ultrasonic, sonic, or air polishing instruments; final placement of orthodontic bands or brackets except in indirect bonding procedures in which the dentist has either performed the final placement of the brackets on the model or when the dentist has written a detailed prescription to the laboratory for placement of the bracket; placement or finishing of any final restoration; the taking of an impression for a final fixed or removable restoration or prosthesis; periodontal screening and probing, or subgingival exploration for hard and soft deposits and sulcular irrigations; root planing or the smoothing and polishing of roughened root surfaces using hand, ultrasonic, or sonic instruments; placement and removal of antimicrobial agents; comprehensive examination or diagnosis and treatment planning; a surgical or cutting procedure on hard or soft tissue including laser and micro abrasion reduction of tooth material; prescription of a drug, medication, or work authorization; final placement and intraoral adjustment of a fixed appliance; final placement and intraoral or extraoral adjustment of a removable appliance; making of any intraoral occlusal adjustment; performance of direct pulp capping or pulpotomy; administration of a local anesthetic, parenteral, Intravenous (IV), inhalation sedative agent, or any general anesthetic agent
	Expanded Duty Dental Assistant (EDDA) (Ch. 5)	To perform **expanded functions** under the direct supervision of a licensed dentist in the state of Louisiana, a dental assistant must earn status as an **Expanded Duty Dental Assistant (EDDA)**. To qualify, one must: Graduate from a CODA-accredited dental assisting program, providing documentation that training was provided in all functions which EDDAs are allowed to perform. If a dental assistant's training is deemed inadequate, the assistant must undergo remediation in a Louisiana board-approved program ***or*** complete an expanded duty dental assistant program approved by the Louisiana State Board of Dentistry	
ME	Dental Assistant	A **dental assistant** in the state of Maine may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Examination, diagnosis and treatment planning; surgical or cutting procedures; prescribing drugs; performing pulp capping; placement and adjustment of prosthetic appliances; administration of anesthesia or sedation; use of power-driven handpieces/instruments to remove amalgam or composite material or for the equilibration of patient occlusion.
	DANB Certified Dental Assistant (CDA)	Dental assistants who hold the national **DANB Certified Dental Assistant (CDA)** Certification are qualified in the state of Maine to perform the functions listed on the opposite page.	
	Expanded Functions Dental Assistant (EFDA)	To perform **expanded functions** under the direct supervision of a licensed dentist in the state of Maine, a dental assistant must earn status as an **Expanded Function Dental Assistant (EFDA)**. To qualify, one must: Be at least 18 years of age ***AND***	

		▯▯Be certified in CPR ***AND*** ▯▯Be a current DANB CDA ***OR*** be a current Registered Dental Hygienist (RDH) ***AND*** ▯▯Successfully complete a Maine Board-approved course ***AND*** ▯▯Successfully complete the Maine Board of Dental Examiners' jurisprudence exam ***AND*** ▯▯Apply for state EFDA certification from the Maine Board of Dental Examiners	
MD	Dental Assistant	A **dental assistant** in the state of Maryland may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Oral prophylactic procedures, including scaling, root planing, and polishing teeth; placing or removing an arch wire; placing elastics or ligatures; p reparing or fitting orthodontic bands; condensing, carving, or finishing any restoration; placing an initial surgical dressing; apply pit and fissure sealants; examination, diagnosis, and treatment planning; surgery on hard or soft tissues; administering injectable local anesthesia; initiation of treatment at any time for the correction of malocclusions and malformations of the teeth or jaws; adjusting occlusion of natural teeth, restorations, or appliances; registration of jaw relations; selecting headgear; adjusting prosthetic appliances; cementing of orthodontic bands, placement of bonded attachments or the removal of cement or bonded orthodontic bands and attachments; cementing permanent crowns or restorations ***** Some of these functions **may** be permitted by Dental Assistants Qualified in Orthodontics; see this state's "Orthodontic Assisting" template
	Dental Assistant Qualified in General Duties	To perform **expanded functions** in the state of Maryland, a dental assistant *must* register as a **Dental Assistant Qualified in General Duties**. To qualify, one must: ▯▯Complete a training program (minimum of 35 hours) approved by the Maryland State Board of Dental Examiners ***and*** pass the Maryland General Dental Assisting Expanded Functions (MDG) exam administered by DANB ***OR*** Pass the national DANB Certified Dental Assistant (CDA) exam ***AND*** ▯▯Apply to the Maryland State Board of Dental Examiners for state recognition as a Maryland Dental Assistant Qualified in General Duties	
	Dental Assistant Qualified in Orthodontics	To perform **orthodontic functions** in the state of Maryland, a dental assistant *must* register as a **Dental Assistant Qualified in Orthodontics**. To qualify, one must: ▯▯Complete a training program (minimum of 35 hours) approved by the Maryland State Board of Dental Examiners ***and*** pass the Maryland Orthodontic Assisting Expanded Functions (MDO) exam administered by DANB ***OR*** Pass the national DANB Certified Orthodontic Assistant (COA) exam ***AND*** ▯▯Apply to the Maryland State Board of Dental Examiners for state recognition as a Maryland Dental Assistant Qualified in Orthodontics	
MA	On-the-Job Trained	An **On-the-Job Trained Dental Assistant** in the state of Massachusetts must be	Place permanent or bonded restorations in or on

	Dental Assistant	trained in the dental office under the supervision of a licensed dentist.	natural teeth; apply cavity liner or base material; take impressions for fabrications of restorations, appliances, or prostheses; condense or carve amalgam or composite restorations; diagnose oral conditions; treatment plans for dental services; surgically cut or remove hard or soft tissue (not to include gingival curettage); prescribe medications or drugs; administer general anesthesia, parenteral sedation or conscious sedation; administer local anesthesia; perform extractions; pace sutures; perform endodontic therapy; intraorally finish margins or adjust the occlusion of restorations; fabricate dentures; adjust dentures; permanently cement or recement cast restorations or stainless steel crowns; perform orthodontic therapy; apply or finish composite or bonding materials for restorative or cosmetic procedures; perform any other procedure prohibited by the Board
	Formally Trained Dental Assistant	To perform **expanded functions** in the state of Massachusetts, a dental assistant *must* earn one of the following designations: **Formally Trained Dental Assistant (FTA)** or **DANB Certified Dental Assistant (CDA).** To qualify as an **FTA,** one must: Successfully complete a CODA-accredited dental assisting program that has included a course in radiological techniques and safeguards	
	DANB Certified Dental Assistant (CDA)	To qualify as a **DANB CDA,** one must: Hold a **current** national DANB CDA Certification	
	DANB Certified Orthodontic Assistant (COA)	To perform **orthodontic functions** in the state of Massachusetts, a dental assistant must earn the national **DANB Certified Orthodontic Assistant (COA)** Certification.	
MI	Dental Assistant	A **dental assistant** in the state of Michigan may perform basic supportive dental specified by the state dental practice act under the direct or general supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Taking impressions for any purpose other than study or opposing models; diagnosing, or prescribing for, any of the following: disease, pain, deformity, deficiency, injury, or physical condition; cutting of hard and soft tissue; removal of any of the following: accretions, stains, or calculus deposits; deep scaling; root planning; any intra-oral restorative procedures; administration of any of the following: local anesthesia, nitrous oxide analgesia, or acupuncture; irrigation and medication of root canals, try-in of cones or points, filing, or filling of root canals; permanent cementation of any restoration or appliance
	Registered Dental Assistant (RDA)	To become licensed as a **Registered Dental Assistant (RDA)** in the state of Michigan, one must: Receive a degree or certificate of dental assisting from an accredited program of dental assisting meeting Michigan board requirements ***AND*** Pass the Michigan board comprehensive and clinical exam ***or*** pass an equivalent exam in another state (proof of out-of-state licensure required) ***AND*** Apply for a license to the Michigan Board of Dentistry	
	Registered Dental Assistant qualified in expanded functions	To perform the **expanded functions** listed on the opposite page under the direct supervision of a licensed dentist in the state of Michigan, a **Registered Dental Assistant** must be licensed by the Michigan Board of Dentistry. To obtain a license, one must: Be licensed as a Registered Dental Assistant *(see below)* ***AND*** Complete a course in the desired functions at a CODA-accredited dental assisting program meeting board requirements	
MN	Dental Assistant	A **dental assistant** in the state of Minnesota may perform basic supportive dental procedures specified by the state dental practice act (see opposite	Scaling of teeth; diagnosis, including interpretation of dental radiographs and treatment planning;

		page) under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	cutting of tooth structure; surgical procedures on hard and soft tissues including, but not limited to, the removal of teeth and the cutting and suturing of soft tissues; prescription, injection, and parenteral administration of drugs; final bending of archwire prior to ligations; administration of general anesthesia or conscious sedation
	Registered Dental Assistant (RDA)	To earn status as a **Registered Dental Assistant (RDA),** dental assistants in the state of Minnesota must: Graduate from a CODA- accredited dental assisting program ***OR*** Pass the national DANB Certified Dental Assistant (CDA) exam ***AND*** Complete a Board-approved course in expanded functions in Minnesota ***AND*** Pass the Minnesota Registration exam within five years prior to application for registration ***AND*** Pass the Minnesota Jurisprudence Exam ***AND*** Apply for registration to the Minnesota Board of Dentistry **Note:** All regulated dental assistants must be current in Cardiopulmonary Resuscitation (CPR) at the Health Care Provider level.	
	Registered Dental Assistant qualified in expanded functions	To perform **expanded functions** under the supervision of a licensed dentist in the state of Minnesota, **Registered Dental Assistants** must complete a CODA-accredited course in each of the expanded functions listed on the opposite page.	
MS	Dental Assistant	A **dental assistant** in the state of Mississippi may perform basic supportive dental procedures (see opposite page) under the direct supervision of a licensed dentist. All dental assistants involved in direct patient care must be certified in CPR (within 180 days of employment.) There are no other education or training requirements for this level of dental assisting.	Placement of any subgingival medicated cords; Carve and place amalgams; place matrix bands; The taking of any impression of the human mouth or oral structure that will be used in the restoration, repair, or replacement of any natural or artificial teeth or for the fabrication or repair of any dental appliance; periodontal screening and probing, or subgingival explorations for hard or soft deposits and sulcular irrigations; use of ultrasonic and/or sonic instruments; placement or cementation in inlays, permanent crowns, fixed bridges, removable bridges, partial dentures, or full dentures; equilibration or adjustment of occlusion on natural or artificial dentition, restoration, or sealants; activation or adjustments of orthodontic appliances; Injections of drugs, medication, or anesthetics; Performing pulp capping, pulpotomy, and other endodontic therapy; intraoral restorative procedures; the removal of calcareous deposits with

			an instrument; brush biopsies; remove facial hair with lasers; administer Oraqix
MO	Dental Assistant	An **dental assistant** in the state of Missouri may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Scaling of teeth; diagnosis, including interpretation of dental radiographs and treatment planning; cutting of tooth structure; surgical procedures on hard and soft tissues including, but not limited to, the removal of teeth and the cutting and suturing of soft tissues; prescription, injection, and parenteral administration of drugs; final bending of archwire prior to ligations; administration of nitrous oxide/oxygen analgesia
	Dental Assistant qualified in expanded functions	To perform **expanded functions** under the direct supervision of a licensed dentist in the state of Missouri, a **dental assistant** must: Pass the Missouri Basic Dental Assisting Skills Exam (administered by DANB) ***AND*** Complete the appropriate Missouri Board-approved expanded functions course(s) ***AND*** Pass a Missouri Board-approved competency exam and provide proof of competence to the Missouri Dental Board **Note:** Dental assistants may assist the administration of and monitor nitrous oxide analgesia under direct supervision if they meet the following requirements: • Successfully complete formal certified training in a course approved by the Missouri Dental Board ***AND*** • Pass an approved competency test regarding clinical and didactic training ***or*** hold certification in another state to assist the administration of and monitoring nitrous oxide subsequent to equivalent training and testing	
	DANB Certified Dental Assistant (CDA)	**Certified Dental Assistants (CDAs)** who have graduated from accredited dental assisting programs in Missouri and are currently Certified by DANB may perform expanded functions. CDAs who were Certified prior to June 1, 1995, or who are graduating from programs outside of Missouri may perform expanded functions if they: Complete a Missouri Board- approved expanded functions course ***AND*** Pass an approved competency exam and can provide proof of competence	
MT	Dental Auxiliary	A **dental auxiliary** in the state of Montana may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct supervision of a licensed dentist. To qualify, one must: Graduate from a CODA- accredited dental assisting program ***OR*** Receive instruction and training by a licensed dentist ***OR*** Receive instruction and training in a board-approved continuing education	Placing, carving, or condensing any permanent restorations; taking final impressions of the involved arch for crowns, bridges, implant prosthesis, partial or complete dentures; diagnosis and treatment planning; cutting hard or soft tissue or extracting teeth; prescribing any drugs; administering or dispensing any drug, without the prior authorization of the supervising dentist; administering intravenous and intramuscular injections or local

		course	anesthetic; bonding or cementing any fixed prosthesis, including veneers, except for provisionals; bonding or cementing orthodontic brackets or orthodontic appliances that would provide activation upon cementation; placing sulcular medicinal or therapeutic materials; periodontal probing; prophylaxis
NE	Dental Assistant	A **dental assistant** in the state of Nebraska may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct or general supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting. **Note:** Dental assistants who monitor nitrous oxide analgesia must hold a current Cardiopulmonary Resuscitation (CPR) certification.	Placing and packing retraction cords; placing and condensing amalgam restorations by the assistant; performing supragingival scaling; placing and finishing composite resin restorations; applying cavity liners and bases; applying pit and fissure sealants; taking final impressions for dentures; taking final impressions for crown and bridge; carving amalgams; remove excess set cement from coronal surfaces of teeth with an instrument (other than for temporary restorations); bending archwires; polishing amalgams; cementing bands and/or bonding brackets; placing tetracycline periodontal fibers; placing dentinal bonding agents; applying enamel/dentin etching agents; cementing permanent restorations; atraumatic restorative therapy (ART); adjustments to dentures and/or partials; applying bleaching products; performing denture adjustments
	Dental Assistant qualified in coronal polishing	To perform **coronal polishing procedures** under the direct supervision of a licensed dentist in the state of Nebraska, a **dental assistant** must: Graduate from a CODA-accredited dental assisting program which includes a coronal polishing course ***OR*** Complete one year (1,500 hours minimum) of clinical work experience as a dental assistant ***and*** a Nebraska Board-approved course in polishing procedures	
NV	Dental Assistant	A **dental assistant** in the state of Nevada may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the supervision of a licensed dentist or dental hygienist. There are no education or training requirements for this level of dental assisting.	The diagnosis, treatment planning, or prescribing of drugs or medicaments, or authorizing the use of restorative, prosthodontic, or orthodontic appliances; surgery on hard or soft tissues within the oral cavity or any other intraoral procedure that may contribute to or result in an irremediable alteration of the oral anatomy; the administration of general anesthesia, conscious sedation, or deep sedation except as otherwise authorized by regulations adopted by the Nevada Board; the performance of a task outside the authorized scope of practice of the employee who is being assigned the task
NH	Dental Assistant (Part 401)	A **dental assistant** in the state of New Hampshire may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct or general supervision of a licensed dentist. There are no education or training requirements for this level of dental	Diagnosis, treatment planning, and prescriptions (including prescriptions for drugs and medicaments or authorization for restorative prosthodontic, or orthodontic appliances); surgical procedures on

		assisting.	hard or soft tissues within the oral cavity; or any other intra-oral procedure that contributes to, or results in, an irremediable alteration of the oral anatomy
	DANB Certified Dental Assistant (CDA) (Part 401)	Dental assistants who hold the national **DANB Certified Dental Assistant (CDA)** Certification are qualified in the state of New Hampshire to perform the functions listed on the opposite page. *Dental assistants in the state of New Hampshire can earn status as a **Graduate Dental Assistant** by graduating from a CODA-accredited program of dental assisting.	
	Graduate Dental Assistant (GDA)qualified to perform expanded functions	To perform **expanded functions** under the direct supervision of a licensed dentist in the state of New Hampshire, a **dental assistant** *must* be qualified as follows:: ***Coronal polishing ; Dental sealants; In-office tooth whitening; Monitor nitrous oxide administration; Orthodontic Duties; Preliminary inspection of the oral cavity; Provisional crown and bridge restorations;***	
NJ	Unregistered Dental Assistant (Pg. 8)	An **unregistered dental assistant** in the state of New Jersey may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	None specified
	Registered Dental Assistant (RDA) (Pg. 8)	To perform **expanded functions** under the direct supervision of a licensed dentist in the state of New Jersey, dental assistants must be licensed as a **Registered Dental Assistant (RDA).** To register as an **RDA**, one must: Successfully complete high school or its equivalent ***AND*** Pass DANB's national Certi- fied Dental Assistant (CDA) or Certified Orthodontic Assistant (COA) exam (within 10 years prior to application) ***AND*** Graduate from a New Jersey Board-approved CODA-accredited dental assisting program (within 10 years prior to application) ***OR*** Obtain at least two years' work experience as a dental assistant (within five years prior to application), success- fully complete a Board-approved program in ex- panded functions, and pass the New Jersey Expanded Duties - General Exam (administered by DANB) ***OR*** Obtain at least two years' work experience as a dental assistant (within five years prior to application) and pass the New Jersey Expanded Duties - General Exam (administered by DANB) ***AND***	

		▯▯Apply for licensure as a Registered Dental Assistant to the New Jersey Board of Dentistry	
NM	Dental Assistant	A **dental assistant** in the state of New Mexico is an individual who may perform basic supportive dental procedures under the direct supervision of a licensed dentist (see notes on opposite page). There are no education or training requirements for this level of dental assistant.	Final impressions for restorations or prosthetic appliances ; removal of, or addition to, the hard or soft tissue of the oral cavity; diagnosis and treatment planning; fitting and adaptation of prostheses; final fitting, adaptation, seating and cementation of any fixed or removable dental appliance or restoration, including but not limited to inlays, crowns, space maintainers, habit devices or splints; irrigation and medication of canals, cone try-in, reaming, filing or filling of root canals; other services defined as the practice of dentistry or dental hygiene
	Dental Assistant with state certification in expanded functions	To perform **expanded functions** under the general supervision of a licensed dentist in the state of New Mexico, a **dental assistant** must earn **state certification**. To qualify, one must: *Rubber cup coronal polishing:* ▯▯Successfully complete a Board- approved training program ***and/or*** assist with/observe five cases of rubber cup coronal polishing ***and*** ▯▯Pass DANB's written exam on rubber cup coronal polishing ***and then*** ▯▯Perform rubber cup coronal polishing (under Board-approved supervision) in five cases ***and*** ▯▯Pass the state take-home jurisprudence exam ***and*** ▯▯Apply for state certification in coronal polishing to the New Mexico Board of Dental Health Care (NMBDHC) *Pit and Fissure Sealants:* ▯▯Have 2,080 hours of dental assisting chairside experience in the two years prior to application ***and*** ▯▯Successfully complete a Board- approved training program ***and*** ▯▯Assist with/observe twelve cases of application of pit and fissure sealants ***and*** ▯▯Pass DANB's written exam on pit and fissure sealants ***and then*** ▯▯Apply pit and fissure sealants (under Board-approved super-vision) in five cases ***and*** ▯▯Pass the state take-home jurisprudence exam ***and*** ▯▯Apply for state certification in pit and fissure sealants to the NMBDHC *Topical Fluoride:* ▯▯Successfully complete a Board- approved training program ***and*** ▯▯Assist with/observe five cases of application of topical fluoride ***and*** ▯▯Pass DANB's written exam on topical fluoride ***and then*** ▯▯Apply topical fluoride (under Board-approved supervision) in five cases ***and*** ▯▯Pass the state take-home jurisprudence exam ***and***	

		Apply for state certification in topical fluoride to the NMBDHC	
NY	Unlicensed Dental Assistant	There are no education or training requirements for this level of dental assisting.	Diagnosing; performing surgical procedures; performing irreversible procedures; performing procedures that would alter the hard or soft tissue of the oral and maxillofacial area; removing calcareous deposits, accretions and stains, including scaling and planing of exposed root surfaces indicated for complete prophylaxis; applying topical agents indicated for a complete dental prophylaxis; removing excess cement from surfaces of the teeth; providing patient education; polishing teeth, including existing restorations; charting caries and periodontal conditions as an aid to diagnosis by the dentist; applying pit and fissure sealants; applying a topical medication not related to a complete dental prophylaxis; placing periodontal dressings; such dental supportive services that a certified dental assistant would not reasonably be qualified to perform based upon meeting the requirements for certification as a certified dental assistant and/or obtaining additional legally authorized experience in the practice of certified dental assisting.
	Dental Assistant with a Limited Permit	A person who has met the first three eligibility requirements listed below (under state licensed requirements) may apply for a ***limited (one-year) permit*** prior to taking and passing the exam requirements. A limited permitee may perform all tasks designated to certified dental assistants, under the direct personal supervision of a licensed dentist. The permit expires after one year and *may* be renewed for an additional year.	
	NY state licensed certified dental assistant	A **dental assistant** in the state of New York must be licensed in order to perform **supportive services** under the direct supervision of a licensed dentist. To be licensed in the state of New York, one must: Be at least 17 years of age Be a high school graduate or its equivalent Successfully complete ***one*** *of the two* ***education*** *options listed below:* • an approved one-year course of study in dental assisting in a degree-granting institution or a board of cooperative educational services program that includes at least 200 hours of clinical experience ***OR*** • an alternate course of study in dental assisting acceptable to the New York State Education Department that includes at least 1,000 hours of relevant work experience in accordance with the Com- missioner's regulations. Successfully complete ***one*** *of the two* ***exam pathways*** *listed below:* • *PATHWAY I:* Pass all three components of the national DANB Certified Dental Assistant (CDA) Exam: Radiation Health & Safety (RHS), Infection Control (ICE), and General Chairside (GC) ***OR*** • *PATHWAY II:* Pass the New York Professional Dental Assisting (NYPDA) exam along with DANB's RHS and ICE component exams. Apply for licensure from the New York State Education Department after completing all of the above requirements	
NC	Dental Assistant I (DA I)	A **Dental Assistant I (DA I)** is an individual who may perform basic supportive dental procedures under the direct control and supervision of a licensed dentist,	Placement or cementation of final restorations; taking of impressions for final fixed or removable restorations or prostheses; prophylaxis; periodontal

		To qualify to *monitor patients under nitrous oxide*, a **DA I** must: Successfully complete a North Carolina Board-approved seven- hour course in nitrous oxide- oxygen conscious sedation	screening; periodontal probing; subgingival exploration for or removal of hard or soft deposits; sulcular irrigation; comprehensive examination, diagnosis, and treatment planning; surgical or cutting procedures on hard or soft tissues, including laser, air abrasion, or micro-abrasion procedures; placement or removal of sulcular nonresorbable agents; the issuance of prescription drugs, medications, or work authorizations; final placement or intraoral adjustment of a fixed or removable appliance; intraoral occlusal adjustments which affect function, fit, or occlusion of any temporary or permanent restoration or appliance; extra-oral occlusal adjustments which affect function, fit, or occlusion of any permanent restoration or appliance; performance of direct pulp capping or pulpotomy; placement of sutures; final placement or cementation of orthodontic bands or brackets; administration of any anesthetic except the administration of topically- applied agents intended to anesthetize only cutaneous tissue; intraoral use of a high speed handpiece
	Dental Assistant II in training (DA II in Training)	A **Dental Assistant II in Training (DA II in Training)** is an individual who has two years of the preceding five (3,000 hours) of full-time employment and experience as a chairside assistant, during which period the assistant may be trained and allowed to perform the functions of a Dental Assistant II under the direct control and supervision of a licensed dentist. To qualify to *monitor patients under nitrous oxide,* a **DA II in Training** must Successfully complete a North Carolina Board-approved seven- hour course in nitrous oxide- oxygen conscious sedation	
	Dental Assistant II (DA II)	To perform **expanded functions** under the direct supervision of a licensed dentist in the state of North Carolina, one must be classified as a **Dental Assistant II (DA II)**. To qualify as a **DA II**, one must: Hold a current Cardiopulmonary Resuscitation (CPR) certification ***AND*** Successfully complete a CODA-accredited dental assisting program ***or*** one academic year or longer in a CODA-accredited dental hygiene program ***OR*** Complete two years (3,000 hours) of full-time employment and experience as a chairside assistant, radiography training as required by law, ***and*** a three- hour course in dental office emergencies ***and*** a three-hour course in sterilization and infection control ***OR*** Pass the national DANB Certified Dental Assistant (CDA) exam To qualify to *perform coronal polishing,* a **DA II** must: Successfully complete a seven-hour (three hours of didactic and four hours of clinical) coronal polishing course To qualify to *monitor patients under nitrous oxide,* a **DA II** must: Successfully complete a North Carolina Board-approved seven- hour course in nitrous oxide- oxygen conscious sedation	
ND	Dental Assistant	A **dental assistant** in the state of North Dakota may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Scaling, root planing, or gingival curettage; placing or contouring of a final restoration, excluding a crown which has not been cemented by a dentist; placing bases or cavity liners; apply pit and fissure sealants (unless requirements have been met); diagnosis and treatment planning; surgery on hard
	Qualified Dental	To earn status as a **Qualified Dental Assistant (QDA)** in the state of North	

	Assistant (QDA)	Dakota, one must: Complete a North Dakota board-approved infection control seminar ***and*** pass the national DANB Radiation Health & Safety (RHS) and Infection Control (ICE) exams ***and*** Have been employed and trained as a dental assistant for at least six months (working at least 24 hours per week) and have received at least 650 hours of dental assisting instruction, including on-the- job training ***and*** Maintain current CPR certification ***and*** Apply to the North Dakota State Board of Dental Examiners	or soft tissue; administering of local or general anesthetics; any irreversible dental procedure or procedures which require the professional judgment and skill of a licensed dentist; any intraoral procedure which would lead to the fabrication of any appliance, with the exception of taking impressions for passive post treatment orthodontic retainers which do not replace missing teeth. Dental assistants may take impressions for athletic mouth guards, splints, bleaching trays, or rapid palatal expanders; activating any type of orthodontic appliance; cementing or bonding orthodontic bands or brackets that have not been placed by a dentist; measuring the gingival sulcus with a periodontal probe
	Registered Dental Assistant (RDA)	To earn status as a **Registered Dental Assistant (RDA)** in the state of North Dakota, one must: Hold current national DANB Certification ***or*** complete a course in dental assisting from a CODA-accredited program ***or*** complete at least 3,200 hours of on-the- job training as a dental assistant and complete a course in dental assisting approved by the North Dakota State Board of Dental Examiners ***and*** Maintain current CPR certification ***and*** Apply for registration to the North Dakota State Board of Dental Examiners	
	Registered Dental Assistant qualified to apply pit and fissure sealants	To **apply pit and fissure sealants** in the state of North Dakota under the direct supervision of a licensed dentist, a dental assistant must: Be a Registered Dental Assistant *(see requirements below)* ***and*** Provide documentation of a successful completion of a North Dakota board-approved sealant class	
OH	Basic Qualified Personnel	**Basic Qualified Personnel** must be trained directly via an employer/dentist, via a planned sequence of instruction in an educational institution or via in-office training.	Retraction of the gingival sulcus prior to the direct or indirect impression technique; final impressions of any tissue-bearing area upon which a prosthetic restoration is to be placed (not including the taking of impressions for athletic mouthguards or similar appliances); definitive diagnosis and treatment planning; final placement of any fixed or removable appliances; final removal of any fixed appliance; therapeutic intra-oral adjustment of any fixed or removable appliance; cutting procedures utilized in the preparation of the coronal or root portion of the tooth; cutting procedures involving the supportive structures of the tooth; placement of the final root canal filling; occlusal registration procedures for any prosthetic restoration; final placement of pre-fabricated or cast restorations or crowns; diagnosis; treatment planning and prescription, including prescription for drugs and medicaments or
	DANB Certified Dental Assistant (CDA) or Ohio certified dental assistant	Dental assistants who hold the national **DANB Certified Dental Assistant (CDA)** Certification can also earn Ohio state certification. To qualify as an Ohio certified dental assistant, one must: Hold a current national DANB Certified Dental Assistant (CDA) Certification ***OR*** Pass the exam administered by the Ohio Commission on Dental Assistant Certification (OCDAC) *Coronal Polishing:* In order to receive a certificate from the OSDB permitting the dental assistant to perform coronal polishing procedures, the DANB CDA or OCDAC certified dental assistant must successfully complete an OSDB-approved training program ***and*** successfully pass standardized testing immediately following successful completion of a skills assessment component of an approved training program. *Pit and Fissure Sealants:* DANB CDAs or OCDAC certified dental assistants may perform pit and fissure sealants upon successfully completing a course	

		containing a minimum of two hours of didactic instruction and six hours of clinical instruction. In addition, the supervising dentist must observe the assistant successfully apply at least six sealants.	authorization for restorative, prosthodontic , or orthodontic appliances
	Expanded Functions Dental Auxiliary (EFDA)	To perform **expanded functions** under the direct supervision of a licensed dentist in the state of Ohio, a dental assistant *must* qualify as an **Expanded Function Dental Auxiliary (EFDA)**. To qualify as an EFDA, one must: Complete a state Board- approved EFDA training course (course may require proof of DANB CDA Certification for entry) ***AND*** Pass the EFDA exam administered by the Commission on Dental Testing in Ohio (CODT) ***AND*** Hold a current Cardiopulmonary Resuscitation (CPR) certification **Note:** Dental assistants are required to apply to the OSDB for registration.	
OK	Dental Assistant (Pg. 27)	A **dental assistant** in the state of Oklahoma may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Placement or removal of restorative materials in a human oral cavity; removal of fully hardened cement; diagnosis; treatment planning; prescription of medications; final placement or removal of orthodontic brackets and bands; surgery or the cutting or severance of hard and soft tissue; placement or adjustment of any removable or fixed prosthesis; administration of injectable local anesthesia; administration of general anesthesia; any procedure that may contribute to or result in an irreversible alteration of the human oral anatomy; those projects allocated exclusively to dental hygienists
	Expanded Functions Dental Assistant (EFDA) (Pg. 27)	The following functions are **not** permitted by any level of dental assistant: 12, 33. Placement or removal of restorative materials in a human oral cavity 61. Removal of fully hardened cement • Diagnosis • Treatment planning • Prescription of medications • Final placement or removal of orthodontic brackets and bands • Surgery or the cutting or severance of hard and soft tissue • Placement or adjustment of any removable or fixed prosthesis • Administration of injectable local anesthesia • Administration of general anesthesia • Any procedure that may contribute to or result in an irreversible alteration of the human oral anatomy • Those projects allocated exclusively to dental hygienists	
OR	Dental Assistant	A **dental assistant** in the state of Oregon may perform basic supportive dental procedures specified by the state dental practice act (see next page) under the indirect supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Place any type of cord subgingivally; condense and carve permanent restorative material, except as provided in OAR 818-042-0095; place periodontal packs; take jaw registrations or oral impressions for supplying artificial teeth as substitutes for natural teeth, except diagnostic or opposing models or for the fabrication of temporary or provisional restorations or appliances; diagnose or plan
	Expanded Functions Dental Assistant (EFDA)	To perform **expanded functions** under the supervision of a licensed dentist in the state of Oregon, a dental assistant *must* earn status as an **Expanded Function Dental Assistant (EFDA)**. To qualify, one must:	

	☐☐Hold an Oregon Certificate of Radiological Proficiency *(see requirements to the right)* ***AND*** ☐☐Complete ***either*** of the following requirements and apply to DANB for the Oregon Board of Dentistry's (OBD's) EFDA state certification: (1) Complete a course of instruction in a CODA- accredited program ***or*** (2) Complete ***all*** of the following requirements: • Pass the Oregon Basic Dental Assisting exam ***or*** the national DANB Certified Dental Assistant (CDA) exam, ***and*** the Oregon EFDA exam***** (all of which are administered by DANB) • Provide certification from a licensed dentist stating that the applicant has completed clinical requirements ***OR*** Complete ***one*** of the following requirements and apply to the OBD for EFDA state certification by credential: • Be certified in another state that has training and certification requirements substantially similar to Oregon's requirements ***or*** • Be certified by an employer dentist that the assistant has been employed for at least 1,000 hours in the past two years as a dental assistant (in a state other than Oregon) and is competent to perform the expanded functions **Note:** An EFDA may apply pit and fissure sealants and temporary soft relines to full dentures upon successful completion of a course of instruction (in the desired expanded function) in a CODA-accredited program or other course of instruction approved by the Oregon Board of Dentistry. **Note:** Dental assistants who have completed specific Board-training and examination can apply to receive a **Restorative Function Endorsement** to perform the functions listed on the next page.	treatment; cut hard or soft tissue; adjust or attempt to adjust any orthodontic wire, fixed or removable appliance or other structure while it is in the patient's mouth; administer or dispense any drug except fluoride, topical anesthetic, desensitizing agents, or drugs* ; prescribe any drug; start nitrous oxide; use a high-speed handpiece or any device that is operated by a high- speed handpiece intra-orally; use lasers, except laser curing lights; use air abrasion or air polishing; remove teeth or parts of tooth structure; apply denture relines; use the behavior management techniques known as Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient; use ultrasonic equipment intra-orally, excluding those Expanded Orthodontic Functions expressly permitted; correct or attempt to correct the malposition or malocclusion of teeth or take any action related to the movement of teeth, excluding those Expanded Orthodontic Functions expressly permitted; cement or bond any fixed prosthetic
Anesthesia Assistant	A dental assistant in the state of Oregon must hold state certification as an **Anesthesia Assistant** in order to perform the functions listed on the opposite page. To qualify, one must: ☐☐Hold a current Health Care Provider BLS/CPR certification ***AND*** ☐☐Successfully complete the Oral and Maxillofacial Surgery Anesthesia Assistants Program***** conducted by the American Association of Oral and Maxillofacial Surgeons ***OR*** Successfully complete the Oral and Maxillofacial Surgery Assistants Course***** conducted by the California	

		Association of Oral and Maxillofacial Surgeons ***OR*** Have passed the national DANB Certified Oral and Maxillofacial Surgery Assistant (COMSA) exam***** ***AND*** Apply to the Oregon Board of Dentistry for state certification	
	Expanded Functions Orthodontic Dental Assistant (EFODA)	To perform **expanded orthodontic functions** in the state of Oregon, a dental assistant must earn status as an **Expanded Function Orthodontic Dental Assistant (EFODA)**. To qualify, one must: (1) Complete a course of instruction in a CODA- accredited dental assisting program ***OR*** Complete ***all*** of the following requirements: • Pass the Oregon Basic Dental Assisting exam ***or*** DANB's national Certified Dental Assistant (CDA) ***or*** Certified Orthodontic Assistant (COA) exams***** (all administered by DANB) ***and*** • Pass the Oregon Expanded Functions Orthodontic Assisting exam***** (administered by DANB) ***and*** • Provide certification from a licensed dentist that the applicant has successfully completed the clinical requirements ***AND*** (2) Apply to DANB for state certification as an EFODA ***OR*** (1) Complete ***one*** of the following requirements: • Be certified in another state that has training and certification requirements substantially similar to Oregon's ***or*** • Be certified by an employer dentist that the assistant has been employed for at least 1,000 hours in the past two years as a dental assistant (in a state other than Oregon and that the assistant is competent to perform the expanded functions ***AND*** (2) Apply to the OBD for state certification by credential as an EFODA	
PA	Dental Assistant	A **dental assistant** in the state of Pennsylvania may perform basic supportive dental procedures (see opposite page) under the direct supervision of a licensed dentist. There are no education or training requirements for this level of dental assistant.	Take impressions other than for study models or diagnostic casts; examine, diagnose, or plan treatment; cut hard or soft tissue; prescribe drugs, medicaments, or lab authorizations; approve the final occlusion; perform pulp capping, pulpotomy, and other endodontic procedures; perform final
	DANB Certified Dental	To perform **expanded functions** in the state of Pennsylvania under the direct	

	Assistant (CDA)	supervision of a licensed dentist, a dental assistant must hold a state certification as an **Expanded Function Dental Assistant (EFDA)**. To obtain this state certification, one must: Graduate from an expanded function dental assisting program at a two-year college or other state board-approved program which offers an Associate Degree ***OR*** Graduate from a CODA- accredited dental hygiene school, which requires the successful completion of at least 75 hours of clinical and didactic instruction in restorative functions ***OR*** Complete a state certification program in expanded function dental assisting of at least 200 hours of clinical and didactic instruction from either a CODA-accredited dental assisting program or a state board-approved dental assisting program ***AND*** Pass a Pennsylvania board- acceptable written exam ***AND*** Apply for state certification in expanded functions to the Pennsylvania State Board of Dentistry	placement/ cementation of fixed and removable prosthetic appliances; administer local anesthesia, parenteral or inhalational sedation, nitrous oxide analgesia, or general anesthesia
RI	Dental Assistant (Part IV)	A **dental assistant** in the state of Rhode Island may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Placement or removal of bonded orthodontic attachments and/or cementation or removal of orthodontic bands; condensing and carving restorative materials in teeth, except temporary restoratives; taking impressions for models upon which full or partial dentures, or permanent crowns, bridges, inlays, onlays, posts, and cores will be fabricated; diagnosis and treatment planning; surgical procedures on hard or soft tissue; prescribing medications; administering injectable local anesthetics; administering parenteral conscious sedation and/or general anesthesia/deep sedation; administering inhalants or inhalation conscious sedation agents; adjusting occlusion of fixed and removable prosthodontic appliances; final cementation of permanent crowns, bridges, inlays, onlays, and posts and cores; and insertion of final prosthesis; placement of sutures; perform direct pulp capping procedures; orthodontic arch wire activation with the exception of minor adjustments to eliminate pain or
	Expanded Duty Dental Assistant (EDDA)	To perform **expanded functions** in the state of Rhode Island under the direct supervision of a licensed dentist, a dental assistant must hold the national **DANB Certified Dental Assistant (CDA)** Certification. **Note:** Individuals who have passed the CDA exam but have not renewed are *no longer* CDAs. In Rhode Island, CDAs may perform the expanded functions listed on the next page provided that they have received academic training in these procedures or completed academic clinical training to clinical competence.	

			discomfort; flush root canal; temporary wire ligation; use of a rotary instrument in the oral cavity unless licensed or certified; oral prophylaxis
SC	Dental Assistant	A **dental assistant** in the state of South Carolina may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	None specified
	Advanced Dental Assistant	To perform **expanded functions** under the direct supervision of a licensed dentist in the state of South Carolina, a dental assistant must earn status as an **Expanded Duty Dental Assistant (EDDA).** To qualify, one must: Graduate from a CODA- accredited dental assisting program ***OR*** Complete two years of continuous full-time employment as a chairside dental assistant **Note:** In order to monitor nitrous oxide conscious sedation, EDDAs must complete a course approved by the South Carolina State Board of Dentistry and receive certification by the South Carolina Board.	
SD	Practical Dental Assistant	**Note:** Advanced Dental Assistants may apply for a permit to *administer* nitrous oxide analgesia under the direct supervision of a dentist. To qualify, an assistant must be trained in the administration of basic life support and complete a Board-approved educational course. Advanced Dental Assistants who wish to *monitor* nitrous oxide must complete an eight-hour course in anesthetic assisting and obtain a license from the South Dakota Board of Dentistry.	Placing, finishing, and adjusting of final restorations; cutting of hard or soft tissue; intraoral procedures that will be used directly in the fabrication of a dental prosthesis; irreversible procedures; injection of medication
	Registered Dental Assistant (RDA)	To perform **expanded functions** under the direct supervision of a licensed dentist in the state of South Dakota, a dental assistant must earn status as an **Advanced Dental Assistant**. To qualify, one must: Hold a current Cardiopulmonary Resuscitation (CPR) certification ***AND*** Graduate from a CODA- accredited dental assisting program ***OR*** Pass the national DANB Certified Dental Assistant (CDA) exam or another exam approved by the South Dakota Board of Dentistry ***OR*** Hold current certification in another state, if deemed equivalent by the South Dakota Board ***AND*** Apply to the Board for licensure as an Advanced Dental Assistant **Note:** Advanced Dental Assistants may apply for a permit to *administer* nitrous	

		oxide analgesia under the direct supervision of a dentist. To qualify, an assistant must be trained in the administration of basic life support and complete a Board-approved educational course. Advanced Dental Assistants who wish to *monitor* nitrous oxide must complete an eight-hour course in anesthetic assisting and obtain a license from the South Dakota Board of Dentistry.	
TN	Registered Dental Assistant qualified to perform expanded functions	To perform **expanded functions** in the state of Tennessee, **Registered Dental Assistants (RDAs)** *must* earn state certification by completing the requirements for each of the desired expanded functions listed below:*Perform coronal polishing procedures:* Successfully complete a Board- approved coronal polishing course (to qualify, an individual must be an RDA and have been employed as a full-time dental assistant for a minimum of one year prior to applying for the course, or be a current DANB CDA) ***and*** Hold a current Cardiopulmonary Resuscitation (CPR) certification ***and*** Pass both the written and clinical exams ***and*** Receive a certificate in coronal polishing from the Tennessee Board of Dentistry *Apply sealants:* Successfully complete a Board- approved course in sealant application (to qualify, one must be a current RDA) ***or*** be enrolled in a CODA-accredited or TN Board-approved program which offers such a course ***and*** Receive a certificate in sealant application from the Board *Monitor nitrous oxide:* Successfully complete a Board- approved nitrous oxide monitoring course (to qualify, one must be a current RDA) ***or*** be enrolled in a CODA-accredited or TN Board-approved program which offers such a course ***and*** Receive a certificate in monitoring nitrous oxide from the Board *Perform restorative and/or prosthetic functions:* Have a minimum of two years of continuous, full-time registered dental assisting employment ***and*** Complete a Board-approved certification course ***and*** Receive a certificate in rest-orative and/or prosthetic functions from the Board **Note:** RDAs who have successfully completed a comparable training program in expanded functions in another state may be eligible to apply directly to the Board for an expanded functions certificate without additional training. For details see *DANB's State Fact Booklet* or contact the Tennessee Board of	Examination, diagnosis, and treatment planning; surgical or cutting procedures on hard or soft tissue, including laser, air abrasion, or micro-abrasion procedures, including curettage or root planning; fitting, adjusting, and placement of prosthodontic appliances; issuance of prescription medications, medications not authorized by T.C.A., or work authorizations; performance of direct pulp capping, pulpotomy, and other endodontic procedures not authorized by T.C.A.; approve the final occlusion; placement of sutures; administration of local anesthesia, nitrous oxide, conscious sedation, or general anesthesia; use of a high-speed handpiece intraorally; utilization of laser equipment and technology; diagnosing of the need for restorations; preparation/cutting of the tooth or soft tissue; modifying existing structure; removal of caries, bases and liners; diagnosing need for any prosthetic appliance; establishing vertical dimension of occlusion and interocclusal records; delivering and/or adjusting appliance; expose radiographs without certification

		Dentistry.	
	Dental Assistant	A **Practical Dental Assistant** is an auxiliary employee of a licensed dentist(s) who is receiving practical chairside dental assisting training from a licensed dentist(s) or is a dental assistant student in an educational program accredited by the Commission on Dental Accreditation (CODA).	
	Registered Dental Assistant (RDA)	**Registered Dental Assistants** in the state of Tennessee may perform the procedures listed for this level on the opposite page. To register as an RDA, one must: Be at least 18 years old ***and*** Have a high school diploma or GED certificate ***and*** Have a current CPR certificate ***and*** Apply for registration to the Tennessee Board of Dentistry	
TX	Dental Assistant qualified to perform expanded functions	To perform **expanded functions** under the direct supervision of a licensed dentist in the state of Texas, a **dental assistant** must successfully complete the requirements listed below: *Apply pit and fissure sealants:* Work at least two years as a dental assistant ***AND*** Complete a current course in basic life support ***AND*** Complete a minimum of 16 hours of Texas Board-approved clinical and didactic education in pit and fissure sealants ***AND*** Register with the Texas State Board of Dental Examiners (TSBDE) *Monitor the administration of nitrous oxide:* Pass a TSBDE-approved nitrous oxide monitoring course ***AND*** Register with the Texas State Board of Dental Examiners (SBDE)	The removal of calculus, deposits, or accretions from the natural and restored surfaces of exposed human teeth and restorations in the human mouth; the placement of any final restoration; the taking of an impression for a final restoration, appliance, or prosthesis; root planing or the smoothing and polishing of roughened root surfaces or exposed human teeth; comprehensive examination or diagnosis and treatment planning; surgical or cutting procedure on hard or soft tissue; the prescription of a drug, medication, or work authorization; the making of an intraoral occlusal adjustment; direct pulp capping, pulpotomy, or any other endodontic procedure; the final placement and intraoral adjustment of a fixed or removable appliance; the authority to an individual to administer a local anesthetic agent, inhalation sedative agent, parenteral sedative agent, or general anesthetic agent; diagnosis, treatment planning, prescription of therapeutic measures and reevaluation; placement of site-specific subgingival medicaments; any other act the delegation of which is prohibited by board rule
	Dental Assistant	A **dental assistant** in the state of Texas may perform basic supportive dental procedures under the direct supervision of a licensed dentist (see opposite page). There are no education or training requirements for this level of dental assisting.	
UT	Dental Assistant (Sec. R156-69-603.)	A **dental assistant** in the state of Utah may perform basic supportive dental procedures under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Place, condense, carve, finish, or polish restorative materials, or perform final cementation; render definitive treatment diagnosis; cut hard or soft tissue or extract teeth; remove stains, deposits, or accretions (except as is incidental to polishing teeth coronally with a rubber cup); initially introduce nitrous oxide and oxygen to a patient for the

			purpose of establishing and recording a safe plane of analgesia for the patient (except under the direct supervision of a licensed dentist); remove bonded materials from the teeth with a rotary dental instrument or use any rotary dental instrument within the oral cavity (except to polish teeth coronally with a rubber cup); take jaw registrations or oral impressions for supplying artificial teeth as substitutes for natural teeth (except for diagnostic or opposing models for the fabrication of temporary or provisional restorations or appliances); correct or attempt to correct the malposition or malocclusion of teeth, or make an adjustment that will result in the movement of teeth upon an appliance which is worn in the mouth; perform sub-gingival instrumentation; render decisions concerning the use of drugs, their dosage, or prescription
VT	Expanded Functions Dental Assistant (EFDA) (Part 7.10)	To perform **expanded functions** in the state of Vermont under the direct supervision of a licensed dentist, a dental assistant must earn status as an **Expanded Function Dental Assistant (EFDA).** To qualify, one must: Hold a current national DANB Certification ***AND*** Be employed by a Vermont licensed dentist ***AND*** Successfully complete a formal program in each of the desired expanded functions at a CODA-accredited program of dental assisting ***AND*** Apply to the Vermont Board of Dental Examiners for registration	Diagnosis, treatment planning, and prescription, including prescription for drugs and medicaments or authorization for restorative, prosthodontic, or orthodontic appliances; surgical procedures on hard and soft tissues within the oral cavity or any other intraoral procedure that contributes to or results in an irremediable alteration of the oral anatomy
	Dental Assistant (part 7)	Dental assistants who hold the national **DANB Certified Dental Assistant (CDA)** Certification can also earn Vermont state certification. To qualify, one must: Hold a current national DANB Certified Dental Assistant (CDA) Certification ***AND*** Be employed by a Vermont licensed dentist ***AND*** Apply to the Vermont Board of Dental Examiners for registration	
VA	Dental Assistant *qualified in anesthesia administration*	A **dental assistant** in the state of Virginia who assists in the administration and monitoring of any form of conscious sedation or deep sedation/general anesthesia must meet one of the following requirements: Minimal training resulting in current certification in basic resuscitation techniques, such as Basic Cardiac Life Support or an approved, clinically	Performing an initial examination of teeth and surrounding tissues including the charting of carious lesions, periodontal pockets or other abnormal conditions for assisting the dentist in the diagnosis; placement of retraction cord; scaling and root planing of natural and restored teeth using hand

		oriented course devoted primarily to responding to clinical emergencies offered by an approved provider of continuing education ***OR*** Current certification as a certified anesthesia assistant by the American Association of Oral and Maxillofacial Surgeons or the American Dental Society of Anesthesiology	instruments, rotary instruments and ultrasonic devices; condensing, contouring, or adjusting any final, fixed, or removable prosthodontic appliance or restoration in the mouth; taking impressions for master casts to be used for prosthetic restoration of teeth or oral structures; final diagnosis and treatment planning; performing surgical or cutting procedures on hard or soft tissue; prescribing or parenterally administering drugs or medicaments; authorization of work orders for any appliance or prosthetic device or restoration to be inserted into a patient's mouth; operation of high speed rotary instruments in the mouth; performing pulp capping procedures; administering general anesthetics and conscious sedation; administering nitrous oxide or oxygen inhalation analgesia; fnal positioning and attachment of orthodontic bonds and bands; final cementation of crowns and bridges; polishing of natural and restored teeth using air polishers; performing a clinical examination of teeth and surrounding tissues including the charting of carious lesions, periodontal pockets or other abnormal conditions for further evaluation and diagnosis by the dentist; subgingival irrigation or subgingival application of topical Schedule VI medicinal agents; duties appropriate to the education and experience of the dental hygienist and the practice of the supervising dentist
	Dental Assistant	A **dental assistant** in the state of Virginia may perform basic supportive dental procedures (see opposite page) under the direction of a licensed dentist. There are no education or training requirements for this level of dental assisting.	
WA	Registered Dental Assistant	Every **dental assistant** in the state of Washington must be registered. To be eligible for registration as a dental assistant, one must: Provide a completed applica- tion on forms provided by the Washington State Dental Quality Assurance Commission ***AND*** Pay applicable fees ***AND*** Provide evidence of comple- tion of seven clock hours of AIDS education and training as required by chapter 246-12 WAC, Part 8 ***AND*** Provide any other information determined by the Washington State Dental Quality Assurance Commission The dental assistant registration must be renewed annually on or before the dental assistant's birthday.	Scaling procedures; removal of or addition to the hard or soft natural tissue of the oral cavity (except for placing and carving direct restorations by an EFDA); diagnosis of or prescription for treatment of disease, pain, deformity, deficiency, injury, or physical condition of the human teeth or jaws, or adjacent structure; administration of general or local anesthetic, including intravenous sedation; oral prophylaxis [except coronal polishing as part of oral prophylaxis as defined in WAC 246-817- 510 and 246-817-520(8)]; intra-orally adjust occlusal of inlays, crowns, and bridges; intra-orally finish margins of inlays, crowns, and bridges; cement or recement, permanently, any cast restoration or

		A registered **dental assistant** in the state of Washington may earn an endorsement in **sealant/fluoride varnish** solely for the purpose of treating children in school-based programs. For information about requirements visit www.doh.wa.gov.	stainless steel crown; incise gingiva or other soft tissue; elevate soft tissue flap; luxate teeth; curette to sever epithelial attachment; suture; establish occlusal vertical dimension for dentures; try-in of dentures set in wax; insertion and post-insertion adjustments of dentures; endodontic treatment (open, extirpate pulp, ream and file canals, establish length of tooth, fill root canal); use of any light or electronic device for invasive procedures; intra-oral air abrasion or mechanical etching devices; place direct pulp caps; fit and adjust occlusal guards. In addition to the functions listed above, the following functions are **not** permitted by a *registered dental assistant*: Placing of permanent or semi-permanent restorations in natural teeth; taking impressions of the teeth or jaws for the purpose of fabricating any intra-oral restoration, appliances, or prosthesis.
	Expanded Function Dental Auxiliary (EFDA)	To become an **Expanded Functions Dental Auxiliary (EFDA**) in Washington, a dental assistant must: Graduate from a CODA-accredited dental assisting program ***OR*** Be DANB CDA Certified through CDA/GC pathway II; in addition to DANB's requirements, the candidate must take an additional dental assisting review course ***AND*** Complete an EFDA course approved by the Dental Quality Assurance Commission (DQAC) ***AND*** Pass the Washington State Restorative Exam (WARE) administered by DANB ***AND*** Pass the clinical exam administered by the Western Regional Examining Board ***AND*** Apply to DQAC for an EFDA license.	
WV	Dental Assistant (pg. 15)	A **dental assistant** in the state of West Virginia may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the direct supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Diagnosis, treatment planning and prescription (including prescriptions for drugs and medicaments or authorizations for restorative, prosthodontic or orthodontic appliances); surgical procedures on hard and soft tissue within the oral cavity or any other intraoral procedure that contributes to or results in an irremediable alteration of the oral anatomy
	Dental Assistant qualified in expanded duties	A **dental assistant** in the state of West Virginia may qualify to perform the **expanded duties** listed on the opposite page upon completing a course and exam in each of the desired expanded duties. The course must be approved by the West Virginia Board of Dental Examiners (WVBDE). **Note:** Dental assistants who visually monitor nitrous oxide analgesia units are also required to hold current Cardiopulmonary Resuscitation (CPR) certification through the American Red Cross or the American Heart Association, and apply to the WVBDE for approval.	
WI	Dental Assistant	A **dental assistant** in the state of Wisconsin may perform basic supportive dental procedures under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Any procedure of a character which may cause damage to the patient's teeth or oral cavity which cannot be remedied without professional intervention; any procedure of a character which may cause adverse or unintended general systemic reaction; any procedures which are intended,

			interpreted, or represented to be preliminary assessments, dental hygiene treatment planning, oral screenings, oral prophylaxes, scaling or root planing, or dental sealants, or any portion of an oral prophylaxis other than supragingival rubber cup and air polishing after calculus is removed if necessary
WY	Dental Assistant	A **dental assistant** in the state of Wyoming may perform basic supportive dental procedures specified by the state dental practice act (see opposite page) under the supervision of a licensed dentist. There are no education or training requirements for this level of dental assisting.	Removal of tooth structure for the placement of orthodontic appliances; activate an orthodontic appliance; diagnosis for orthodontic treatment; remove direct bond attachments; any procedure billed as a prophylaxis

Dental Assisting Functions List

The following is a list of 70 dental assisting tasks developed by the ADAA/DANB Alliance in the course of its research. These selected tasks were determined to be representative of a broad range of dental assisting core competencies.

Functions in each state that correspond to the national Core Competency Study functions are **numbered** in the Career Ladder Template, using language directly from the state's dental practice act. Functions listed with **bullets** in the Career Ladder Template are part of the state's practice act but are not specific matches to DANB research.

1. Perform mouth mirror inspection of the oral cavity
2. Chart existing restorations or conditions
3. Phone in prescriptions at the direction of the dentist
4. Receive and prepare patients for treatment, including seating, positioning chair, and placing napkin
5. Complete laboratory authorization forms
6. Place and remove retraction cord
7. Perform routine maintenance of dental equipment
8. Monitor and respond to post- surgical bleeding
9. Perform coronal polishing procedures
10. Apply effective communication techniques with a variety of patients
11. Transfer dental instruments
12. Place amalgam for condensation by the dentist
13. Remove sutures
14. Dry canals
15. Tie in archwires
16. Demonstrate knowledge of ethics/ jurisprudence/patient confidentiality
17. Identify features of rotary instruments
18. Apply topical fluoride
19. Select and manipulate gypsums and waxes

20. Perform supragingival scaling
21. Mix dental materials
22. Expose radiographs
23. Evaluate radiographs for diagnostic quality
24. Provide patient preventive education and oral hygiene instruction
25. Perform sterilization and disinfection procedures
26. Provide pre- and post-operative instructions
27. Place and remove dental dam
28. Pour, trim, and evaluate the quality of diagnostic casts
29. Size and place orthodontic bands and brackets
30. Using the concepts of four- handed dentistry, assist with basic restorative procedures, including prosthodontics and restorative dentistry
31. Identify intraoral anatomy
32. Demonstrate understanding of the OSHA Hazard Communication Standard
33. Place, cure and finish composite resin restorations
34. Place liners and bases
35. Place periodontal dressings
36. Demonstrate understanding of the OSHA Bloodborne Pathogens Standard
37. Take and record vital signs
38. Monitor vital signs
39. Clean and polish removable appliances and prostheses
40. Apply pit and fissure sealants
41. Prepare procedural trays/ armamentaria set-ups
42. Place orthodontic separators
43. Size and fit stainless steel crowns
44. Take preliminary impressions
45. Place and remove matrix bands
46. Take final impressions
47. Fabricate and place temporary crowns
48. Maintain field of operation during dental procedures through the use of retraction, suction, irrigation, drying, placing and removing cotton rolls, etc.
49. Perform vitality tests
50. Place temporary fillings
51. Carve amalgams
52. Process dental radiographs
53. Mount and label dental radiographs
54. Remove temporary crowns and cements
55. Remove temporary fillings
56. Apply topical anesthetic to the injection site
57. Demonstrate understanding of the Centers for Disease Control and Prevention Guidelines
58. Using the concepts of four- handed dentistry, assist with basic intraoral surgical procedures, including extractions, periodontics, endodontics, and implants
59. Monitor nitrous oxide/oxygen analgesia
60. Maintain emergency kit
61. Remove permanent cement from supragingival surfaces

62. Remove periodontal dressings
63. Place post-extraction dressings
64. Fabricate custom trays, to include impression and bleaching trays, and athletic mouthguards
65. Recognize basic medical emergencies
66. Recognize basic dental emergencies
67. Respond to basic medical emergencies
68. Respond to basic dental emergencies
69. Remove post-extraction dressings
70. Place stainless steel crown

Levels of Supervision

An important consideration in the discussion of the delegation of tasks to dental assistants is that of supervision of dental assistants by their dentist-employers. The American Dental Association (ADA) has identified four levels of supervision for dental auxiliaries, including dental assistants, which it defines in its "Comprehensive Policy Statement on Allied Dental Personnel," (2006: 307) which is part of its *Current Policies,* last updated in 2007. Note that "allied dental personnel" refers to dental assistants, dental hygienists, and dental laboratory technicians.

The four levels of supervision defined by the ADA are as follows:

Personal supervision. A dentist is personally operating on a patient and authorizes the allied dental personnel to aid treatment by concurrently performing a supportive procedure.

Direct supervision. A dentist is in the dental office or treatment facility, personally diagnoses the condition to be treated, personally authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel and, before dismissal of the patient, evaluates the performance of the allied dental personnel.

Indirect supervision. A dentist is in the dental office or treatment facility, has personally diagnosed the condition to be treated, authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the allied dental personnel, and will evaluate the performance of the allied dental personnel.

General supervision. A dentist is not required to be in the dental office or treatment facility when procedures are being performed by the allied dental personnel, but has personally diagnosed the condition to be treated, has personally authorized the procedures, and will evaluate the performance of the allied dental personnel.

Furthermore, the ADA's Comprehensive Policy Statement on Allied Dental Personnel stipulates that intraoral expanded functions should be performed by allied dental personnel "only under the direct supervision of a dentist."

A COMPARISON OF BRACKET BONDING COMPOSITE REMOVAL BY DIFFERENT PROVIDER GROUPS.

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January, 1996

Edward H. Angle
Society of Orthodontists

Partial funding for this project was provided by the North Central Orthodontic Committee of the Minnesota Association of Orthodontists.

Literature Review

Even in todays' changing society it must remain a goal of the specialty of orthodontics to provide quality, efficient care. One strategy to increase the capacity to deliver cost effective care is to utilize to a greater extent allied health professionals. There have been few objective studies in orthodontic practices to evaluate this premise. It was, therefore, decided to design a project to evaluate one aspect of dental health care delivered by allied health personnel; the removal of orthodontic composite resin.

In 1992, the Minnesota Legislature enacted statutes referred to as MinnesotaCare, in an attempt to contain health care costs, improve the quality of care, as well as increase access to care. [1] This wide sweeping legislation initially included all health care professionals including those in dentistry. Subsequent modifications have minimized the mandated role that dentistry will be required to play in MinnesotaCare. However, if a practitioner does participate, there will remain a set percentage of care with reduced reimbursement. The concept of maintaining quality care at reduced costs remains a public priority.

The Pew Health Professions Commission "is charged with assisting health professionals, work force policy makers, and educational institutions in responding to the challenges of the changing health care system." The commission's September 1995 report in part addresses state practice acts, and one of their recommendations addresses removing barriers to allow for full use of competent health care workers. Given initial and continuing competence, practice acts should allow for overlap of scope of practices, recognizing skill and experience. [2]

An exhaustive effort by the Institute of Medicine culminated in a lengthy report published in 1995. In the area of education, the committee recommended that students and faculty participate in clinical activities that would emphasize team work and cost effective utilization of well trained allied dental personnel. Relative to productivity, they concluded that the "dental team of the future" would provide "new and challenging roles. . . for dental assistants in acting as dentist extenders." The conclusion of the committee was that practice acts "unreasonably restrict the use of appropriately trained allied dental personnel." In spite of evidence that dental allied personnel in less restrictive delivery systems can provide competent high quality care, there exist barriers to advancing the team strategy. Historical, political, and economic influences by dental and allied dental groups often influence and shape practice acts, and have little to do with need or abilities. [3]

O'Brien and Shaw in The British Journal of Orthodontics, developed an economic model to demonstrate the cost effectiveness of using expanded function orthodontic auxiliaries. They did caution, however, that treatment goals and quality should be maintained and proper supervision provided. [11]

In a very limited study, it was not surprising that Oliver showed that one untrained hygienist was significantly slower than one experienced orthodontist in using a tungsten carbide bur to remove in vitro residual orthodontic composite. However, there were no clear differences between the hygienist and the orthodontist in the quality of the enamel surfaces as reviewed under a scanning electron microscope. Given time and experience he concluded that hygienists would be able to provide high quality, cost effective care in the removal of composite resin. [12]

In 1986, based on a survey of accredited dental hygiene programs in the United States, Everett reported a number of interesting findings. Only 21 of the 172 responding dental hygiene institutions taught debonding. Twenty-three respondents stated that debonding was illegal, and sixty-five of the schools did not know or did not respond to whether debonding was illegal. Fifty-five of the respondents did not perceive a need to include it, at least at that time. There was no significant correlation between the legality of debonding in the state and inclusion of debonding in the curriculum. Some programs taught composite resin removal with use of scalers only. Everett concluded that dental hygiene educators need to be better informed about debonding procedures. [13]

Turner discussed a ten day program to teach dental hygienists selected orthodontic procedures including fixed appliance and composite removal. His conclusion was that he was ". . . impressed with the technical abilities of the hygienists". [14]

Since 1981 a bi-annual survey of various orthodontic practice indicators has been conducted by Gottlieb et al. [15] In the 1995 survey, 32.2% of the 1,129 orthodontists responding indicated that they delegated bond removal to allied dental personnel. This is up only slightly from 30.8% in 1981. Also in the survey, 74.6% of the respondents indicated that they delegated removal of cement, versus 62% of the respondents in 1981.

The most recent information compiled by the American Dental Association on delegating specific expanded functions does not list debonding. [16] It does, however, include removing cement from coronal surfaces of the teeth, which is reportedly permitted by dental assistants in 38 states; some states requiring additional training and/or credentialing. Four states report cementing bands/bonding brackets as an allowable delegated function. Three states reported that dental assistants may place and finish composite restorations. Twenty-three states allow dental assistants to polish coronal surfaces of the teeth.

The number of orthodontic graduates appears to be decreasing relative to the population. [17] If in fact the public demands orthodontics by educationally qualified specialists, there will be increased need to delegate certain functions to allied health personnel.

It was with this background that this study was undertaken to evaluate in one area, orthodontic composite removal, the relative capabilities of dentists and dental assistants. Incomplete composite resin removal and/or gouged enamel provides niches for the accumulation of plaque. There are a number of accepted techniques for debonding residual composite resin. One early endorsed and commonly practiced enamel friendly technique utilizes a tungsten carbide finishing bur with subsequent polishing. [4, 5, 6, 7, 8, 9, 10]

Materials and Methods

Upon appliance removal, 80 consecutive patients at Mayo Clinic were evaluated for enamel integrity and gingival status. The composite utilized for each patient was noted, and subsequently the composite was removed by individuals in one of two provider groups: registered dental assistants (graduates from a program accredited by the American Dental Commission on Accreditation) or dentists (orthodontic residents). There were eight providers, four per group, each randomly assigned to ten patients. Following composite removal, the surrounding oral tissue and the gingival status were evaluated, as well as the completeness of composite removal and enamel integrity for teeth #'s 5-12 (maxillary right first premolar through maxillary left first premolar). Prior to initiating the project, all eight providers were instructed in the protocol and removal techniques were demonstrated.

Bracket removal was uniformly accomplished by use of a Dentronics No. 230N debonding plier with no subsequent attempt at the time to remove any excess composite. The evaluator then examined the indicated teeth of each patient after isolation with cotton rolls and air drying. A periodontal probe manipulation, as outlined by Silness and Löe, was used to evaluate the ginigal integrity. [18] A single recording for each tooth was appropriately assigned;

No ginigivitis - 0G
(normal gingiva)
Mild gingivitis - 1G
(mild inflammation, slight change in color, slight edema; no bleeding on palpation)
Moderate gingivitis - 2 G
(moderate inflammation, redness, edema, and glazing; bleeding on palpation)
Severe gingivitis - 3G
(severe inflammation, marked redness and edema, ulcerations; tendency to spontaneous bleeding)

Bleeding either before or after tissue manipulation was recorded per tooth;

Bleeding - +B
No bleeding - 0B

Enamel surface condition was evaluated and recorded as:

Unaffected - 0E
Superficial lesion - 1E
Lesion with a catch (which included cavitation) - 2E

To maintain this as a blind study, the evaluator left the clinical area and the treatment coordinator randomly assigned one of the providers to perform the composite removal. The provider completely removed composite and recorded the time for composite removal including polishing of teeth #'s 5-12 Composite removal was accomplished by the use of a slow speed handpiece (30,000 rpm) fitted with a No. 1157 carbide finishing burr. Teeth were polished with Nupro medium pumice prophylaxis paste.

Upon completion of the procedure, the provider left the patient, and the treatment coordinator summoned the investigator for post-composite removal evaluation. Associated soft tissues, tongue, cheeks, and lips were observed for trauma, either superficial or deep before the teeth were isolated and air dried. Gingival tissue was evaluated and deemed to have:

No visible mechanical damage - OD
Minor damage - 1D
Major damage - 2D

Bleeding was noted as being:

Present - +B'
Absent - 0B'

Removal of composite was evaluated using a sharp Star Dental No. 5 explorer as well as by visual inspection. Where residual composite remained, it was noted as:

Smooth, with no catch - 1C
With a catch - 2C

Enamel modification as a result of composite removal was noted as:

None - 0E'
Minor - 1E'
Major - 2 E'

All study procedure evaluations were performed by the first author. The patient was given a questionnaire at the completion of treatment to ascertain the patient's perception of the procedure and his/her opinion and perception of various orthodontic treatment procedures that could be performed by dental hygienists, registered dental assistants, or dentists.

For statistical analysis, the evaluation of each tooth was interpreted as a numerical score, and the subject's scores were averaged over the eight teeth. The Wilcoxon rank-sum test was used to compare results between the assistants and the residents. Computations were carried out with the SAS statistical package (Cary, NC).

Results

The respondents had a median age of 14, (range 12-48), and were 56% female (41/73). There were no significant differences in demographic variables between the patients assigned to the two provider groups. Patient scores for gingival condition, bleeding, and enamel surface condition, prior to composite removal, were not significantly different between provider groups. (Table 1) The patients in the assistants group had a greater number of teeth with enamel defects, 106, compared to 78 teeth with enamel defects in the dentists patient group. (Table 2) Surprisingly, both groups showed a decrease in the number of patients with enamel surface defects after composite removal. (Table 3) There was no significant difference after composite removal in the amount of residual composite, enamel surface modification, bleeding, or gingival damage (Table 4). Out of 640 teeth, there was a total of seven teeth with residual composite. (Table 5) However, only one had composite with a catch remaining and that was in the dentist group. There were only nine areas where gingival damage could be observed, five to the assistant group and four to the dentist group. No patient exhibited any major gingival damage. In neither the assistants' nor the dentists' groups were there any incidents of damage to the tongue, cheek, or lips. However, six percent of the patients reported their perception that the provider injured the gums, tongue, or lips, with no significant difference between the provider groups.

There was a tendency, although not significantly different, for the assistants as a group to take longer then the dentists to remove composite. (Table 6) In addition, there was a wide range of individual times in both the assistant and dentist groups. (Fig 1)

The patients were satisfied by the service performed even though they were unsure who was providing the service. (Tables 7 & 8) Of the respondents, 76% said that it didn't make any difference who was the provider if competent; and were indifferent regarding the gender of the provider.

Unrelated to the specific study, responses to Part II of the questionnaire related to opinions and perceptions of the patients relative to delegated functions. Only in the area of placing and removing braces, can we observe that patients think that only the dentist can perform these duties. (Table 9)

From the patient responses, it is apparent that there is little understanding of who regulates what can be delegated to a dental assistant/hygienist. (Table 10) This correlates to the responses on Part I of the questionnaire where patients said it didn't make any difference.

Discussion

From the results, it was clear that there was no significant difference between the two provider groups. Additional information from the study will be the basis for future reports to include differences in tissue condition per tooth and side, time of removal for different composites, effect if any of the different composites on the gingival tissues/enamel, and patient age differences relative to gingival status and enamel condition.

Even though the dental assistant group of patients had a tendency for greater pre-enamel defects, suggesting a more difficult patient group, there is no significant difference in the post removal measured parameters nor in the time taken to perform the procedures. Of the 640 teeth evaluated, only seven had any clinically discernible residual composite. Of the seven, only one tooth had a catch, which was found subgingivally on a tooth noted to have severe gingivitis.

The surprising finding was that in both provider groups, fewer patients had post-composite removal defects than had precomposite removal defects. Possible reasons for this would include the difficulty in discerning slight defects from residual composite, perceived enamel defects under composite undercuts, or that there was a polishing away of very superficial defects in the removal process. In any case, the reduction was similar for both groups of patients.

The instructions to the eight providers included removal of all composite regardless of the gingival status. In both groups, 12 patients had some degree of gingivitis in at least half of their teeth. Minor gingival damage in nine patients is not surprising, given the number of patients with some degree of gingivitis. Since there was no observable damage to tongue, lips, and cheeks, the five patients (six percent) reporting damage must have perceived damage to the gingiva. Thus, four patients were not aware that some damage had occurred in the removal process as observed by our appraisal.

Bleeding upon manipulation with a probe was found on approximately two teeth per patient at the median level. This would appear to suggest that patient oral hygiene monitoring/compliance during treatment could be enhanced. To underscore this observation, approximately three teeth per patient exhibited some degree of gingivitis.

Better information could possibly have been obtained by either improving pre-questionnaire instructions to the patient and/or a more explicit response form relative to the functions that can be performed by the assistant/hygienist versus the dentist. As reported in the results, there was no clear indication that the respondents were aware of what limits the procedures that can be performed by dental assistants/hygienists. Further

evaluation based upon patients' ages, (less than 18 versus those 18 or greater) showed no difference in their understanding. In fact, based upon responses to the two questionnaires, it can be safely said that few know and even fewer care.

Finally, it is satisfying to demonstrate that 100% of the patients perceive that the provider knew what they were doing and that 99% of the patients felt that the service was completely performed (response levels 5, 4, and 3 combined). Seventy-eight percent were completely satisfied with the procedure. On the other hand, only 64% thought they completely understood the procedures that were to be performed.

It was curious to learn that 41% of the patients did not know what type of a provider was delivering the service. This is in spite of the fact that most of these patients were under treatment for 12-24 months and that most if not all of the providers were wearing name badges identifying their professional status.

Conclusion

The results of this study confirm that there is no difference between registered dental assistants and dentists in the removal of orthodontic composite resin. Further, patient satisfaction is similar between the two groups. Thus, delegating to assistants the removal of orthodontic composite resin can be done with no significant increase in time to the patient and with no decrease in quality of patient care.

The authors would like to thank the orthodontic staff: Drs. Sather, Guenthner and Larson; Cheryll Eggert, dental assistant supervisor; Denise Schouweiler, secretary; as well as the participating dental assistants and orthodontic residents.

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TABLE 1

PATIENTS

PRECOMPOSITE REMOVAL SCORES

	MEDIAN	MINIMUM	MAXIMUM	WILCOXON TEST p value
Gingival Tissue Condition (0-3)				
Assistants	1.13	0.13	2.63	.92
Dentists	1.31	0.0	3.0	
Bleeding (0-1)				
Assistants	0.25	0.0	1.0	.69
Dentists	0.37	0.0	1.0	
Enamel Surface Condition (0-2)				
Assistants	0.25	0.0	1.5	.26
Dentists	0.19	0.0	1.0	

TABLE 2

PRE COMPOSITE REMOVAL

ENAMEL SURFACE CONDITION
(NUMBER OF TEETH)

	UNAFFECTED	SUPERFICIAL LESION	LESION WITH CATCH	TOTAL	CHI SQUARE TEST p value
ASSISTANT					
Number of Teeth	214	92	14	320	
Percent	67	29	4	100	
					0.042
DENTIST					
Number of Teeth	242	70	8	320	
Percent	76	22	2	100	

TABLE 3

POST COMPOSITE REMOVAL EVALUATION
(NUMBER OF TEETH)

	PRE-COMPOSITE REMOVAL	POST COMPOSITE REMOVAL
Enamel Surface		
Assistants	29	17
Dentists	25	17
Bleeding		
Assistants	26	27
Dentists	28	24

TABLE 4

PATIENTS

POST COMPOSITE REMOVAL SCORES

	MEDIAN	MINIMUM	MAXIMUM	WILCOXON TEST p value
Gingival Tissue Condition (0-3)				
Assistants	0.0	0.0	0.25	.68
Dentists	0.0	0.0	0.13	
Bleeding (0-1)				
Assistants	0.25	0.0	1.0	.54
Dentists	0.25	0.0	1.0	
Residual Composite (0-2)				
Assistants	0.0	0.0	0.25	.25
Dentists	0.0	0.0	0.25	
Enamel Surface Condition (0-2)				
Assistants	0.0	0.0	0.75	.60
Dentists	0.0	0.0	0.63	

TABLE 5

POST COMPOSITE REMOVAL EVALUATION
(NUMBER OF TEETH)

	NO CATCH (SMOOTH)	CATCH	TOTAL
Residual Composite			
Assistants	5	0	5
Dentists	1	1	2

	MINOR	MAJOR	TOTAL
Gingival Damage Post			
Assistants	5	0	5
Dentists	4	0	4

TABLE 6

TIME OF COMPOSITE REMOVAL
(MINUTES)

	MEDIAN	MINIMUM	MAXIMUM	WILCOXON TEST p value
Assistants	10.0	5.0	17.0	.06
Dentists	7.4	4.3	25.0	

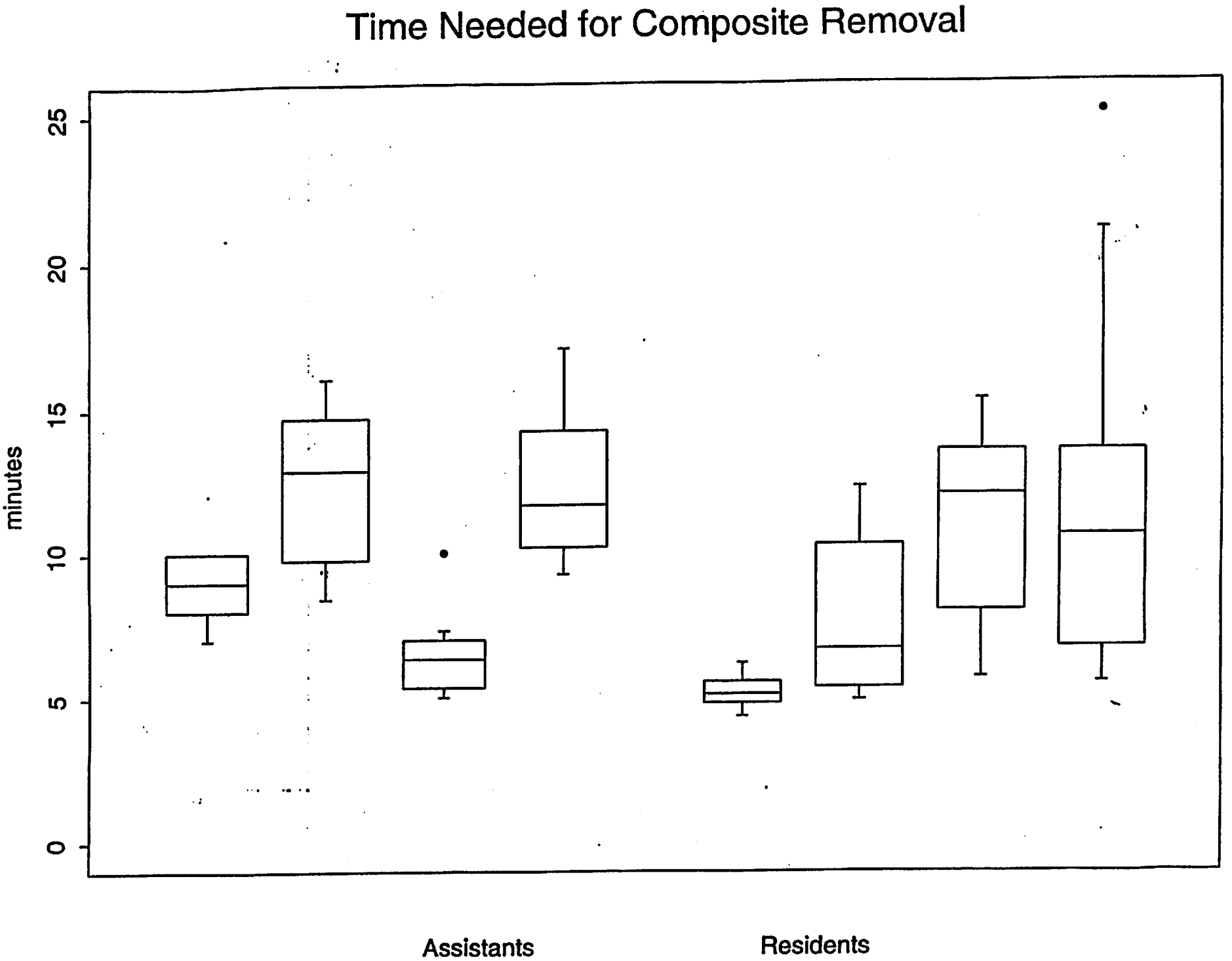
Time Needed for Composite Removal
minutes
0
5
10
15
20
25
Assistants
Residents

TABLE 7

PATIENT RESPONSES
(PERCENTAGES)

	YES COMPLETELY 5	4	3	2	NO NOT AT ALL 1
Did you understand what was to be done today?	64	33	4	0	0
The person knew what he or she was talking about?	96	3	1	0	0
The service was completely preformed?	91	6	3	0	0
Overall, how satisfied were you with the service provided today?	78	20	1	1	0

	A LOT				NONE
How much pain or discomfort didyou experience?	1	6	16	39	38

TABLE 8

PATIENTS' PERCEPTION
WHO WAS PERFORMING THE SERVICE

CATEGORY	PERCENTAGE
Dentist/orthodontist	36
Dental assistant	16
Dental hygienist	4
Nurse	3
Not sure	41

TABLE 9

OPINIONS/PERCEPTIONS

FUNCTION	Dental Hygienist (Registered)	Dental Assistant (Registered)	Dentist Only (Orthodontist)
Polish teeth with a dental handpiece	83	76	61
Remove and tie in orthodontic arch wires	55	76	69
Place the separators used before your bands were fitted	46	66	73
Take impressions for the study molds of your teeth	59	83	63
Remove braces	31	41	90
Remove glue from your teeth with a dental hand piece	61	79	64
Provide patient education	83	73	65
Place braces (cement or glue)	38	58	80
Insert retainers	55	69	74

USE OF A HIGH SPEED HANDPIECE

TO REMOVE ORTHODOTIC CEMENT OR RESIN

A STUDY MODULE

Developed by
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June 2006

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USE OF THE HIGH SPEED HANDPIECE TO REMOVE ORTHODONTIC CEMENT OR RESIN

Course Description

The primary objective of this course is to provide the dental assistant with the background knowledge and clinical experience in use of a high speed handpiece to remove orthodontic cements or resins to enable him or her to perform the procedure in a practical setting. Upon completion of this course the student will receive a certificate of completion indicating competency in performing this procedure.

Required Text

Curriculum outline: Use of a High Speed Handpiece to Remove Orthodontic Resin or Cement

Use of a High Speed Handpiece to Remove Orthodontic Resin or Cement, a study module developed by Terrie Beckman, CDA, BSEd, Boise State University 2006.

Course Requirements

For successful completion of this course, each participant must complete the following requirements:

1. Meet requirements to take the course
2. Read the module.
3. Remove cement from a dentoform or extracted teeth.
4. Perform gross removal of cement on a patient under direct supervision of an orthodontist
5. Perform complete removal of cement on a patient under direct supervision of an orthodontist.
6. Achieve a minimum of 85 % on the written examination.
7. Submit verification of competency in practical skill by supervising orthodontist.

INTRODUCTION

This course is designed for currently employed orthodontic assistants to provide them with the knowledge and skills necessary to train and perform, under direct supervision of a licensed practicing orthodontist, the expanded function of use of a high speed handpiece to remove orthodontic cement or resin as provided for in the Rules of the Idaho State Board of Dentistry. Rule 35, Dental Assistants- Practice.

01. Prohibited Duties. Subject to other applicable provisions of these rules and of the Act, dental assistants are hereby prohibited from performing any of the activities specified below.(f). The following expanded functions unless authorized by a Certificate of Registration or certificate or diploma of course completion issued by an approved teaching entity:

(vi) use of a high speed handpiece restricted to removal of orthodontic cement or resin.

It should be understood that any handpiece utilization by an assistant does NOT include removal or adjustment of tooth structure or definitive restorations.

LEGAL AND ETHICAL CONSIDERATIONS

Each state has a dental practice act which regulates the practice of dentistry in that state. The law differs as to who may perform which types of dental procedures including the coronal polish procedure. It is the responsibility of each dental auxiliary to be aware of and abide by the governing regulations of the state in which they practice.

Idaho State Dental Practice Act:

As of July 1, 2004, the Regulations of the Idaho State Board of Dentistry were amended to include use of a high speed handpiece for remove orthodontic cement or resin by dental assistants who have successfully completed courses, which have been approved by the Idaho State Board of Dentistry.

A dental assistant is defined by the Idaho Code as a person who need not be licensed, but who is regularly employed by a dentist at his office, who works under the dentist's direct supervision, and is adequately trained and qualified according to the standards** established by the Board to perform the dental services permitted to be performed by assistants by this Chapter and applicable rules of the Board.

The role of the Idaho State Board of Dentistry is to assure the public health, safety and welfare in the State of Idaho by the licensure and regulation of dentists and dental hygienists.

Ethics:

The law requires formal training and education before one can perform this procedure. It is also the moral and ethical responsibility of every auxiliary to sufficiently prepare himself/herself to be able to perform at a high standard.

The patient's health and safety are your responsibility when performing this procedure. If an emergency arises or if diagnostic decisions are necessary during treatment, request immediate assistance from the dentist/supervisor.

It is also your responsibility to request assistance or consultation from a more qualified individual when the procedure requires skills or training beyond your level of competency.

The expanded function-Use of the high Speed Handpiece- is an exception to the other expanded functions. This expanded function can only be offered to a dental assistant who (1) is employed by an Idaho licensed and practicing orthodontist that is a graduate of an ADA accredited orthodontic program **who will directly supervise training, (2) has been employed for at least 6 (six) months for that orthodontist, and (3) has completed (a) Fundamentals of Dental Assisting **or** (b) graduated from a program approved by the Idaho State Board of Dentistry, **or** (c) has current credentials as a Certified Dental Assistant **or** (d) has two years of documented work assisting work experience.

ASEPTIC TECHNIQUE

Prevention of disease transmission by careful attention to aseptic technique before, during and after the procedure is required, as it is for all intra-oral procedures. Infection control guidelines for dental offices which have been published by the Center for Disease Control should be followed. Personal protection and barrier protection measures should be followed (e.g., gloves, mask, protective eye wear and lab coat). Cross-contamination should be avoided. Do not touch instruments, areas which have not been sterilized or disinfected; practice proper hand washing techniques; properly clean, sanitize, disinfect or sterilize all instruments and equipment. Over gloves should be worn if the need arises to obtain more supplies.

Rotary instruments should be used with caution on a patient with a communicable disease. Aerosols are created during polishing and remain suspended in the air for extended periods of time. This creates a great risk for disease transmission. Individuals

who present in the office with such a disease should be encouraged to reschedule their appointment.

During cement removal, the patient's eyes should be protected by providing a shield or eyeglasses.

The patient treatment area should be clean and orderly and as sanitary as possible before, during, and after use. The laboratory area used for preclinical practice in should also be kept as clean, orderly, and sanitary as possible.

All products used should be as sanitary as possible. Products are considered sanitary when taken from the manufacturer's container.

Any item placed on the patient's tray and not used is discarded unless it can be sterilized before returning to storage.

Summary:

1. Use aseptic technique to prevent disease transmission.
2. Use PPE.
3. Follow the Center for Disease Control guidelines for infection control.
4. Protect the patient's eyes during procedure.
5. Keep the operatory or laboratory clean and orderly at all times.
6. Use appropriate maintenance procedures for the components of the armamentarium.

PATIENT-OPERATOR POSITION:

It is assumed that you are already familiar with the requirements for satisfactory patient/operator position. However, the important factors will be reviewed since both you and the patient should be comfortably seated in order to increase the ease and efficiency with which the procedure is accomplished.

First, it is important for the operator stool to be at the proper height for the operator. This height is such that the upper and lower leg form a right angle (90 degrees) at the knee. Your body weight should be completely supported by the chair (avoid sitting on the edge of the chair).

When the patient is positioned in the supine to semi-supine position, the following positions should be evaluated. The patient's mouth should be at approximately the level of your elbow when you are both seated (measure this level when your arm is hanging beside your body). This will allow you to work comfortably with your back straight and your arms in a position which minimizes strain. If the patient is too high, you must raise your arms to reach into the mouth and this can be very fatiguing. If the patient is too low, you will have to bend over to work and this can be very tiring.

It is recommended that when working on the maxillary teeth, the back of the chair be positioned parallel to the floor and the patient be requested to tilt the head so the occlusal plane of the maxillary teeth is perpendicular (at a 90-degree or right angle to the floor). When working on the mandibular teeth, the back of the chair is raised to a position of approximately a 20-degree angle to the floor and the patient instructed to tip the head so the occlusal plane of the mandibular teeth is parallel to the floor. The patient's head can be tilted toward you or away from you. A good rule of thumb is to request that the patient turn the head slightly away from you when you are working on the tooth surface which is facing you and have the patient turn the head toward you when you are working on the tooth surface which is away from you (e.g., buccal of maxillary or mandibular right, lingual of maxillary or mandibular left—patient turns head away from you. Lingual of maxillary or mandibular right and buccal of maxillary or mandibular left—patient turns head toward you.)

Access and visibility of the buccal aspect of the maxillary posteriors is frequently difficult. A helpful technique for this area is to have the patient slide the lower jaw toward the side you are working on and open approximately half way. Sometimes access to the buccal aspect of mandibular molars is hampered by the patient opening too wide which decreases the space between the tooth and cheek.

For patient comfort and to assist in maintaining aseptic technique, ask the patient to make the changes in their head position, rather than touching the face or head to move it. Also, to maximize patient comfort and minimize disease transmission, you should try to keep your face 10-14 inches from the patient's face.

Your position will vary from an 8:00-12:00 o'clock position if you are right-handed, and 4:00-12:00 o'clock if you are left handed. Your position will depend on which area of the mouth you are working on and which position affords optimal visibility and accessibility. It is suggested that in your early training you work from 8:00-11:00 o'clock if right handed; while working on the facial surfaces of the anterior teeth, and from 12:00 o'clock when working the lingual of the maxillary and mandibular anterior teeth. Experience will help you decide which positions are most comfortable and which give the best visibility and accessibility.

Position all equipment and armamentarium as close and convenient as possible to reduce reaching distance and maximize efficiency.

Summary

(1) Use proper draping and protective eyewear.
(2) Patients' head is level with the lower half or the operator's upper arm.
(3) The mouth should be fully illuminated.
(4) For mandibular teeth, the occlusal plane is parallel to the floor.
(5) For maxillary teeth the occlusal plane is at a 45-degree angle to the floor.

GRASP/FULCRUM

Although some sources indicate the use of the pen grasp, it is not recommended here. All instruments and the handpiece are held with a modified pen grasp. A modified pen grasp is accomplished by placing the index finger and thumb opposite each other on the handle of the instrument or handpiece with the pad of middle finger placed on the shank of the instrument. On the handpiece, the pad of the middle finger is placed on the handpiece at a distance from the working end that allows the greatest control and balance of the handpiece. When possible, the handpiece should rest against your hand for balance and to help minimize operator fatigue from the weight of the handpiece. Hand size will affect the exact positioning of your fingers but remember to use the pad of the third finger on the instrument, not the side of the finger. **Using the pad of the middle finger is critical for providing a secure grasp, which will keep the instrument from slipping or rotating unintentionally**.

After a secure grasp is established a stable fulcrum must be established to assure complete control of the instrument and handpiece. The ring finger is used as the fulcrum finger when using the modified pen grasp. The purpose of a fulcrum while using dental instruments or the handpiece is to provide a pivot point for the hand in order to move the instrument or handpiece to adapt them to the contours of the teeth.

The fulcrum must be established on a stable surface. Whenever possible, the fulcrum should be on tooth-structure (e.g., occlusal or incisal surfaces or embrasure areas

of facial or lingual surfaces of the teeth). Placement of the fulcrum finger on the direct labial or lingual surfaces is not recommended as these surfaces are generally slippery, so do not provide a stable fulcrum. Soft tissue such as lips, cheeks, and chin also do not provide a stable fulcrum. Additionally, pressure is applied when fulcruming and this may pinch or bruise the tissue. Placing the fulcrum on the lips, cheeks, and chin is also not recommended because aseptic technique is not maintained. Mobile or sensitive teeth should be avoided as a fulcrum area because of the pressure which must be applied against them when fulcruming.

Sometimes, suitable tooth structure is not available for a secure fulcrum (e.g., only missing, mobile, or sensitive teeth are present in the fulcrum area). When these situations occur, it may be helpful to place a finger of the opposite hand against the alveolar ridge or in the vestibule and fulcrum on your finger. It may be useful to support the tooth with the fore finger of the opposite hand as well.

There may be times when fulcruming on soft tissue cannot be avoided. In these cases, it is advised that the soft tissue have a firm base (e.g., alveolar ridge, chin) and you should dry the tissue with a 2 x 2 gauze or compressed air to prevent slippage of the fulcrum finger. You should also place your fulcrum finger so the fingernail of your fulcrum finger does not cause patient discomfort.

A proper grasp and a stable fulcrum are important during the procedure for stability and controlled action of the handpiece or instrument. This will enhance patient comfort and confidence in the operator's ability to manipulate the instrument and decrease the risk of injuring the patient's soft tissue.

USE OF THE MOUTH MIRROR

The mirror is used for indirect vision, indirect illumination, or retraction during cement removal. The mirror is used for indirect vision to view teeth or other intra-oral surfaces which are difficult or impossible to view directly. You position the mirror to see the reflection of the tooth or structure in the mirror. Indirect vision is very useful when working on the lingual surfaces of the teeth and in the most posterior areas of the mouth. You will find that by angling the mirror, that is, by turning and tilting the mirror, even very inaccessible areas can be easily seen.

It is important that you learn to use a mouth mirror for indirect vision so you can see where you are working with each polishing instrument. This will help prevent damage to the soft tissue. It will also help you evaluate the difference between stain an enamel. If you have difficulty using the mouth mirror, consult your instructor.

Using the mouth mirror, for indirect illumination, is very advantageous for areas where you cannot direct sufficient light for good vision. To use the mouth mirror for indirect illumination, adjust the dental unit light to provide the best illumination possible in the area, then position the mouth mirror so that it will catch and reflect light directly onto the surfaces you want to see.

The mouth mirror is also used for retraction of the lip, cheeks, or tongue to increase your view of the areas in which you are working.

When using the mouth mirror, there are some precautions to consider to prevent patient discomfort. Avoid resting the mouth mirror against the patient's alveolar bone. Also avoid pinching the lip between the mirror handle and the teeth or setting the mirror or mirror handle directly against the teeth. It can also be very uncomfortable for the patient if the mirror handle is allowed to pull at the corner of the patient's mouth. To avoid doing this, use the back of the mirror to retract the corner of the mouth.

A right-handed operator usually holds the mirror in the left hand to have the right hand free to manipulate other instruments such as the handpiece or explorer. A modified pen grasp and stable fulcrum should be used. Practice holding the mouth mirror in your left hand throughout the procedure to keep efficiency at a maximum. When the mirror is not being used, palm grasp it with the mirror head next to your little finger.

ROTARY INSTRUMENTS

Rotary Instruments: The most commonly used are abrasive stones, disks and finishing burs. They are available in a variety of shapes, sizes, degrees of abrasiveness, and in either high speed or slow speed. To reduce the frictional heat and thus minimize the potential for damage to the tooth and/or restoration, the technique described in this module recommends the use the lowest speed possible. The choice of abrasive stones, disks, and burs is dependent upon the office policy and the preference of the operator.

a. Finishing burs differ from cutting burs (used for cavity preparations) in that their blades are finer, their sizes smaller, and their number of blades greater. They, too, are available in a variety of shapes and sizes. It is recommended a flame or barrel shaped finishing bur be used. The finishing bur is used to remove the bulk of the cement from the facial and lingual surfaces. Flame finishing burs will remove a small amount of cement at a time. They also can be positioned slightly under the gingival. Care must be used not to groove or ditch the enamel with the flame bur. The barrel finishing bur will remove larger amounts of adhesive and are less apt to groove the enamel. However, the barrel cannot be used close to or under the gingival.

b. Finishing disks are also available in variety of sizes and grits. The appropriate disks determined by the accessibility to the area. Use of a medium grit disk is always followed by the application of a finer grit disk which cuts less. Disks are used primarily on the proximal, buccal, lingual surfaces. Because of their flatness, they are not routinely used on the convex and concave areas of the occlusal surface. Finishing disks are placed on a mandrel. Extreme care should be used to protect the gingival during use.

c. Abrasive points and cups. Other polishing agents are available in the form of abrasive-impregnated points and cups (Shofu Brownies, Greenies, Super Greenies; black abrasives; white diamond impregnated abrasives). These points and cups are very easy to use, readily adapt into all areas. The drawbacks to their use are expense pieces can break or fly off when used in the high speed handpiece causing injury to patient or operator and the fact that the rubber contributes to heat generation (refer to precautions for minimizing heat precaution). They must not be allowed to touch the gingiva , this will prevent scraping or abrading. They are to be used in the following order (most abrasive to least abrasive): Brownies, then Greenies, followed by Super greenies.

ABRASION

Abrasion occurs when a material composed of particles of sufficient hardness and sharpness to cut or scratch a softer material when drawn across its surface. An abrasive agent causes abrasion, the wearing away of surface material by friction. Marked or severe abrasion would be destructive to the tooth surface. Polishing is the production, especially by friction, of a smooth, glossy, mirror like surface that reflects light. A very fine agent is used for polishing after a coarser agent is used for removal of substances. Abrasive particles are characterized by their shape, hardness and size. Particles that are irregularly shaped with sharp edges produce deeper grooves and a faster rate of abrasion than rounded particles with dull edges. The particles in an agent must be harder than the substance to be removed or tooth surface to be polished.

The rate of abrasion during cement removal is not only determined by the abrasive agent used (e.g. bur, disk, abrasive points) but also by the manner in which the abrasive agent is used. (e.g., the quantity applied, the speed of application, and the pressure of the application). The more particles applied per unit of time, the faster the rate of abrasion (brownie vs. greenie) and the more frictional heat produced.

The faster the application of abrasive particles, the faster the rate of abrasion. The amount of frictional heat produced is also increased.

Pressure of application of the abrasive particles also affects the rate of abrasion. The greater the pressure applied against the tooth the faster the rate of abrasion. Abrasive particles to which pressure is applied produce deep grooves in the tooth surface at first, but fracture according to their impact strength and may disintegrate. Heavy pressure is contra-indicated because it increases the production of frictional heat and pain.

When applying abrasive agents during cement removal low speeds should be used, and a light, sweeping stroke should be used. Improper technique and high handpiece speed can cause damage to the patient or tooth.

USE OF THE HIGH SPEED HANDPIECE AND ROTARY INSTRUMENTS:

Precautions

There are several important precautions that should be taken during this procedure to prevent damage to the tooth, the restoration, and the patient's soft tissue.

One important precaution to be aware of during this procedure is the minimization of heat production. The creation of heat during the polishing procedure is potentially dangerous for two reasons: 1) heat can cause thermal damage to the pulp and (2 pain to the patient!

To minimize heat production:

1. Use light, intermittent pressure with rotary instruments lifting the instrument off of the restoration frequently. Heavy or prolonged pressure generates heat.

2. Use slow to moderate speed with rotary instruments. High speeds increase friction and thus generate heat.

3. Use compressed air or water to cool whenever possible.

4. Use a sharp bur.

A burning smell or pain and sensitivity is a sign of too much heat production. The procedure should be adjusted **immediately** when this occurs.

Maintain functional anatomy by using rotary instruments in the prescribed manner. Do not destroy functional anatomy by flattening cusps or marginal ridges, by removing the contact, or by ditching or grooving the enamel. Special attention must be given to teeth that are hypocalcified, hypofluorosed, decalcified, or soft enamel. To prevent loss of anatomy:

1. Start all rotary instruments just prior to touching the restoration.

2. Keep instruments moving over the surface.

3. Use sweeping back and forth strokes.

4. Keep finishing burs as parallel to tooth structure as possible, do not tip in or out.

5. Use steady pressure on the foot control and the slowest possible speed.

6. Use each rotary instrument on the surface it was designed for.

7. Keep area fully illuminated.

Too much pressure and improper direction of force on the tip of a bur can cause gouging and/or grooving of the enamel surface. The application of excessive pressure on one area or lack of movement of any bur or disk can also cause undesired grooving.

Prevent damage to the patient's soft tissues. Some of the abrasive materials used for this procedure (particularly disks and finishing strips) can be very painful and/or damaging to the patient if the operator should accidentally "slip" off the tooth. To avoid such situations always:

1. Retract the tongue, cheeks and lips during the procedure.

2. Position instruments so they will not abrade or lacerate gingival tissues.

3. Use a secure grasp and stable fulcrum with all instruments.

4. Rinse all abrasive agents from the mouth as soon as possible.

Protect the patient from polishing debris. It is important to protect the patient from the possibility of aspirating polishing agents and debris or potential damage to the patient's eyes by:

1. Removing abrasive debris from the mouth as soon as possible with water and suction.

2. Provide eye protection for the patient.

3. Do not carry instruments or materials over the patients' face.

Removal of Orthodontic Cements or Resins with a High Speed Handpiece

PROCEDURE:

I) Tasks to Master = 43.

II) Intended Outcome: Given the necessary supplies and equipment for removing orthodontic resin cements with a high speed handpiece, the student will perform the following tasks with 100% accuracy. NOTE: THE PROCEDURES FOR REMOVAL OF ORTHODONTIC CEMENTS CAN ONLY BE DONE IN AN OFFICE UNDER DIRECT SUPERVISION OF A DENTIST

III) Tasks:

SET UP AND PATIENT PREPARATION

(1) Take universal precautions.

(2) Assemble the tray set up. (Note: In an actual office you may find some of these items are not used.)

(a) Mouth mirror.
(b) Explorer.
(c) Cotton pliers.
(d) High-speed handpiece.
(e) Cotton rolls or other isolation materials.
(f) High volume evacuator/saliva ejector.
(g) 3-way syringe tip.
(h) Appropriate finishing bur
(i) Abrasive rotary disks, cups, points .

(3) Seat and drape the patient. Place protective eyewear.

(4) Explain the dental procedure to the patient**.**

(5) Place PPE

REMOVING ORTHODONTIC CEMENTS ON A DENTOFORM OR EXTRACTED TEETH

The assistant must show competency in a laboratory setting before

performing the procedure on any patient.

(1) Select abrasive device for removal gross removal of cement and place in handpiece.
(2) Position patient (e.g. dentoform mounted teeth) and operator. Refer to the previous sections for correct positioning.
** A systematic sequence should be used to ensure cement is removed from all teeth.
(3) Using a modified pen grasp and a stable fulcrum, bring the device close to the surface of the tooth.
(4) Apply steady pressure to the foot control to activate the handpiece.
(5) Keeping the abrasive device parallel to the tooth surface, remove cement with a sweeping back and forth movement. Use a light touch.
(6) Complete initial or gross removal watching for color and texture changes indicating approach to enamel. Adhesive looks dull and feels rough when explored with an instrument. The adhesive will also be a different color than enamel.
(7) **Do not** remove to the level of the enamel.
Rinse and /or suction area as needed.
(8) Select appropriate adhesive devise (abrasive impregnated rubber point, non-crosscut finishing bur, or other conservative abrasive device) and place in the handpiece.
(9) Using a modified pen grasp and a stable fulcrum, bring the device close to the surface of the tooth.
(10) Apply steady pressure to the foot control to activate the handpiece. Run at near stall speed.
(11) Keeping the abrasive device parallel to the tooth surface remove cement with a sweeping movement. Use a light touch.
(12) Complete final removal of the adhesive.
Rinse and suction area as needed.
(13) Check tooth with explorer mirror and illumination. Using illumination, a mouth mirror, and a hand instrument (e.g. explorer or scaler) look for markings, scrapes, dull surfaces on tooth. Check all surfaces including the interproximal.
(14) Have dentist evaluate procedure.

GROSS REMOVAL OF ORTHODONTIC CEMENTS ON A PATIENT

After the assistant has shown proficiency in removal of orthodontic cements in a laboratory setting, gross removal of cement or adhesive on a patient can be

attempted under the direct supervision of the orthodontist. One tooth per quadrant should be mastered first with final removal completed by the doctor.

(1) While under direct observation by the dentist
(2) Select abrasive device for removal gross removal of cement and place in handpiece.
(3) Position patient and operator. Refer to the previous sections for correct positioning.
** A systematic sequence should be used to ensure cement is removed from all teeth.
(4) Using a modified pen grasp and a stable fulcrum, bring the device close to the surface of the tooth.
(5) Apply steady pressure to the foot control to activate the handpiece.
(6) Complete initial or gross removal watching for color and texture changes indicating approach to enamel. Cement looks dull and feels rough when explored with an instrument. The adhesive will also be a different color than enamel.
(7) Do not remove to the level of enamel.
** Rinse and/or suction as needed.
(8) The dentist evaluates and completes procedure.
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COMPLETE REMOVAL OF ORTHODONTIC CEMENTS ON A PATIENT

After the assistant has shown proficiency in gross removal of orthodontic cement, final removal of cement or adhesive on a patient can be attempted under the direct supervision of the orthodontist. One tooth per quadrant should be mastered first. **The final result on all patients should be evaluated by the orthodontist.**

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(1) While under direct supervision of dentist.
(2) Position patient and operator. (refer to previous sections for correct positioning)
** A systematic sequence should be used to ensure cement is removed from all teeth.
(3) Select abrasive device for removal gross removal of cement and place in handpiece.
(4) Using a modified pen grasp and a stable fulcrum, bring the device close to the surface of the tooth.
(5) Apply steady pressure to the foot control to activate the handpiece.

(6) Keeping the abrasive device parallel to the tooth surface, remove cement with a sweeping back and forth movement. Use a light touch.
(7) Continue removal watching for color and texture changes indicating approach to enamel.
(8) **Do not** remove to the level of the enamel.
**** Rinse and /or suction as needed.
(9) Select appropriate adhesive devise (abrasive impregnated rubber point, non-crosscut finishing bur, or other conservative abrasive device) and place in the handpiece.
(10) Using a modified pen grasp and a stable fulcrum, bring the device close to the surface of the tooth.
(11) Apply steady pressure to the foot control to activate the handpiece. Run at near stall speed.
(12) Keeping the abrasive device parallel to the tooth surface remove cement with a sweeping movement. Use a light touch.
(13) Complete final removal of the adhesive.
Rinse and /or suction as needed.
(14) Check tooth with explorer, mirror and illumination. Using illumination, a mouth mirror, and a hand instrument (e.g. explorer or scaler) look for markings, scrapes, dull surfaces on tooth. Check all surfaces including the interproximal. Have patient check surface with tongue.
(15) Dentist evaluates procedure.

It is recommended that a coronal polish with prophy cup and fluoride prophy paste be used to remove any remaining stain. If adhesive must be removed from composite or porcelain restorations, a commercial polishing system should be used to obtain optimal shine and finish.

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Idaho State Orthodontic Society High Speed Handpiece Utilization Curriculum, developed by the ISOA

ORIGINAL ARTICLE

Enamel loss associated with orthodontic adhesive removal on teeth with white spot lesions: An in vitro study

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Teeth with white spot lesions (WSL) might be more prone to enamel loss during bracket debonding. This in vitro study compared enamel loss from teeth with (n = 14) and without (n = 14) WSL after polishing with low-speed finishing burs or disks (Sof-Lex, 3M ESPE, St Paul, Minn). Debonded surfaces were analyzed with a contact stylus profilometer, and digitized data were compared with baseline readings by using AnSur NT software (Regents, University of Minnesota, Minneapolis, Minn). Specimen surfaces were also examined with a scanning electron microscope. Two-way analysis of variance was performed to analyze the data. In teeth without WSL, the volume losses were 0.16 mm^3 for the bur group and 0.10 mm^3 for the disk group; the mean maximum depths were 47.7 μm for the bur group and 54.3 μm for the disk group. In teeth with WSL, the volume losses were 0.06 and 0.17 mm^3, and the mean maximum depths were 35.1 and 48.7 μm for the bur and disk groups, respectively. There were no significant differences in enamel loss between the 2 groups of teeth without WSL ($P = .12$). However, in teeth with WSL, the burs removed less enamel than the disks ($P = 0.006$). Scanning electron microscope examination showed that any damage on the enamel surface was usually located in the cervical third of the teeth. On most specimens, even though tooth surfaces appeared resin-free to the naked eye, there were remnants of it. The differences between groups were so small that they might be clinically insignificant. (Am J Orthod Dentofacial Orthop 2004;125:733-40)

Because of the widespread use of direct-bonding materials in orthodontics, there has been concern over how to remove the residual bonding resin most effectively and efficiently. Many investigations have focused on the debonding methods to determine the best technique that would leave an ideal finish for the tooth surface without removing an excessive amount of tooth structure. These methods have included diamond burs, tungsten carbide fissure burs, and Sof-Lex disks (3M ESPE, St Paul, Minn), and other techniques that were abandoned because of excessive enamel loss.[1-4] Today, the tungsten carbide finishing bur at low speed is most frequently recommended for removing residual bonding material.[5,6] It has been suggested that this technique provides easy and rapid removal of material and produces satisfactory surfaces without causing damage to the enamel. Although many studies have made recommendations based on the enamel surface characteristics after debonding, only a few have measured directly the actual enamel loss associated with debonding and adhesive removal.

During orthodontic treatment, the development of white spot lesions (WSL) is almost inevitable when oral hygiene is poor. Clinically detectable areas of enamel decalcification are known to contribute to the prolonged retention of bacterial plaque on the enamel surface around the brackets.[7,8] These incipient caries can appear in only 2 to 3 weeks after plaque accumulation in gingival areas of the teeth.[9] Gorelick et al[7] reported that demineralization of enamel during orthodontic treatment occurred in 50% of patients and involved approximately 10% of teeth. In reality, there was a large variation in the number of WSL per patient in that

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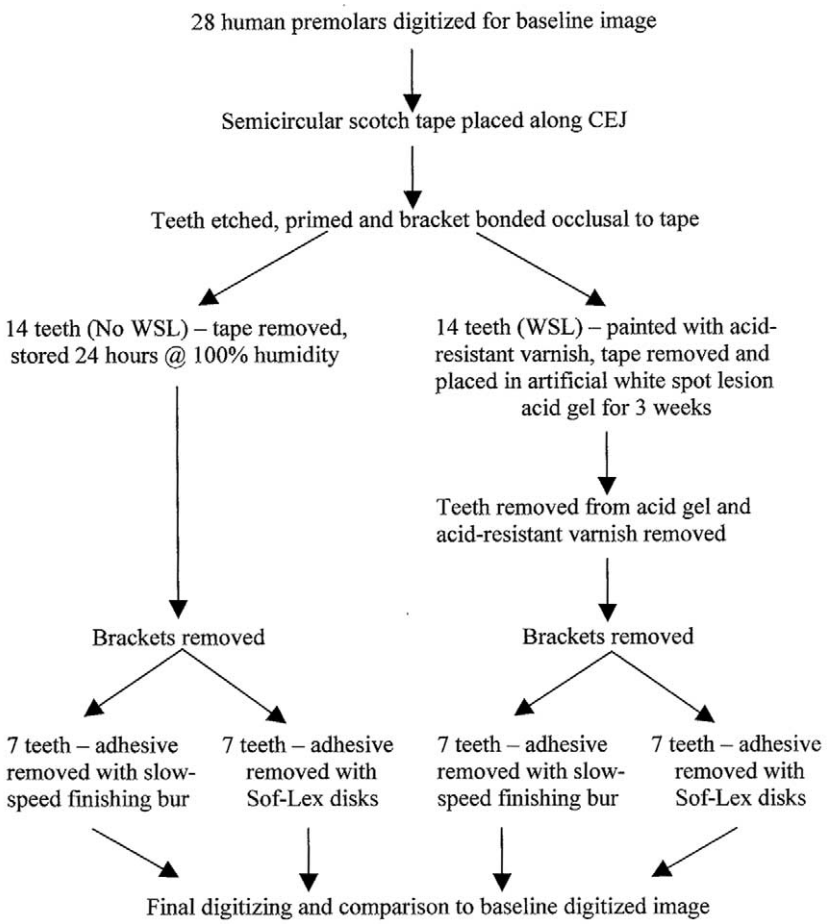

Fig 1. Study design showing groups tested and sample sizes.

study.[7] Previous studies have evaluated the mechanical and crystallographic characteristics of these incipient carious lesions and found about a 10% reduction in the mineral content.[10-16] This reduction in the inorganic content of the WSL is an important contributing factor to their increased abrasion in vivo.[13] Consequently, these areas of decalcification might be more prone to significant loss of enamel during orthodontic debonding. Although many studies have examined enamel loss with various debonding and resin removal techniques, none has examined a technique for resin removal from teeth with WSL.

The specific aims of this study were to (1) determine the enamel loss associated with adhesive removal from teeth with WSL created in vitro, (2) determine which of 2 removal techniques better preserved the enamel surface, and (3) analyze qualitatively the microscopic characteristics of the tooth surfaces after debonding, by using profilometry and scanning electron microscopy (SEM).

MATERIAL AND METHODS

Twenty-eight extracted premolars were used to analyze the amount of enamel lost during 2 different debonding procedures: slow-speed carbide finishing burs and Sof-Lex disks. Samples of teeth with and without artificially created WSL were used in the study (Fig 1). All teeth were polished with a pumice and water mixture, rinsed, and air-dried. The teeth were stored in 100% humidity throughout the study, except during specimen preparation, bonding, debonding, and surface observations and measurements. All teeth were mounted with green die stone (Die Keen, Modern Materials/Heraeus Kulzer, Armonk, NY) in individual nylon rings, leaving the labial third of the crown and the cervical portion of the root exposed for the bonding and debonding procedures. The test specimen surfaces were initially digitized by using a null-point contact stylus system as described in previous studies.[17,18] The surface contours for the baseline teeth were established

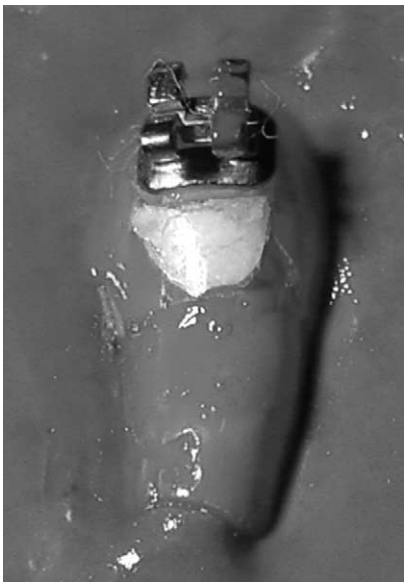

Fig 2. Mounted tooth specimen coated in acid-resistant varnish. Region gingival to bracket was isolated for WSL formation (shown here after removal of transparent adhesive tape).

from a series of linear profiles. The digitized image of each specimen surface consisted of approximately 20,000 points in 3 dimensions. After the baseline digitization, a portion of the enamel in the gingival third of the tooth was isolated by covering the surface with a 4.5-mm diameter semicircular piece of clear adhesive tape, placed with its curved edge adjacent to the facial cementoenamel junction and the flat portion of the semicircle coinciding with the future bracket position. This created a standardized surface area gingival to the bracket where the artificial WSL was planned to be developed in vitro for the teeth in the WSL group. Although WSL might occur on areas adjacent to the brackets both cervically and occlusally, in this study, the location was limited to the gingival portion of the surfaces, because previous studies have shown a higher incidence in those regions.[7,8] A premolar bracket (Minnesota Integrated System, American Orthodontics, Sheboygan, Wis) was bonded on each specimen. A standardized light-cure bonding method was used; it consisted of the following steps: 30 seconds of acid-etching with 37% phosphoric acid, 15 seconds of rinsing with water followed by air drying, 20 seconds of light curing of the primer (Transbond XT Light Cure Adhesive Primer, 3M Unitek), and 20 seconds of light curing the composite resin adhesive paste (Transbond XT Light Cure Adhesive Paste, 3M Unitek). An acid-resistant varnish (nail polish), a lacquer coating of contrasting color, was then applied over the entire area of the tooth. After the surface was dried, the tape was removed, leaving a standardized area of exposed enamel gingival to the bracket (Fig 2).

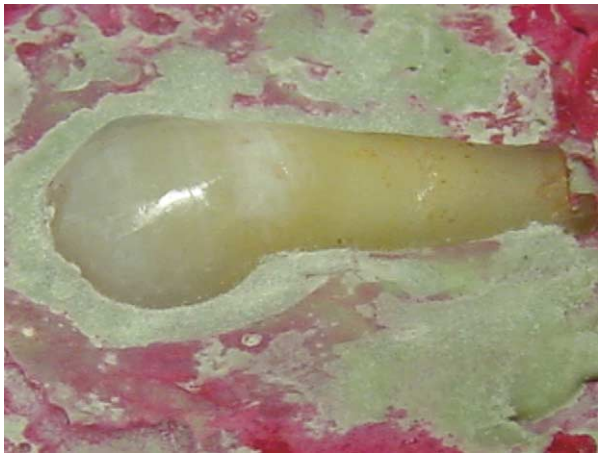

Fig 3. Tooth specimen with WSL.

On half of the teeth (n = 14), WSL were artificially created in vitro with a process similar to that described by Tantbirojn et al.[19] The unprotected surfaces of enamel were exposed to an acidic gel at 37°C for 3 weeks. The gel composition was 6wt% hydroxyethylcellulose in 0.1 mol/L lactic acid and 1.0 mol/L sodium hydroxide solution and had a pH of 5.1.[13,19,20] For the 14 remaining teeth, WSL were not generated. These samples were stored in 100% humidity at 37°C for a comparable 3-week period, after which the acid-resistant varnish was removed with acetone. The brackets were carefully removed from the tooth surface by using debonding pliers in the same manner for each sample.

After bracket debonding, the 14 teeth with WSL were divided into 2 subgroups of 7. One group had the resin adhesive removed with a tungsten carbide bur and a slow-speed handpiece (WSL/burs), and the other group had the resin removed with medium and fine Sof-Lex disks (WSL/disks). Figure 3 shows the surface of a mounted tooth specimen from the WSL group. The 14 debonded specimens without WSL were divided into 2 similar subgroups of 7 that had the adhesive resin removed with either tungsten carbide burs (no-WSL/burs) or Sof-Lex disks (no-WSL/disks). The samples without WSL served as controls for the corresponding WSL groups.

After the bracket debonding and resin removal, the surfaces for all specimens in the 4 groups (WSL/burs, WSL/disks, no-WSL/burs, no-WSL/disks) were redigitized. The amount of enamel lost was determined by comparing the baseline recording with the final post-

Table I. Digitized surface results for enamel loss from 2 groups of teeth with and without WSL after resin removal with tungsten carbide bur or Sof-Lex disks

	Volume loss (mm^3 ± SD)	*Maximum depth (μm ± SD)*	*Mean maximum depth (μm ± SD)*
No WSL			
Burs (n = 7)	0.16 (± 0.060)	109.8 (± 53.9)	47.7 (± 23.4)
Disks (n = 7)	0.10 (± 0.073)	117.0 (± 56.8)	54.3 (± 32.4)
WSL			
Burs (n = 7)	0.06 (± 0.040)*	91.5 (± 83.7)	35.1 (± 37.4)
Disks (n = 7)	0.17 (± 0.103)*	108.1 (± 70.8)	48.7 (± 23.0)

*Significant differences ($P < .01$).

debonding recording. The digitized data were processed with AnSur NT software (Regents, University of Minnesota, Minneapolis, Minn) to measure the amount of enamel lost. This computer program fitted the postdebonding surface to the baseline surface where the surface changes were not expected and also provided a color-contour map that showed the surface changes for each sample. A standardized area of the enamel surface, including the middle and gingival thirds of the buccal surface of the premolar, between the mesial and distal marginal ridges and the cementoenamel junction, was evaluated for enamel loss or wear. This region, which encompassed both the WSL and bracket position, corresponded to the area where enamel loss would be expected. The software mathematically calculated the volume of enamel lost, the maximum depth of enamel lost, and the mean maximum depth of enamel lost for this area of interest.

Data for volume loss (mm^3) were analyzed with 2-way analysis of variance to determine whether statistically significant differences at the $\alpha = 0.05$ level existed among the 4 groups. The 2 factors were tooth surface condition (WSL or no WSL) and resin removal technique (tungsten carbide bur or Sof-Lex disk). Specimen surfaces were also examined with a SEM (JSM-820, JEOL, Tokyo, Japan) to compare qualitatively the effect of the resin removal technique on the loss of enamel. Before the SEM analyses, specimens were sputter-coated with a thin layer of gold-palladium alloy to prevent electrical charging. Representative photomicrographs at various magnifications were taken of the specimen surfaces in the secondary image mode, by using an accelerating voltage of 15 kV.

RESULTS

Results for the 4 groups are given in Table I as volume of enamel lost, maximum depth of enamel lost, and mean maximum depth of enamel lost. Sof-Lex disks removed less enamel from the teeth without WSL than the tungsten carbide burs, but the mean volumes of enamel lost were not significantly different ($P = .12$). For the teeth with WSL, the volume of enamel lost was significantly less when the tungsten carbide burs were used for resin removal, compared with the Sof-Lex disks ($P = .01$). Both the maximum depth and the mean maximum depth of enamel removal were less in the tungsten carbide bur group than in the Sof-Lex disks group for the teeth with and without WSL. However, these differences were not significantly different in either group.

Table II. Pooled data summary for enamel loss

	Volume loss (mm^3)	*Maximum depth (μm)*	*Mean maximum depth (μm)*
WSL (n = 14)	0.11	99.8	41.9
No WSL (n = 14)	0.13	113.4	51.0
Burs (n = 14)	0.11	100.7	41.4
Disks (n = 14)	0.14	112.6	51.5

In addition to comparisons of the 4 different conditions, the data were pooled into 2 sets. The first set contained the teeth with WSL (n =14) and without WSL (n =14). The pooled data were analyzed to observe whether the teeth with WSL were more prone to enamel loss under both adhesive removal conditions. Interestingly, the teeth with WSL trended toward less enamel loss, although the results were not significantly different (Table II).

SEM examination of the tooth surfaces after resin removal with the 2 techniques showed that any enamel damage was generally located in the cervical third of the tooth (Figs 4 and 5). Only a few specimens had evident damage from the tungsten carbide burs or the Sof-Lex disks in the middle third of the tooth surfaces. Along with the enamel damage, bur or disk marks were also evident (Fig 6). The pit depths were shallower for the specimens in the no-WSL/disk group than in the no-WSL/bur group. The specimens in the WSL/bur group had minimal enamel damage with a more uniform appearance. Even though tooth surfaces appeared

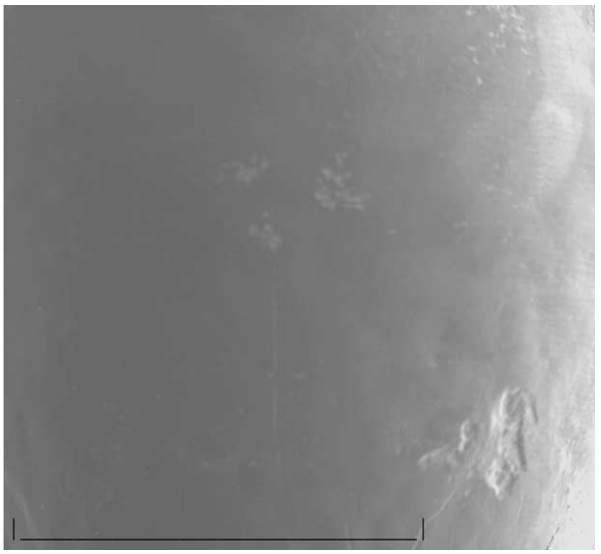

Fig 4. Cervical third portion of tooth with no WSL created; resin was removed with Sof-Lex disks (no-WSL/disk group). Note enamel damage on right (bar equals 3 mm).

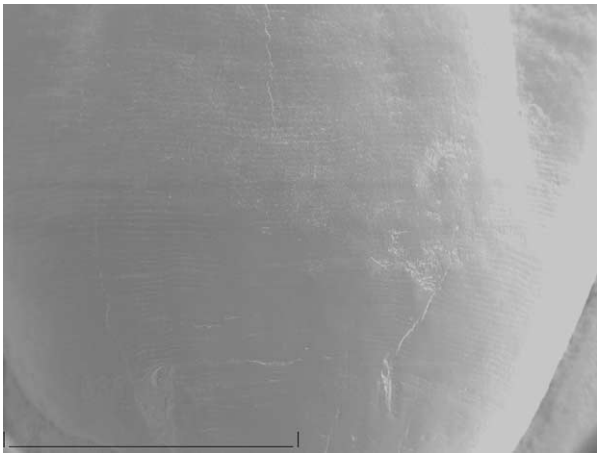

Fig 5. Cervical third of tooth with created white spot lesion; resin was removed with tungsten carbide bur (WSL/bur group). Note there was very little enamel damage (bar equals 3 mm).

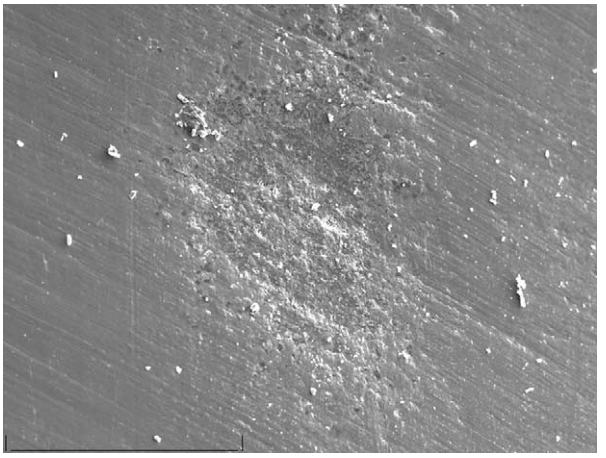

Fig 6. Middle third portion of tooth with created WSL; resin was removed with Sof-Lex disks (WSL/disk group). Enamel damage can be seen in middle of picture, along with enamel spindles (bar equals 200 μm).

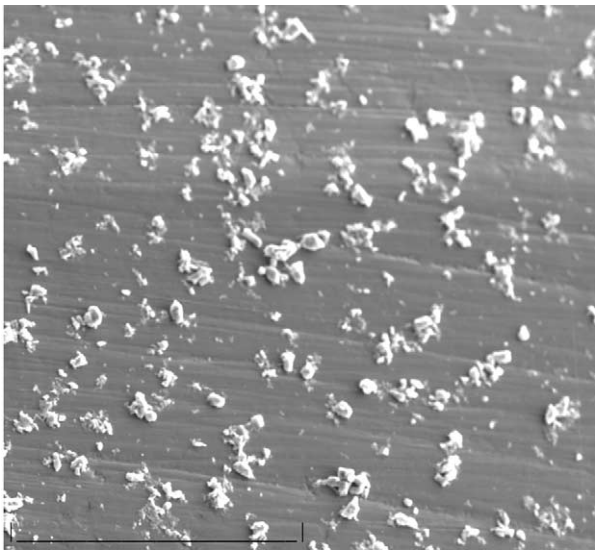

Fig 7. Surface of tooth with no WSL; resin was removed with tungsten carbide bur (no WSL/bur group), showing islets of remaining resin on tooth surface (bar equals 100 μm).

to be resin-free visually, many small islets of resin remained when examined with the SEM (Fig 7). These resin deposits were approximately 1 to 2 μm in diameter.

DISCUSSION

Although this in vitro study enabled the investigation of enamel loss associated with adhesive removal, which could be otherwise relatively difficult to accomplish in vivo, 3 concerns should be noted: (1) a relatively small sample size, (2) the technique for in vitro creation of WSL, and (3) the method for adhesive removal.

Although this study established some possible guidelines for residual resin adhesive removal after debonding, a larger sample size might be needed to draw conclusions.

The artificial WSL that were created in the extracted teeth were not as severe as those found in orthodontic patients. Moreover, dissolution of the gypsum-based mounting stone might have affected the acid-gel medium near the exposed enamel surface, thereby inhibiting the formation of WSL. For future studies, mounting the teeth in a nonmineral-based product might help to eliminate this potential problem.

There could also be a concern about the adhesive removal procedure in this study, in which the acid-resistant varnish was used to locate the enamel-adhesive interface. The varnish provided a guide for adhesive removal that would not be found clinically. Because only the teeth in the WSL group were coated with the acid-resistant varnish, this created a confounding factor by exposing the teeth to another variable in addition to the WSL.

The finding that Sof-Lex disks removed more enamel than slow-speed burs for the tooth surfaces with WSL agrees with previous studies,[5,21] although there are differences in the materials and methods used for those studies and this study. Beyer et al[21] found that Sof-Lex disks abraded approximately twice as much bovine enamel as did slow-speed tungsten-carbide burs. The finding that Sof-Lex disks are more abrasive on enamel than burs also agrees with the study by Howell and Weekes.[5] Although these authors did not quantitatively determine enamel loss, they observed with a SEM that the medium-grit Sof-Lex disks resulted in rough enamel surfaces. However, when progressive-grit Sof-Lex disks were used, a smooth surface was achieved at the expense of abrading enamel.[5]

There are several possible explanations for the decreased enamel loss in WSL teeth that had the adhesive removed with slow-speed finishing burs. During resin removal from the surface, the adjacent enamel might be more prone to wear from the disk than from the bur. The point of application and the amount of pressure might be less controlled when disks are used, because a disk contacts a larger surface area than a bur during the resin removal process. This could lead to decreased precision in the point of force application, which in turn might cause damage to the adjacent enamel surface, when the clinician is trying to remove relatively small areas of composite resin. WSL are demineralized enamel areas that are softer than normal mineralized enamel and potentially more susceptible to abrasion.[19,22] The softer enamel surfaces associated with WSL might be more readily removed through inadvertent contact with the Sof-Lex disks when they are used to remove residual composite resin. However, when a carbide finishing bur is used to remove the composite resin that is near the WSL, the areas of demineralization might be more easily avoided, because the clinician can see the WSL. The finding from the digitized tooth surfaces that Sof-Lex disks removed less enamel than tungsten carbide burs in the no-WSL group was not statistically significant, and this was also suggested qualitatively by SEM observations. Although the pits of damage were shallower in the bur group (Table I), the differences were not significantly different ($P = .12$).

The mean maximum depth of enamel damage associated with resin removal ranged from 35 to 54 μm; this agrees with previously reported values.[23] By providing better control of the point of contact during adhesive removal, using tungsten carbide finishing burs could help to preserve the decalcified enamel surface for remineralization, as suggested by Øgaard et al.[24]

In all groups, enamel damage was generally limited to the cervical third of a tooth. In a few cases, there was damage in the middle third, where the bracket was originally placed. This might be due to some loss of operator control of the bur or the disk, to a longer time spent to remove the remaining composite resin, or even to enamel fractures during debonding. Even though the amounts of enamel lost and the depths of enamel damage found in this study appear minimal, the clinician should exercise great caution when removing resin.

CONCLUSIONS

This in vitro study establishes some possible guidelines for residual adhesive resin removal after debonding. In teeth with WSL, Sof-Lex disks were more abrasive and produced a greater loss of enamel than slow-speed tungsten carbide finishing burs ($P <$ 01). Although some results had statistical significance, the differences are so small that they might be clinically insignificant. There were no statistically significant differences between the disks and the burs on teeth without WSL. Based upon these findings, the use of slow-speed tungsten carbide burs is recommended for orthodontic adhesive removal. In addition, the use of burs seems to provide better operator control of the point of contact during resin removal; this might help the clinician avoid the areas of decalcification. This could be beneficial for enabling subsequent remineralization with commercially available fluoride products.

We thank Dr Satish Alpati and Ms Heidi Roehrich for their technical assistance with SEM analyses.

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COMMENTARY

The authors of this study present a novel and detailed method for measuring both volume and enamel depth loss after bracket debonding and subsequent polishing. The original hypothesis—that teeth with white spot lesions (WSL) are more prone to enamel loss during bracket debonding—was not supported by the data. The authors conclude using a slow-speed tungsten carbide bur for adhesive removal is preferrable to using an abrasive disk.

However, the study showed that teeth without WSL lost more enamel when polished with the slow speed bur compared with the abrasive disk. These results might be related to operator pressure and hand-piece control as well as the inherent variability in enamel samples.

Polishing can be defined as the consistent abrasion or "scratching" of a surface with progressively finer materials. Although the specific tungsten carbide bur used in this study was not mentioned, the most common one in clinical orthodontics for adhesive removal is the 12-fluted composite finishing bur.

Because all methods of adhesive removal produce some scarring and enamel loss, I prefer to begin with a 30-fluted bur, which produces a smaller and more consistent "scratch" pattern, followed by a previously described sequence of abrasives.[1] I use the bur in a high-speed hand-piece for efficiency and patient comfort. A light brush stroke with minimal pressure allows me to polish precisely near the adhesive without damaging the adjacent enamel. The debate over high-speed versus slow-speed hand-pieces will continue, but my patients prefer the high-speed one because it vibrates less.

As the authors mentioned, WSL tend to occur primarily in the gingival third of the tooth. With proper bonding techniques, the enamel under the bracket, although altered somewhat by acid etching, is protected from the conditions that cause WSL. Therefore, teeth with WSL would be expected to have no greater enamel loss after polishing than those without WSL, if the polishing is limited to the area of the adhesive.

There is no doubt that enamel solubility is increased

CHAPTER 1

GENERAL PROVISIONS

Section 1. Authority. These Board Rules are adopted to implement the Board's authority under Wyoming Statute 33-15-108(g) and 16-3-103(j) as it relates to the licensure and discipline of dentists and dental hygienists and regulation of the practice of dentistry and dental hygiene in Wyoming.

Section 2. Statement of Purpose. These Board Rules are adopted to implement the Board's authority to establish administrative procedures.

Section 3. Definitions.

(a) "Act" means the Wyoming Dental Practice Act, W.S. 33-15-101 through -133.

(b) "ADA" means American Dental Association.

(c) "ADHA" means American Dental Hygienists' Association.

(d) "Advertising" means a communication to the public about a dentist or services offered by a dentist.

(e) "ARC" means Application Review Committee.

(f) "BLS" means basic life support for healthcare providers.

(g) "Board Rules" means the administrative rules and regulations promulgated by the Board.

(h) "CE" means continuing education.

(i) "CODA" means Commission on Dental Accreditation.

(j) "DANB" means Dental Assisting National Board.

(k) "DC" means Disciplinary Committee.

(l) "Dentist-Patient Relationship" means a formal inferred relationship between the dentist and a patient of record, which is established once the dentist assumes or undertakes the dental care or treatment of a patient in the state where the patient resides. A dentist-patient relationship is assumed to have been created after there is a physical examination of a patient (e.g., when a patient is seen in a dentist's office), but is not assumed in others (e.g., when a dentist performs a physical examination as a health screening procedure at a health fair event).

(m) "EKG" means Electrocardiogram.

(n) “Hands on” means involving or offering active participation rather than theory.

(o) “INBDE” means Integrated National Board Dental Examination.

(p) “NBDHE” means National Board Dental Hygiene Examination.

(q) “Supervision” of dental auxiliary means the act of overseeing or directing duties performed by a dental auxiliary. Types of supervision may include:

(i) “General Supervision” of a dental auxiliary means that a dentist has diagnosed and authorized the procedures which are being carried out; however, a dentist need not be present when the authorized procedures are being performed;

(ii) “Direct Supervision” of a dental auxiliary means that a dentist is physically present in the dental office, a dentist has diagnosed the condition to be treated, a dentist has authorized the procedure to be performed, and before dismissal of the patient, a dentist has approved the work performed by the auxiliary; or

(iii) “Indirect Supervision” of a dental auxiliary means that a dentist is physically present in the dental office, a dentist has diagnosed the condition to be treated, and a dentist has authorized the procedure to be performed.

(r) “Teledentistry” means the use of data transmitted through interactive audio/video or data communications either by synchronous or asynchronous technology for the purposes of examination, diagnosis, treatment planning, consultation or directing the delivery of treatment by dentists and dental auxiliary in settings permissible and consistent with the rules of supervision. Teledentistry service may include telephone, electronic mail message, or facsimile transmitting, or online tool.

(i) Synchronous technology: secure two-way audio/visual technology that allows a dentist and dental auxiliary to see and communicate in real time with a patient who is located in a different physical location.

(ii) Asynchronous technology: the transmission of recorded health information (radiographs, photographs, video and other digital media) through a secure electronic communications system to a dentist and dental auxiliary who uses the information to evaluate a patient’s condition or render a service outside of a real-time or live interaction.

(s) “WAPA” means Wyoming Administrative Procedure Act, W.S. 16-3-101 through 115.

Section 4. Board Office. The Board Office shall be located at 2001 Capitol Avenue, Cheyenne, Wyoming.

Section 5. Board Meetings. The Board shall set its regular meetings by resolution.

Section 6. Reference by Incorporation.

(a) Each rule and code incorporated by reference is further identified as follows:

(i) Principles of Ethics and Code of Professional Conduct, excluding Principles 5.H. and 5.I., adopted by the ADA and revised November 2018, found at: https://dental.wyo.gov/rules.

(ii) Bylaws and Code of Ethics, adopted by the ADHA and effective on June 2020, found at: https://dental.wyo.gov/rules.

(iii) Dental Assisting National Board's Code of Professional Conduct, adopted by the DANB and revised February 2018, found at: https://dental.wyo.gov/rules.

(iv) Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care, adopted by the Centers for Disease Control and Prevention and revised October 2016, found at: https://dental.wyo.gov/rules.

(v) Centers for Disease Control Guideline for Prescribing Opioids for Chronic Pain - United States, 2016, adopted by the Centers for Disease Control and Prevention and effective March 18, 2016, found at: http://dental.wyo.gov/rules.

(vi) Chapter 2 - Uniform Rules for Contested Case Practice and Procedure, adopted by the Office of Administrative Hearings and effective on July 20, 2017, found at: https://dental.wyo.gov/rules.

(vii) Chapter 2 - Uniform Procedures, Fees, Costs, and Charges for Inspection, Copying, and Producing Public Records, adopted by the Department of Administration and Information and effective on September 6, 2016, found at https://dental.wyo.gov/rules.

(b) For these rules incorporated by reference:

(i) The Board has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules;

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (a) of this section; and

(iii) The incorporated rules are maintained at the Board Office and are available for public inspection and copying at cost at the same location.

Section 7. Public Records Inspection. Public records inspections shall be conducted pursuant to the Department of Administration and Information’s rules concerning public records.

Section 8. Change of Name, Address, or Telephone Number. Each applicant and licensee shall notify the Board in writing of any change to their legal name, home address, business address, e-mail address, or telephone number within thirty (30) days of the change.

CHAPTER 3

REQUIREMENTS FOR LICENSURE AND RENEWAL

Section 1. Authority. The Board is authorized under Wyoming Statute 33-15-108(g) and 33-15-120(e) to promulgate rules and regulations related to the application, licensure, and renewal procedures to dentistry and dental hygiene in Wyoming.

Section 2. Statement of Purpose. These Board Rules are adopted to implement the Board's authority to establish the requirements for licensure, annual license renewal, and volunteer licenses.

Section 3. Application Status.

(a) For those applicants seeking licensure, competency shall be met during the timeframe identified immediately prior to submitting a completed application.

(b) Applications shall be deemed "complete" when all necessary documentation has been received by the Board office.

(c) Applications shall expire one (1) year after submission. If an application expires, an applicant shall submit a new application, including payment of fee.

Section 4. ARC Review of Applications.

(a) An applicant for licensure or certification shall have committed no acts that are grounds for disciplinary action, or if an act was committed, the ARC has found after investigation that sufficient restitution has been made and the applicant no longer presents a threat to public safety.

(b) If the ARC questions an applicant's competency, the ARC may request an applicant complete a regional clinical examination or other program.

Section 5. Jurisprudence Examination.

(a) The Board shall issue a dental or dental hygiene license to any applicant who meets the qualifications for licensure identified in Sections 6, 7, 8, 9, and 14 and successfully passes the jurisprudence examination.

(b) To successfully pass the jurisprudence examination, the applicant shall score at least an 80% on the exam.

(c) Applicants that fail the examination shall wait one (1) week to retest.

Section 6. Dental Licensure by Examination.

(a) Eligibility. An applicant may seek initial licensure if the applicant is not licensed to practice in another jurisdiction, or if licensed in another jurisdiction but that jurisdiction's licensure requirements are not equivalent to Wyoming, or if the applicant fails to meet other licensure methods.

(b) Application Requirements. Applicant shall:

(i) Submit a completed application and payment of fee;

(ii) Submit current certification in BLS;

(iii) Request official transcripts from a CODA accredited dental program;

(iv) Request score reports documenting successful passage of the INDBE;

(v) Request score reports documenting successful passage of a regional clinical examination that indicates competency in:

(A) Endodontics, including access opening of a posterior tooth and access, canal instrumentation and obturation of an anterior tooth;

(B) Fixed Prosthodontics, a full crown procedure and a separate bridge with two (2) abutment preparations.

(C) Periodontics, including scaling on a patient in a clinical setting; and

(D) Restorative Dentistry, including a class II amalgam or composite preparation and restoration and a class III composite preparation and restoration on a patient in a clinical setting. Slot preps shall not be accepted.

(vi) If an applicant has been out of clinical practice for more than one (1) year, the applicant shall submit the following evidence to demonstrate competency:

(A) Graduation from a CODA accredited dental program in the preceding twelve (12) months; or

(B) Successful completion of a regional clinical examination that meets the criteria in Section 6(b)(v) within the preceding five (5) years and completion of eight (8) hours hands-on clinical CE for each year out of clinical practice. The CE must be earned from a CODA accredited dental program or pre-approved by the ARC prior to completion.

Section 7. Dental Licensure by Endorsement.

(a) Eligibility. An applicant may seek dental licensure by endorsement if the applicant has a license in good standing in another jurisdiction with licensure requirements equivalent to Wyoming's requirements.

(b) Application Requirements. Applicant shall:

(i) Submit a completed application and payment of fee;

(ii) Submit current certification in BLS;

(iii) Submit evidence demonstrating completion of requirements identified in Section 6(b)(iv) and (v). If applicant successfully passed a regional clinical examination as identified in Section 6(b)(v) which did not include a fixed prosthodontics component, applicant shall submit evidence of active clinical practice of 5,000 hours in the last five (5) years or verification of completion of a general practice residency (GPR), advanced education in general dentistry (AEGD), or other specialty practice residency as identified in Chapter 6;

(iv) Request verification of an active license in another jurisdiction;

(v) Submit a copy of the diploma from a CODA accredited program; and

(vi) If an applicant has been out of clinical practice for less than five (5) years, the applicant shall submit the following evidence to demonstrate competency:

(A) Active clinical practice of 1,000 hours in the last twelve (12) months;

(B) Successful completion of a regional clinical examination that meets the criteria in Section 6(b)(v) within twelve (12) months; or

(C) Completion of eight (8) hours of hands-on clinical continuing education for each year not actively practicing. The CE must be earned from a CODA accredited dental program or pre-approved by the ARC prior to completion.

(vii) If an applicant has been out of active clinical practice for more than five (5) years, the applicant shall submit the following evidence to demonstrate competency:

(A) Successful completion of a regional clinical examination within twelve (12) months; and

(B) Completion of eight (8) hours of hands-on clinical continuing education for each year not actively practicing. The CE must be earned from a CODA accredited dental program or pre-approved by the ARC prior to completion.

Section 8. Dental Hygiene Licensure by Examination.

(a) Eligibility. An applicant may seek initial licensure if the applicant is not licensed to practice in another jurisdiction, or if licensed in another jurisdiction but that jurisdiction's licensure requirements are not equivalent to Wyoming, or if the applicant fails to meet other licensure methods.

(b) Application Requirements. Applicant shall:

(i) Submit a completed application and payment of fee~~s~~;

(ii) Submit current certification in BLS;

(iii) Request official transcripts from a CODA accredited program;

(iv) Request score reports documenting successful passage of the NBDHE; and

(v) Request score reports documenting successful passage of a patient-based clinical licensure examination

(vi) If an applicant has been out of clinical practice for more than one (1) year, the applicant shall submit the following evidence to demonstrate competency:

(A) Graduation from a CODA accredited program in the preceding twelve (12) months; or

(B) Successful completion of a regional clinical examination that meets the criteria in Section 8(b)(v) within the preceding five (5) years and completion of eight (8) hours hands-on clinical CE for each year out of clinical practice. The CE must be earned from a CODA accredited dental hygiene program or pre-approved by the ARC prior to completion.

Section 9. Dental Hygiene Licensure by Endorsement.

(a) Eligibility. An applicant may seek dental hygiene licensure by endorsement if the applicant has a license in good standing in another jurisdiction with licensure requirements equivalent to Wyoming’s requirements.

(b) Application Requirements. Applicant shall:

(i) Submit a completed application and payment of fee;

(ii) Submit current certification in BLS;

(iii) Submit evidence demonstrating completion of requirements identified in Section 8(b)(iv) and (v);

(iv) Submit verification of an active license in another jurisdiction;

(v) Submit a copy of the diploma from a CODA accredited program; and

(vi) If an applicant has been out of active clinical practice for less than five (5) years, the applicant shall submit the following evidence to demonstrate competency:

(A) Active clinical practice of 800 hours in the last twelve (12) months;

(B) Successful completion of a regional clinical examination that meets the criteria in Section 8(b)(v) within twelve (12) months; or

(C) Completion of eight (8) hours of hands-on continuing education for each year not actively practicing. The CE must be earned from a CODA accredited dental hygiene program or pre-approved by the ARC prior to completion.

(vii) If an applicant has been out of clinical practice for more than five (5) years, the applicant shall submit the following evidence to demonstrate competency:

(A) Successful completion of a regional clinical examination that meets the criteria in Section 8(b)(v) within twelve (12) months; and

(B) Completion of eight (8) hours of hands-on clinical continuing education for each year not actively practicing. The CE must be earned from a CODA accredited dental hygiene program or pre-approved by the ARC prior to completion.

Section 10. Annual Licensure Renewal.

(a) Expiration.

(i) All dental and dental hygiene licenses shall expire December 31 of every second year.

(ii) Unless a licensee timely renews their license, the licensee shall not practice after their expiration date.

(b) Renewal Application. A dental or dental hygiene licensee seeking renewal shall:

(i) Submit a completed renewal application and payment of fee;

(ii) Verify current certification in BLS; and

(iii) Acquire sixteen (16) hours of CE that complies with Section 11.

(iv) Verify active clinical practice within the preceding five (5) years.

(c) Competency Requirement. After five (5) years of inactive clinical practice, an applicant shall demonstrate competency by successful completion of regional clinical examination that meets the requirements in Section 6(b)(v) for dentists and Section 8(b)(v) for dental hygienists.

Section 11. Continuing Education Requirements.

(a) Renewal Period. CE shall be obtained January 1 of even years through December 31 of odd years. The first CE period begins on January 1st following the date the license was issued.

(i) For a new hygienist with a license issued in an even year, the licensee shall submit eight (8) hours of CE.

(ii) For a new dentist with a license issued in an even year, the licensee shall submit eight (8) hours of CE, three (3) of which must be related to the responsible prescribing of controlled substances.

(b) CE Content.

(i) The subject matter shall relate directly to the professional competence of the licensee or patient care rendered by the licensee. Acceptable CE subjects include, but are not limited to, the following clinical subjects relating to the dental profession: oral surgery, operative dentistry, oral pathology, preventive dentistry, orthodontics, clinical patient management, pediatric dentistry, oral biology, periodontics, prosthodontics, dental materials, implantology, radiology, infection control, endodontics, management of medical emergencies, dental anesthesiology, professional ethics, and pharmacology.

(ii) Unacceptable subjects include, but are not limited to, practice building and business management courses.

(iii) CE may be acquired in any jurisdiction.

(iv) CE earned in excess of the sixteen (16) hours required for renewal may not be carried forward to apply toward the next renewal period.

(c) Of the required sixteen (16) hours, a dentist shall obtain three (3) hours of CE related to the responsible prescribing of controlled substances every two (2) years. This requirement shall not apply to dental hygienists.

(d) Waiver. The Board may grant a waiver for CE requirements to licensees who have petitioned and demonstrated just cause based on extenuating circumstances.

(e) CE Audit.

(i) The licensee shall maintain evidence of CE compliance for at least four (4) years after the renewal period in which the course was applied.

(ii) Failure to provide the documents requested for audit within thirty (30) days may subject the licensee to disciplinary action.

(iii) If the Board disallows any CE, the licensee shall have one hundred twenty (120) days from notice of such disallowance to:

(A) Provide evidence that the disallowed CE meet the criteria established by these rules;

(B) Provide documentation of having acquired additional CE during the required time frame; or

(C) Resolve the disallowance by acquiring the required number of CE.

(D) Any CE activity completed past the renewal date to resolve a disallowance may not be reported on subsequent applications for license renewal.

(iv) If a licensee fails to complete the required number of CE, the licensee shall be subject to disciplinary action.

Section 12. Failure to Timely Renew.

(a) Unlicensed Practice. Failure to timely renew may subject the licensee to disciplinary action for unlicensed practice.

(b) Administrative Grace Period.

(i) The administrative grace period shall be from January 1st to March 31st following the renewal period.

(ii) Licensees who failed to timely renew may apply for renewal during the administrative grace period. However, licensees shall not practice until the Board approves their license.

(iii) Licensees who failed to timely renew shall:

(A) Submit a completed renewal application and payment of fee;

(B) Verify current certification in BLS; and

(C) Complete CE that meets the requirements in Section 11.

(iv) On April 1st following the renewal period, any license not renewed shall lapse.

Section 13. Lapsed License.

(a) If a dental license lapses, the dentist shall apply for relicensure.

(b) If a dental hygiene license lapses, the dental hygienist may restore their lapsed license until December 31st of the year the license lapsed. After December 31st, the dental hygienist shall apply for relicensure.

Section 14. Dental and Dental Hygiene Relicensure.

(a) Eligibility. An applicant may seek dental or dental hygiene relicensure if the applicant has been licensed in Wyoming and allowed his or her license to lapse.

(b) Application Requirements. Applicant shall:

(i) Submit a completed relicensure application and payment of fee;

(ii) Verify current certification in BLS;

(iii) Submit eight (8) hours CE for each year the license has lapsed; and

(iv) Successfully pass the jurisprudence examination.

(c) Competency Requirement for Return to Practice. An applicant applying for relicensure who has not actively practiced in five (5) years shall also demonstrate competency by:

(i) Successful completion of a regional clinical examination per Section 6(b)(v) for dentists and Section 8(b)(v) for hygienists within twelve (12) months; and

(ii) Submitting evidence of completion of eight (8) hours of hands-on clinical continuing education for each year not actively practicing. The CE must be earned from a CODA accredited dental program or pre-approved by the ARC prior to completion.

Section 15. Reinstatement.

(a) Eligibility. An applicant may seek to have his or her dental or dental hygiene license reinstated if the applicant's Wyoming dental or dental hygiene license has been revoked, surrendered, suspended, conditioned, or restricted.

(b) Application Requirements. Applicant shall:

(i) Submit a completed application and payment of fee;

(ii) Verify current certification in BLS;

(iii) Submit evidence of complying with the requirements of a previous Board order;

(iv) Submit evidence of applicant's ability to safely and competently practice; and

(v) Submit evidence demonstrating just cause for reinstatement.

Section 16. Volunteer's License. Any applicant that meets the qualifications under W.S. 33-15-131 shall submit a completed application.

Section 17. Temporary Educator's License. Any applicant that meets the qualifications under W.S. 33-15-133 shall submit a completed application.

CHAPTER 4

DENTAL PRACTICE

Section 1. Authority. The Board is authorized under Wyoming Statutes 33-1-303(a)(iv), 33-15-108(h), and 33-15-130 to promulgate rules and regulations related to telemedicine and x-ray machine inspection procedures in Wyoming.

Section 2. Statement of Purpose. These Board Rules are adopted to implement the Board's authority to regulate the practice of dentistry in Wyoming.

Section 3. Teledentistry.

(a) The practice of dentistry occurs where the patient is located. Where an existing dentist-patient relationship is not present, a licensee must take appropriate steps to establish a dentist-patient relationship in utilizing teledentistry services that is consistent with the prevailing standard of care.

(b) Before rendering dental advice or care using teledentistry services, the licensee shall:

(i) Verify and authenticate the location and to the extent possible, confirm the identity and contact information of the requesting patient.

(ii) Disclose and validate the licensee's identity, credentials and contact information.

(iii) Obtain appropriate written treatment consent from the requesting patient.

(iv) Obtain patient's medical and dental health history.

(v) Detail security measures taken as well as potential risks to privacy and the loss of information due to technical failures.

(vi) Determine if the condition being diagnosed or treated is appropriate for teledentistry.

(vii) Determine appropriate treatment and follow up care if needed.

(c) Dental Records. Any dental record made through the use of teledentistry shall be consistent with the same record retention standards as a record made through a traditional, in person dental encounter.

(d) Confidentiality. The licensee shall ensure that any electronic and digital communication used in the practice of teledentistry is secure to maintain the confidentiality of

the patient's medical/dental information as required by the Health Insurance Portability and Accountability Act of 1996 including the retention and disposal of electronic and digital equipment and data.

(e) Violation of any provision above shall be considered "unprofessional conduct" within the meaning of Chapter 9 and shall constitute grounds for disciplinary action by the Board.

Section 4. Satellite Offices. Licensees using satellite offices shall ensure all offices maintain the appropriate standard of care.

Section 5. Radiograph Use. Inspections of x-ray machines are required as follows:

(a) Inspectors. Any individual who performs x-ray machine assembly, installation or service shall meet the following educational and experience requirements:

(i) Completion of a structured educational program that includes training in radiation machine safety, assembly, installation and service, including, but not limited to:

(A) A baccalaureate degree in electrical engineering with specialized training in radiation producing devices;

(B) A one-year associate degree in biomedical equipment repair;

(C) Equivalent manufacturer, military or other technical school training; and

(ii) At least six (6) months of supervised, documented training on inspection and calibration of the applicable x-ray machine.

(b) Inspections. Inspections of x-ray equipment shall be conducted in accordance with relevant national standards. All machines shall be inspected at the time of installation and thereafter every five (5) years for x-ray machines and every three (3) years for computed tomography machines.

(c) Waiver. Licensees may be granted a six (6) month waiver to the inspection requirement at the discretion of the Board.

(d) Compliance and Documentation. Failure to abide with the requirements of this section shall be considered "unprofessional conduct" within the meaning of Chapter 9 and shall constitute grounds for disciplinary action by the Board.

(i) Inspector should provide evidence for dentists to place on machines indicating the last inspection date and next inspection due date.

(ii) Evidence of compliance to the Board is not required unless specifically requested.

CHAPTER 5

ANESTHESIA ADMINISTRATION AND SEDATION PERMIT PROCEDURES

Section 1. Authority. The Board is authorized under Wyoming Statute 33-15-130 to promulgate rules and regulations related to the application and licensure procedures to administer sedation and provide for sedation inspection in Wyoming.

Section 2. Statement of Purpose. These Board Rules are adopted to implement the Board's authority to establish a regulatory framework for issuance of a sedation permit pursuant to W.S. 33-15-130.

Section 3. Definitions. For the purpose of this chapter, the following definitions shall apply:

(a) "ACLS" means advanced cardiac life support.

(b) "Anxiolysis" is minimal sedation.

(c) "Applicant" means a Wyoming licensed dentist applying for a sedation permit.

(d) "ASA" means American Society of Anesthesiology classification.

(e) "Combination inhalation" means using an inhalation agent and a sedative agent at the same time.

(f) "Competent" means displaying special skill or knowledge derived from training and experience.

(g) "Deep sedation" means a drug-induced depression of consciousness during which the patient cannot be easily aroused but responds purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. The patient may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

(h) "Dental hygienist" means a Wyoming licensed dental hygienist holding an appropriate expanded duties permit including local anesthesia and/or nitrous oxide anxiolysis.

(i) "Enteral" means a route of administration in which the agent is absorbed through the gastrointestinal tract or mucosa [i.e., oral, rectal, nasal, or sublingual].

(j) "Facility Permit" means a permit issued to any location where sedation is being performed that has been inspected and approved by the Board.

(k) "Facility Permit Holder" means a Wyoming licensed dentist designated as the

responsible dentist for a facility permit.

(l) "General anesthesia" means a drug-induced loss of consciousness during which the patient is not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. The patient often requires assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

(m) "Inhalation" means a route of administration in which a gaseous or volatile agent is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed.

(n) "Local anesthesia" means the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

(o) "Minimal sedation" (previously known as anxiolysis) means a minimally depressed level of consciousness produced by a pharmacological method that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory, and cardiovascular functions are unaffected. Minimal sedation includes administration of oral medication and/or nitrous oxide.

(p) "Moderate sedation" previously known as "conscious sedation and/or twilight sedation or parenteral sedation" means a drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. The drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the sedation permit holder. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

(q) "MRD" means maximum recommended dose of a drug as printed on Food and Drug Administration approved labeling for unmonitored home use.

(r) "Nitrous oxide anxiolysis" means the administration by inhalation of a combination of nitrous oxide and oxygen producing an altered level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command.

(s) "PALS" means Pediatric Advanced Life Support.

(t) "Parenteral" means a route of administration in which the drug bypasses the gastrointestinal tract [i.e., intramuscular, intravenous, intranasal, submucosal, subcutaneous, or

intraosseous].

(u) "Qualified anesthesia provider" means a licensed anesthesiologist, certified registered nurse anesthetist, or sedation permit holder with appropriate sedation level permit.

(v) "Responsible dentist" means a licensed dentist who assumes responsibility for a facility permit.

(w) "Sedation Inspector" means a Board-approved inspector of sedation facilities and sedation permit applicant's surgical/anesthetic technique cases.

(x) "Sedation permit" means a permit issued by the Board for administration of moderate sedation or deep sedation and/or general anesthesia by a sedation permit holder.

(y) "Titration" means administration of multiple or incremental doses of a drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response, and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

Section 4. Standard of Care.

(a) For all levels of sedation, a dentist or sedation permit holder shall have the training, skills, drugs, and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical services) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

(b) A dentist or sedation permit holder shall be responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation, deep sedation, and/or general anesthesia and providing the equipment, drugs, and protocol for patient rescue.

(c) Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, a dentist or sedation permit holder intending to produce a given level of sedation shall be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.

(d) The concept of rescue is essential to safe sedation. A dentist or sedation permit holder shall have the skills to rescue the patient from a deeper level than that intended for the procedure. The ability to rescue means that a dentist or sedation permit holder shall be able to recognize the various levels of sedation and have the skills necessary to provide appropriate cardiopulmonary support if needed.

(i) If the intended level of sedation is "minimal," a dentist or sedation permit holder shall be able to rescue from "moderate sedation."

(ii) If the intended level of sedation is "moderate," a sedation permit holder shall have the skills to rescue from "deep sedation."

(iii) If the intended level of sedation is "deep sedation," a sedation permit holder shall have the skills to rescue from a state of "general anesthesia."

(e) If a patient enters a deeper level of sedation than the dentist or sedation permit holder is qualified to provide, the dentist or sedation permit holder shall stop the dental procedure until the patient returns to the intended level of sedation.

(f) Children (under the age of 12) may become moderately sedated despite the intended level of minimal sedation; if this occurs, the requirements for moderate sedation shall apply.

(g) Except in extraordinary situations, the dentist or sedation permit holder shall not use preoperative sedatives for children prior to arrival in the dental office due to the risk of unobserved respiratory obstruction during transport by untrained individuals.

(h) All local anesthetic agents are cardiac depressants and may cause central nervous system excitation or depression. Particular attention shall be paid to dosage in children. To ensure that the patient will not receive an excessive dose, the maximum allowable safe dosage (i.e., mg/kg) shall be calculated before administration. There may be enhanced sedative effects when the highest recommended doses of local anesthetic drugs are used in combination with other sedatives or narcotics.

(i) Patients considered for minimal sedation, moderate sedation, and/or general anesthesia must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this may consist of a review of their current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

(j) Pre-operative preparation shall include:

(i) Consideration of dietary restrictions based on the sedative technique prescribed; and

(ii) Verbal and written instructions shall be given to the patient, parent, escort, guardian or care giver.

(k) An appropriate scavenging system shall be available if gases other than oxygen or air are used.

Section 5. Requirements for Administering Minimal Sedation.

(a) A sedation permit shall not be required for a dentist to administer minimal

sedation.

(b) A dentist shall only administer minimal sedation by an enteral route.

(c) To administer minimal sedation, a dentist or dental hygienist shall:

(i) Have adequate equipment with fail-safe features and 25% minimum oxygen flow; and

(ii) Demonstrate competency and/or training in administering minimal sedation by:

(A) Completion of CODA recognized program; or

(B) Completion of a Board-approved course.

(d) Office Equipment Requirements. Any dentist who administers minimal sedation shall provide the following equipment, which shall be functional and available at all times:

(i) A continuous pulse oximeter;

(ii) A blood pressure cuff of appropriate size;

(iii) Stethoscope or equivalent blood pressure monitoring devices;

(iv) An appropriate size bag-valve-mask apparatus or equivalent with an oxygen hook-up; and

(v) A manual or automatic external defibrillator.

(e) A dentist or sedation permit holder shall document every administration of minimal sedation. Documentation for administration of minimal sedation shall include, but is not limited to, the following:

(i) Pertinent medical history including, but not limited to:

(A) Previous medication(s);

(B) Allergies; and

(C) Sensitivities;

(ii) Weight (nitrous oxide excluded);

(iii) Vital Signs, including, but not limited to:

(A) Baseline heart rate; and

(B) Blood pressure.

(iv) Beginning and ending oxygen saturation levels; and

(v) Medication(s) administered and dosage(s).

(f) All dental personnel shall be certified in administering BLS. A dentist or sedation permit holder may delegate patient monitoring to qualified dental personnel. During a procedure where nitrous oxide anxiolysis or minimal sedation is administered, at least one (1) dental personnel shall be present.

(g) When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the MRD dose of a drug that can be prescribed for unmonitored home use.

(h) Nitrous oxide administration may be used in combination with a single enteral drug in minimal sedation.

(i) Nitrous oxide administration when used in combination with a sedative agent(s) may produce moderate sedation, deep sedation, and/or general anesthesia which requires a sedation permit.

Section 6. Requirements for Administering Moderate Sedation, Deep Sedation, and/or General Anesthesia.

(a) A sedation permit shall be required for a sedation permit holder to administer moderate sedation, deep sedation, and/or general anesthesia.

(b) Office Equipment Requirements.

(i) Any sedation permit holder who administers moderate sedation, deep sedation, and/or general anesthesia shall have available the required equipment in Section 5(d) and the following additional equipment and faculties, which shall be functional and available at all times:

(A) Suitable operating suite;

(B) Recovery area;

(C) Gas storage facilities with back up tanks and mobile back-up oxygen, which generally meet accepted safety standards;

(D) Suction system;

(E) Back-up suction equipment;

(F) Back-up lighting equipment;

(G) Parenteral access or the ability to gain parenteral access, if clinically indicated;

(H) Capnograph (end tidal carbon dioxide monitor);

(I) EKG;

(J) Appropriate emergency medications;

(K) Endotracheal tubes suitable for patients being treated;

(L) Endotracheal tube forceps (i.e., magill);

(M) A laryngoscope with reserve batteries and bulbs;

(N) Oropharyngeal airways;

(O) Nasopharyngeal airways; and

(P) At least one (1) additional airway device.

(ii) Volatile Anesthesia Delivery Systems. Any sedation permit holder who administers volatile anesthesia shall provide the required equipment listed in Section 5(d) and Section 6(b)(i) and the following additional equipment and facilities, which shall be functional and available at all times:

(A) Capability to deliver oxygen to a patient under positive pressure, including a back-up oxygen system;

(B) Gas outlets that meet generally accepted safety standards preventing accidental administration of inappropriate gases or gas mixture;

(C) Fail-safe mechanisms for inhalation of nitrous oxide anxiolysis;

(D) The inhalation equipment must have an appropriate scavenging system if volatile anesthetics are used; and

(E) Gas storage facilities, which meet generally accepted safety standards.

(c) A sedation permit holder shall document every administration of moderate sedation, deep sedation, and/or general anesthesia. Documentation for administration of

moderate sedation, deep sedation, and/or general anesthesia shall include the required documents listed in Section 5(e) and the following additional documentation:

(i) Current and comprehensive medical history, including:

(A) Medical conditions; and

(B) Age;

(ii) Physical examination, including:

(A) Airway assessment;

(B) Respiratory rate; and

(C) Temperature;

(iii) ASA Classification;

(iv) Procedure(s);

(v) Informed Consent;

(vi) Anesthesia Record, which shall include:

(A) Vital signs before and after anesthesia is utilized;

(B) Parenteral access site and method, if utilized;

(C) Medication(s) administered;

(D) Time anesthesia commenced and ended;

(E) Monitor blood pressure, heart rate, and oxygen saturation at least every five (5) minutes;

(F) EKG;

(G) Capnograph (end tidal carbon dioxide monitor);

(H) Ventilation status (spontaneous, assisted, or controlled);

(I) Intravenous fluids, if utilized;

(J) Response to anesthesia, including any complications;

(K) Starting time of recovery and time of discharge; and

(L) Condition of patient at discharge and authorization of sedation permit holder.

(d) All dental personnel shall be certified in administering BLS. A dentist or sedation permit holder may delegate patient monitoring to qualified dental personnel.

(i) Moderate Sedation. During a procedure where moderate sedation is administered, the sedation permit holder and at least one (1) other dental personnel shall be present.

(ii) Deep Sedation and/or General Anesthesia. During a procedure where deep sedation and/or general anesthesia is administered, the sedation permit holder and at least two (2) other dental personnel shall be present and at least one (1) shall be experienced in patient monitoring and documentation.

(e) A dentist or sedation permit holder shall be subject to disciplinary action if:

(i) A dentist administers moderate sedation, deep sedation, and/or general anesthesia without a sedation permit; or

(iii) A permit holder administers deep sedation and/or general anesthesia with a sedation permit for moderate sedation.

Section 7. Application Process for Administering Moderate Sedation.

(a) The applicant shall submit a completed application, including fees, and provide evidence of:

(i) Current certification in ACLS or PALS; and

(ii) Demonstrating competency and/or training in administering moderate sedation within two (2) years immediately preceding the application as follows:

(A) Completion of a specialty residency recognized by CODA;

(B) Completion of a general practice residency recognized by CODA that meets the minimal training requirements identified in subsection (D);

(C) Submit proof that applicant has administered moderate sedation, deep sedation and/or general anesthesia in another jurisdiction within generally accepted standards of dental practice and provide documentation of at least 40 moderate sedation cases; or

(D) Completion of a training course to administer and manage moderate sedation within twelve (12) months prior to application. For moderate sedation, such

training shall include a minimum:

(I) 60 hours of didactic instruction;

(II) 20 solo intubations (patient-based and/or acceptable electronic simulated manikin);

(III) 20 moderate sedation cases;

(IV) Physical diagnosis rotation; and

(V) Advance Airways and Emergency Management.

(b) While reviewing a completed application, the ARC shall consider any pending complaints before the Board against the applicant.

(c) Surgical/Anesthetic Techniques. Each sedation inspector shall review at least three (3) separate cases in which the applicant administered anesthesia. The sedation inspector may require additional cases to observe at his/her discretion. If no cases are available (i.e. the applicant has just completed a residency program), three (3) separate standardized cases shall be reviewed.

(d) Simulated Emergencies. The applicant and his/her team shall be able to demonstrate their expertise in managing the following emergencies:

(i) Laryngospasm;

(ii) Bronchospasm;

(iii) Emesis and aspirator of vomitus;

(iv) Management of foreign bodies in the airway;

(v) Angina Pectoris;

(vi) Myocardial Infarction;

(vii) Cardiopulmonary Resuscitation;

(viii) Hypotension;

(ix) Hypertensive crisis;

(x) Acute allergic reaction;

(xi) Convulsions; and

(xii) Hyperventilation syndrome.

(e) Discussion Period. The applicant may be required to answer additional questions by the sedation inspector.

Section 8. Application Process for Administering Deep Sedation and/or General Anesthesia.

(a) The applicant shall submit a completed application, including fees, and provide evidence of:

(i) Current certification in ACLS or PALS;

(ii) Demonstrating competency and/or training in administering deep sedation and/or general anesthesia within two (2) years immediately preceding the application as follows:

(A) Completion of a residency program that includes training in sedation and/or general anesthesia that is approved by CODA, the American Dental Society of Anesthesiology, the Accreditation Council for Graduate Medical Education, the American Osteopathic Association or any successor organization to any of the foregoing; or

(B) Completion of a post-doctoral training program (e.g., oral and maxillofacial surgery) that affords comprehensive and appropriate training necessary to administer and manage deep sedation and/or general anesthesia that is approved by CODA or other program approved by the Board.

(b) While reviewing a completed application, the ARC shall consider any pending complaints before the Board against the applicant.

(c) Surgical/Anesthetic Techniques. Each sedation inspector shall review at least three (3) separate cases in which the applicant administered anesthesia. The sedation inspector may require additional cases to observe at his/her discretion. If no cases are available (i.e. the applicant has just completed a residency program), three (3) separate standardized cases shall be reviewed.

(d) Simulated Emergencies. The applicant and his/her team shall be able to demonstrate their expertise in managing the following emergencies:

(i) Laryngospasm;

(ii) Bronchospasm;

(iii) Emesis and aspirator of vomitus;

(iv) Management of foreign bodies in the airway;

(v) Angina Pectoris;

(vi) Myocardial Infarction;

(vii) Cardiopulmonary Resuscitation;

(viii) Hypotension;

(ix) Hypertensive crisis;

(x) Acute allergic reaction;

(xi) Convulsions; and

(xii) Hyperventilation syndrome.

(e) Discussion Period. The applicant may be required to answer additional questions by the sedation inspector.

Section 9. Sedation Permit Renewal and Expiration.

(a) Sedation permits shall be renewed on or before December 31 every second year.

(b) A sedation permit holder shall submit a completed sedation permit renewal application, including fees, and provide evidence of:

(i) Current certification in ACLS or PALS; and

(ii) Sixteen (16) hours sedation continued education renewal course every two (2) years with requirements that the course contain medical emergencies and airway management skills training with a hands on component.

(iii) The Board may request more documentation if necessary.

Section 10. Reinstatement of Expired and Revoked Sedation Permits.

(a) A dentist may apply for reinstatement of their expired sedation permit by meeting the application requirements established in Section 7 and/or Section 8.

(b) A dentist may apply for reinstatement of their revoked sedation permit by meeting the application requirements established in Section 7 and/or Section 8 and submit evidence of:

(i) Meeting requirements of previous Board order; and

(ii) Demonstrating just cause for reinstatement.

Section 11. Sedation Inspector Qualifications and Duties.

(a) Sedation Inspector Qualifications. The inspector shall:

(i) Submit a completed application;

(ii) Actively practice as a dental anesthesiologist, oral maxillofacial surgeon, anesthesiologist, or certified nurse anesthetist; and

(iii) Hold a current and unencumbered Wyoming license in their field.

(b) Sedation Inspector Duties. A Board-approved sedation inspector shall:

(i) Be considered an agent for the Board;

(ii) Comply with the Board Rules for inspecting sedation facilities within Wyoming;

(iii) Not have a conflict of interest with an applicant. A sedation inspector's receipt of payment from the applicant for services as a sedation inspector is acceptable and does not constitute a conflict of interest; and

(iv) Review a sedation permit applicant's surgical/anesthetic techniques required in Section 7(c) and Section 8(c).

Section 12. Initial Facility Permit Application Process.

(a) Application Requirements. Applicant shall:

(i) Submit a completed application and payment of fee; and

(ii) Have two (2) approved sedation inspectors submit sedation facility inspection reports for each location where sedation is intended to be administered.

(iii) Applicant shall be responsible for payment of sedation facility inspection fee to sedation inspectors.

(b) Renewal Requirements.

(i) Facility permits shall be renewed on or before December 31 every second year.

(ii) A facility permit holder shall submit a completed facility permit renewal application, including fees. The facility permit holder shall provide evidence of re-inspection every five (5) years.

Section 13. Sedation Facility Inspection Process.

(a) Initial Inspection Process.

(i) Each sedation inspector shall review the office equipment, documentation, and emergency medications as required in Section 6.

(ii) After a sedation inspector has completed the onsite sedation facility inspection, the sedation inspector shall submit his/her findings and necessary documentation.

(b) Re-Inspection Process.

(i) Permitted sedation facilities shall be re-inspected every five (5) years. Responsible dentist bears the burden of ensuring that their permitted sedation facilities are re-inspected no later than five (5) years from the previous inspection.

(ii) Each re-inspection of a permitted sedation facility may be inspected by one (1) Board approved sedation inspector.

(iii) The Board may require re-inspection of a permitted sedation facility.

CHAPTER 7

DENTAL AUXILIARIES

Section 1. Authority. The Board is authorized under Wyoming Statute 33-15-119, 33-15-129(a), 33-15-123, and the WAPA to promulgate rules and regulations related to the application and licensure procedures to practice of dental hygiene and dental auxiliaries in Wyoming.

Section 2. Statement of Purpose. These Board Rules are adopted to implement the Board's authority to regulate the practice of dental hygiene and other dental auxiliaries.

Section 3. Dental Auxiliary Personnel. Except as otherwise provided, dental auxiliary personnel shall not perform irreversible procedures.

Section 4. Practice of Dental Hygiene.

(a) The dental hygienist shall:

(i) Work under the supervision of a Wyoming licensed dentist; and

(ii) Be responsible for maintaining a high degree of proficiency in the practice of dental hygiene that is consistent with current educational standards of the profession.

(b) Dental hygienists may work in the private office of a licensed dentist, in the Armed Forces of the United States, in federal or state institutions, in public health settings, and nursing or retirement facilities.

(c) Dental hygienists are encouraged to promote oral health. They may accomplish this through presentations to schools, institutions, groups, or individuals. In no event should these presentations be used for the purpose of advertising or soliciting patients for himself/herself or a dentist.

Section 5. Supervision of Procedures Performed by the Dental Hygienist.

(a) General Supervision. The following procedures require general supervision:

(i) Community dental health activities which includes public health services at federally funded health centers and clinics; nursing homes; extended care facilities; home health agencies; group homes for the elderly, disabled and youth; public health offices; Women, Infants, and Children; Head Start programs; child development programs; early intervention programs; migrant work facilities; free clinics; health fairs; public and private schools; state and county correctional institutions; community school-based prevention programs; and public health vans.

(A) Public health services solely consist of prophylaxis, topical fluoride applications, oral health education, and dental screenings. These services can be provided by the hygienist without prior authorization of the dentist. All patients seen shall be referred to a dentist annually.

(B) The hygienist shall maintain a Collaboration Agreement with a Wyoming licensed dentist. The hygienist must have a current Wyoming dental hygienist license with a minimum of two (2) years clinical experience.

(ii) Duties authorized for dental assistants set forth in the Board Rules;

(iii) Root plane, scale and polish teeth;

(iv) Polish amalgams and composites;

(v) Screen the oral cavity for disease;

(vi) Place temporary fillings that require no removal of tooth structure;

(vii) Place, expose, and process radiographic images;

(viii) Place pit and fissure sealants and silver diamine fluoride; and

(ix) Apply subgingival anesthetic (i.e. Oraqix) if the dental hygienist holds a local anesthetic expanded duties permit.

(b) Direct Supervision. The following procedures require direct supervision:

(i) Prepare, place, and remove periodontal packs;

(ii) Remove overhanging margins;

(iii) Treat diagnosed dry sockets;

(iv) Treat diagnosed pericoronitis;

(v) Perform whitening procedures; and

(vi) Perform expanded dental duties.

Section 6. Expanded Duties Permits.

(a) Permit. To obtain an expanded duties permit, a dental hygienist shall meet educational standards, or pass an examination approved by the Board, or both. Applicant shall submit a completed application for each duty.

(b) Training Course Approval.

(i) Training programs shall be approved in advance in writing by the Board. Due to the varied programs, individual courses shall require individual approval after course content is reviewed by the Board.

(ii) Applicant shall provide evidence of satisfactory completion of each expanded duties course.

(iii) In the case of use of lasers, the applicant shall provide proof of certification from the Academy of Laser Dentistry or completion of a laser course through a CODA accredited dental hygiene program.

(iv) An in-person evaluation for an expanded duties permit may be required by the Board to ascertain the applicant's knowledge of the expanded duties that the applicant wishes to be permitted to perform.

(c) Expanded Duties. The following may be performed by a dental hygienist with an appropriate expanded duties permit:

(i) Administer local anesthetics;

(ii) Administer and monitor nitrous oxide/oxygen; or

(iii) Use lasers to provide soft tissue therapy within the dental hygienists scope of practice. Dental hygienists shall NOT use lasers at settings intended to cut/remove hard tissue or tooth structure.

Section 7. Dental Assistants. The following applies to all dental assistants:

(a) Dental Assistant. A dentist holding a current Wyoming license may employ persons designated as "Dental Assistants." They may be trained by their employer or by an accredited or Board approved program for dental assistants.

(b) General Supervision. The following procedures require general supervision:

(i) Take vital statistics and health histories;

(ii) Instruct patients in proper dental health care;

(iii) Process radiographs;

(iv) Fabricate and cement temporary crowns;

(v) Replace ligature wires and/or place elastic ties;

(vi) Remove ligature wire and/or elastic ties;

(vii) Place and remove orthodontic separators;

(viii) Remove broken bands, brackets, wires and appliances in emergency situations or as needed for operative or prophylactic purposes; and

(ix) Place and expose x-ray image receptors (either film or digital) with a dentist's order, either verbal or written.

(c) Indirect Supervision. The following procedures require indirect supervision:

(i) Take impressions other than final or master impressions and/or digital scan impressions;

(ii) Apply topical medications, excluding pit and fissure sealants and silver diamine fluoride;

(iii) Mix dental materials to be used by the dentist; and

(iv) Insert arch wires that have been adjusted by the dentist into the brackets or attachments and secured in place.

(d) Direct Supervision. The following procedures require direct supervision:

(i) Remove sutures;

(ii) Assist the dentist in all operative and surgical procedures;

(iii) Place and remove rubber dams;

(iv) Place and remove matrices;

(v) Remove excess cement from the coronal surfaces of the teeth;

(vi) Prepare and remove periodontal packs;

(vii) Polish the coronal surfaces of the teeth, rubber cup only, but not for the purpose of prophylaxis.

(viii) Perform whitening procedures;

(ix) Place and remove orthodontic wires and/or appliances that have been activated by the dentist;

(x) Take impressions for orthodontic procedures, i.e. retainers and removable appliances;

(xi) Remove direct bond attachments and bands;

(xii) Place pit and fissure sealants; and

(xiii) Treat diagnosed dry socket.

(e) Prohibitions. The following procedures may not be performed by dental assistants:

(i) Remove tooth structure;

(ii) Diagnose for treatment;

(iii) Take final impressions either digital or conventional or deliver a permanent prosthesis of any type;

(iv) Any procedure billed as a dental prophylaxis;

(v) Use high speed handpiece intraorally; or

(vi) Use low speed handpiece intraorally, except for coronal polishing.

Section 8. Exposure of Radiographic Images by Dental Assistants.

(a) Eligibility. An applicant may seek a permit to expose dental radiographs under the indirect supervision of a dentist, if the applicant demonstrates competency.

(b) Application Requirements. Applicant shall:

(i) Submit a completed application and payment of fee; and

(ii) Demonstrate competency by submitting evidence the applicant has:

(A) Completed a course or examination in dental radiography approved by the Board within one (1) year immediately prior to the date of application; or

(B) Been authorized to expose dental radiographs in another jurisdiction within the last five (5) years.

(c) Renewal. A permit to expose radiographs shall expire December 31 every second year, unless renewed.

(d) Late Renewal. A permit to expose radiographs that was not timely renewed may be renewed within five (5) years of the date the permit expired by submitting a late renewal application and the late fee. After five (5) years, the assistant must reapply and document completion of a new radiography course within one (1) year immediately prior to the date of application.

Section 9. Placement of Pit and Fissure Sealants by Dental Assistants.

(a) Eligibility. An applicant may apply for a pit and fissure sealant permit if the applicant has successfully completed a Board approved course which may include:

(i) Board approved course meeting the requirements identified in subsection (c); or

(ii) CODA accredited dental hygiene program or a dental assisting program.

(b) Application Requirements. Applicant shall submit:

(i) Completed application and payment of fee; and

(ii) Completed checklist demonstrating competency and completion of course within one (1) year immediately prior to the date of application.

(c) Education. The education program shall include:

(i) Didactic Education including:

(A) Infection Control;

(B) Microbiology;

(C) Chemistry;

(D) Dental anatomy;

(E) Ethics related to pit and fissure sealant application;

(F) Jurisprudence related to pit and fissure sealant application; and

(ii) Clinical Instruction including supervised application of sealants.

(d) Renewal. A permit to place pit and fissure sealants shall expire December 31 every second year, unless renewed.

(e) Late Renewal. A permit to place pit and fissure sealants that was not timely renewed may be renewed within five (5) years of the date the permit expired by submitting a late

renewal application and the late fee. After five (5) years, the assistant must reapply and document completion of a new pit and fissure training course within one (1) year immediately prior to the date of application.

Section 10. Code of Ethics for Dental Hygienists and Dental Assistants. Each dental hygienist and dental assistant practicing in the state of Wyoming shall:

(a) Provide oral health care utilizing highest professional knowledge, judgment, and ability;

(b) Serve all patients without discrimination;

(c) Hold professional patient relationships in confidence;

(d) Utilize every opportunity to increase public understanding of oral health practices;

(e) Generate public confidence in members of the dental health profession;

(f) Cooperate with all health professions in meeting the health needs of the public;

(g) Recognize and uphold the laws and regulations governing this profession;

(h) Maintain professional competence through continuing education;

(i) Exchange professional knowledge with other health professions;

(j) Represent dental hygiene and/or dental assisting with high standards of personal conduct; and

(k) Comply with the provisions of ADHA's Code of Ethics or Dental Assisting National Board's Code of Professional Conduct as referenced in Chapter 1.

CHAPTER 9

PRACTICE AND PROCEDURES FOR DISCIPLINARY, APPLICATION, AND LICENSURE MATTERS

Section 1. Authority. The Board is authorized under Wyoming Statute 33-15-112, 33-15-121, and the WAPA to promulgate rules and regulations related to the discipline of dentists and dental hygienists in Wyoming.

Section 2. Statement of Purpose. These Board Rules are adopted to implement the Board's authority to:

(a) Conduct investigations, hearings, and proceedings concerning:

(i) Alleged violations of the Act or the Board Rules; or

(ii) Actions relating to an application for a licensure including granting or denying.

(b) Determine and administer appropriate disciplinary action against licensee.

(c) For the purposes of this chapter, "licensee" means a dentist or dental hygienist.

Section 3. Grounds for Discipline. The Board may take disciplinary action or refuse to issue or renew a license for the any one (1) or more of the following acts or conduct:

(a) Violations of the Act or Board Rules;

(b) Unprofessional conduct. Unprofessional conduct relates to the practice of dentistry or any dental auxiliary occupation that constitutes a departure from or failure to conform to the standards of acceptable and professional practices, including, but not limited to:

(i) Conduct that indicates the licensee or applicant is grossly ignorant of health care and dental related standards and protocols;

(ii) Conduct that indicates the licensee or applicant is inefficient by failing to provide timely care to a patient or by failing to refer the patient when circumstances indicate referral is appropriate;

(iii) Conduct or factors that indicate the licensee's or applicant's competency is compromised;

(iv) Impairment due to drug abuse, alcohol abuse, or a physical or mental condition, which may have compromised, or may compromise, patient safety;

(v) Employing directly or indirectly any unlicensed person to perform operations of any kind of treatment for human teeth or jaws, or to perform any task which constitutes the practice of dentistry;

(vi) Betraying patient confidences;

(vii) Failing to make and maintain complete patient records that conform to prevailing record-keeping standards within the licensee holder's profession;

(viii) Failing to provide a patient, or the Board, with a full and complete copy of all patient records, x-rays, molds, or any other item kept in the course of treatment or services rendered by the license holder, for any patient, if either the patient, the patient's legal guardian, or the Board requests said copies;

(ix) Providing false, deceptive, or misrepresented information to the Board, committees or staff:

(A) In procuring or attempting to procure a license to practice dentistry;

(B) In filing or reporting any health care information, including but not limited to client documentation, agency records or other essential health documents;

(C) In signing any report or record as a dentist; or

(D) In submitting any information to the Board;

(x) Failure of a dentist to verify that all staff employed by the dentist or individuals contracted with the dentists, are licensed or certified by the Board to perform all tasks requiring licensure or certification before such tasks are performed at the direction of the dentist;

(xi) Directing or permitting any staff member to perform any procedure for which they are not licensed, certified, or competent;

(xii) Performing any act or gesture which, from the standpoint of the patient, exploits the patient's trust between the patient and the patient's dentist. Such acts may include intimate or sexual advances, intimate or sexual contact, or the use of any unnecessary sedative substance without explicit written consent by the patient;

(xiii) Performing any study or research without following standardized protocols for the research, including obtaining written and informed consent by the patient for any study;

(xiv) Failure to maintain current BLS certification;

(xv) Reprimand or other disciplinary action imposed by any academic institution or professional organization for cheating or plagiarizing;

(xvi) Financial insolvency which may jeopardize the efficacy of treatment or appropriate standard of care provided to patients;

(xvii) Violation of any order, term, restriction, or condition imposed by the Board; or

(xviii) Failure to conform with any provision of the ADA Principles of Ethics and Code of Professional Conduct, ADHA Bylaws and Code of Ethics, Dental Assisting National Board's Code of Professional Conduct, ~~or~~ the Centers for Disease Control's Summary of Infection Prevention Practices in Dental Settings, or the Centers for Disease Control's Guideline for Prescribing Opioids for Chronic Pain as referenced in Chapter 1.

Section 4. Application Review and Investigation Process.

(a) Application Review.

(i) Every application for a license or permit issued by the Board shall be subject to investigation to determine whether the requirements set forth in the Act and Board Rules are satisfied.

(ii) If any application, including renewals, reveals any information that merits further investigation, the matter shall be assigned to the ARC.

(b) ARC Action. The ARC may recommend:

(i) A license or permit be issued, renewed, relicensed, or reinstated;

(ii) A license be issued, renewed, relicensed, or reinstated subject to conditions, restrictions, or other disciplinary action;

(iii) Approval of a settlement agreement, which may include the issuance of a license or renewal with the imposition of restrictions, conditions, reprimand, or a combination thereof; or

(iv) Denial of the application.

(c) Notice of Intent. The ARC shall notify the applicant of its intent to recommend:

(i) Issuance of a license subject to conditions, restrictions, other disciplinary action; or

(ii) Denial of a license.

(d) The Notice of Intent shall contain:

(i) A brief description of the facts or conduct that warrant denial or issuance of a license subject to conditions, restrictions, other disciplinary action;

(ii) A statement of the nature of the actions which warrant denial or issuance of a license subject to conditions, restrictions, other disciplinary action and a citation to the applicable statutory provisions or Board Rules involved;

(iii) An opportunity to show compliance with all lawful requirements for retention of the license or respond within fifteen (15) days from the date of mailing; and

(iv) Notice of the right to a hearing if a written request is received in the Board office within thirty (30) days of the date of mailing the notice of intent.

(e) Applicant's Response to Notice of Intent. Within thirty (30) days of the date of the Notice of Intent, the applicant shall submit a written request to the Board office to:

(i) Hold a hearing on the ARC's recommendation;

(ii) Table consideration of the application; or

(iii) Withdraw the application.

(f) Applicant's Failure to Respond to Notice of Intent. If the applicant fails to timely respond to the Notice of Intent, the Board shall dismiss the application.

Section 5. Petition for Modification of Conditions or Restrictions.

(a) Petition for Modification of Conditions or Restrictions.

(i) A licensee may petition the Board for modification of the conditions or restrictions imposed upon their license.

(ii) A licensee shall submit a written petition for modification to the Board office. The petition for modification shall include documentation demonstrating:

(A) Compliance with a previously entered Board order;

(B) That the modification is consistent with their treatment place, if applicable; and

(C) That the modification is sufficient to ensure the public is adequately protected.

(b) Investigative Committee Action. A petition for modification shall be reviewed by the IC.

(i) If the IC agrees with the requested modification, the parties may file a stipulated motion with the Board.

(ii) If the IC does not agree with the requested modification, the IC shall notify the licensee of its intent to recommend denial of the petition.

(c) Board Consideration.

(i) The Board shall consider the petition, the IC's recommendation, and/or a stipulated motion at its earliest convenience.

(ii) The Board may approve or deny the petition for modification.

Section 6. Complaint Review and Disciplinary Investigation Process.

(a) Complaint Review. Every complaint submitted to the Board or initiated on behalf of the Board shall be investigated by an IC.

(b) Investigative Committee Action. The IC may recommend:

(i) Dismissal of a complaint;

(ii) Issuance of an advisory letter;

(iii) Approval of a settlement agreement, which may include voluntary surrender, suspension, imposition of restrictions or conditions, reprimand, or other discipline;

(iv) Disciplinary action against the licensee including revocation, suspension, reprimand, restrictions or conditions, or other discipline;

(v) Summary suspension; or

(vi) Approval of a voluntary surrender.

Section 7. Summary Suspension.

(a) Recommendation. If the IC recommends summary suspension, the Board shall conduct an expedited proceeding to determine whether the licensee's continued practice imperatively requires emergency action to protect the public health, safety or welfare.

(b) Notice of Intent to Recommend Summary Suspension.

(i) The IC shall notify the licensee of its intent to recommend summary suspension;

(ii) The Notice of Intent shall contain:

(A) Copy of the complaint; and

(B) Notice that an expedited summary suspension proceeding shall be set at the earliest opportunity a quorum of Board members may be assembled;

(c) Notice of Expedited Proceeding. Upon confirmation of the date and time of the expedited proceeding, the IC shall notify the licensee in writing of the date and time of the proceeding.

(d) Scope of Expedited Proceeding. The scope of the expedited summary suspension proceeding shall be limited to a presentation of the evidence the IC believes warrants summary suspension and any information the licensee may present on his or her behalf. The board shall order summary suspension if it concludes probable cause exists that the allegations, if proven, would imperatively require emergency action to protect the public health, safety, or welfare. The board shall incorporate a finding to that effect in its order granting summary suspension.

Section 8. Voluntary Surrender.

(a) A licensee may petition the Board, in writing, to voluntarily surrender their license in lieu of discipline.

(b) The Board shall consider the petition at its earliest convenience.

(c) The Board may consider whether the licensee is under investigation and may approve or deny the petition.

Section 9. Formal Proceedings for Disciplinary Action.

(a) Notice of Intent to Recommend Disciplinary Action.

(i) The IC shall notify the licensee of its intent to recommend disciplinary action.

(ii) The Notice of Intent shall:

(A) Include a brief description of the facts or conduct that warrants the intended action; and

(B) Provide the licensee an opportunity to show compliance or respond to the allegations for disciplinary action within fifteen (15) days of the date of mailing.

Section 10. Petition.

(a) The IC shall initiate formal proceedings for disciplinary action by filing a Petition with the Board office and serving a copy upon the licensee to the last known address of the licensee by regular U.S. mail.

(b) Failure to respond to the Petition within twenty (20) days of the filing with the Board office may result in a default judgment.

Section 11. Notice of Hearing.

(a) Timing of Hearing. Upon receipt of a written request for hearing from an applicant or filing of a Petition, the Board shall conduct a hearing. Board staff shall serve a Notice of Hearing on the applicant or licensee at least thirty (30) days prior to the hearing.

(b) Notice of Hearing. The notice of hearing shall contain:

(i) The name and last known address of the applicant or licensee;

(ii) A brief statement of the matters asserted:

(A) In application matters, the recommendation, the facts upon which the recommendation is based, and the statutory provisions or Board Rules the applicant is alleged to have violated; or

(B) In disciplinary matters, the nature of the Petition, the facts upon which the Petition is based, and the statutory provisions or Board Rules the licensee is alleged to have violated.

(iii) The time, place, and nature of the hearing;

(iv) The legal authority and jurisdiction; and

(v) A statement indicating that:

(A) The applicant's failure to appear at a noticed hearing or pursue proceedings may result in a dismissal; or

(B) The licensee's failure to answer the allegations contained in the Petition within twenty (20) days of the date of mailing and failure to appear at a noticed hearing may result in a default judgment.

Section 12. Lawful Service. There shall be a presumption of lawful service of a petition, notice of hearing, or any other communication required by these Board Rules if sent to the last known address.

Section 13. Dismissal or Default.

(a) The Board may dismiss an application where the applicant or the applicant's representative has not requested a hearing or appeared at a noticed hearing.

(b) The Board may enter an order of default judgment based on the allegations contained in the Petition in any case where the licensee or the licensee's representative has not answered the Petition and has not appeared at a noticed hearing.

Section 14. Contested Case. The hearing officer shall preside over the formal contested case hearing which shall be conducted pursuant to the WAPA and the Office of Administrative Hearings' rules concerning contested case proceedings as referenced in Chapter 1.

Section 15. Burden and Standard of Proof.

(a) Application Matters. The applicant shall bear the burden to prove by a preponderance of the evidence, that he or she meets the qualifications for licensure. The burden shall shift to the ARC to prove by clear and convincing evidence, that the applicant should be denied a license. The burden shall shift back to the applicant to persuade the Board that the ARC's grounds for denial or issuance of a license subject to conditions or restrictions are insufficient.

(b) Disciplinary Matters. The IC shall bear the burden to prove by clear and convincing evidence that the licensee violated the Act, Board Rules, or both.

(c) Petition for Modification Matters. The Board shall grant petitions for modification of conditions in its own discretion.

Section 16. Board Decision and Order.

(a) Board Action. The Board may resolve an application matter, complaint, or Petition by:

(i) Approving the recommendations of the IC or ARC;

(ii) Dismissing a complaint;

(iii) Issuing an advisory letter;

(iv) Ruling in favor of a party on a dispositive motion;

(v) Conducting a contested case hearing. Following the hearing and deliberation of all evidence admitted at a contested case hearing, the Board may:

(A) Issue, renew, relicense, or reinstate a license;

(B) Issue, renew, relicense, or reinstate a license with conditions, restrictions, or other disciplinary action;

(C) Deny a license, renewal, relicense, or reinstatement;

(D) Dismiss the complaint or Petition;

(E) Dismiss the complaint or Petition with an advisory letter; or

(F) Impose a reprimand, conditions, restrictions, suspension, revocation, other discipline, or a combination thereof.

(b) Board Order. The Board shall issue a written decision and order. The decision and order shall be sent to the applicant, licensee, or their representatives by regular mail.

Section 12. Appeals.

(a) Appeals from decisions of the Board are governed by the WAPA and the Wyoming Rules of Appellate Procedure.

(b) Costs of transcripts and any reasonable costs assessed by the Board regarding the record on appeal shall be borne by the party making the appeal.

CHAPTER 10

FEES

Section 1. Authority. The Board is authorized under Wyoming Statute 33-15-106 and the WAPA to promulgate rules and regulations related to the establishment of fees for issuance of licenses and administration of examinations in Wyoming.

Section 2. Statement of Purpose. These Board Rules are adopted to implement the Board's authority to determine and collect reasonable fees.

Section 3. General Information.

(a) Fees shall be payable in the exact amount and shall be paid in advance of the services rendered.

(b) All fees collected by the Board are non-refundable.

(c) Fees related to public records requests shall be assessed pursuant to the Department of Administration and Information's rules concerning public records.

Section 4. Fees. Services for which the Board charges a fee shall include, but not be limited to, the following fee schedule:

(a) Dentists:

(i)	Application for Licensure by Examination	$300
(ii)	Application for Licensure by Endorsement	$750
(iii)	Biennial License Renewal	$350
(iv)	Late License Renewal (Jan 1 – Mar 31)	$370
(v)	Relicensure	$370
(vi)	Reinstatement	$750

(b) Sedation Permit Holders:

(i)	Application for Moderate Sedation Permit	$500
(ii)	Application for Deep Sedation/General Anesthesia Permit	$500
(iii)	Application for Facility Permit	$25

	(iv)	Biennial Moderate or Deep Sedation/General Anesthesia Permit Renewal	$475
	(v)	Biennial Facility Permit Renewal	$50
	(vi)	Sedation Permit Reinstatement	$500
(c)	Dental Hygienists:		
	(i)	Application for Licensure by Examination	$150
	(ii)	Application for Licensure by Endorsement	$200
	(iii)	Applications for Dental Hygiene Expanded Functions	$30
	(iv)	Biennial License Renewal (including functions)	$170
	(v)	Late License Renewal (Jan 1 – Mar 31)	$190
	(vi)	Relicensure	$190
	(vii)	Reinstatement	$200
(d)	Dental Assistants:		
	(i)	Application for Radiograph Permit	$30
	(ii)	Application for Pit and Fissure Permit	$30
	(iii)	Biennial Radiograph Permit Renewal	$20
	(iv)	Biennial Pit and Fissure Permit Renewal	$20
	(v)	Late Permit Renewal	$15
(e)	Other Fees:		
	(i)	License or Permit Verification	$25
	(ii)	Replacement Document	$25
	(iii)	Non-Sufficient Fund Fee	$30

CHAPTER 1

GENERAL PROVISIONS

Section 1. Authority. These Board Rules are adopted to implement the Board's authority under ~~the Act~~ Wyoming Statute 33-15-108(g) and 16-3-103(j)~~the WAPA~~ as it relates to the licensure and discipline of dentists and dental hygienists and regulation of the practice of dentistry and dental hygiene in Wyoming.

Section 2. Statement of Purpose. These Board Rules are adopted to implement the Board's authority to establish administrative procedures.

Section 3. Definitions.

(a) "Act" means the Wyoming Dental Practice Act, W.~~yoming~~ S.~~tatute~~ 33-15-101 through -133.

(b) "ADA" means American Dental Association.

(c) "ADHA" means American Dental ~~Hygiene~~Hygienists' Association.

(d) "Advertising" means a communication to the public about a dentist or services offered by a dentist.

(e) "ARC" means Application Review Committee.

(f) "BLS" means basic life support for healthcare providers.

(g) "Board Rules" means the administrative rules and regulations promulgated by the Board.

~~(h) "CDCA" means Commission on Dental Competency Assessments (formerly North East Regional Board).~~

(h)~~(i)~~ "CE" means continuing education.

~~(j) "CITA" means Council of Interstate Testing Agencies.~~

(i)~~(k)~~ "CODA" means Commission on Dental Accreditation.

~~(l) "CPR" means Cardiopulmonary Resuscitation.~~

~~(m) "CRDTS" means Central Regional Dental Testing Service.~~

(j)~~(n)~~ "DANB" means Dental Assisting National Board.

(k)~~(o)~~ "DC" means Disciplinary Committee.

(l)~~(p)~~ "Dentist-Patient Relationship" means a formal inferred relationship between the dentist and a patient of record, which is established once the dentist assumes or undertakes the dental care or treatment of a patient in the state where the patient resides. A dentist-patient relationship is assumed to have been created after there is a physical examination of a patient (e.g., when a patient is seen in a dentist's office), but is not assumed in others (e.g., when a dentist performs a physical examination as a health screening procedure at a health fair event).

(m)~~(q)~~ "EKG" means Electrocardiogram.

(n)~~(r)~~ "Hands on" means involving or offering active participation rather than theory.

(o)~~(s)~~ "INBDE" means Integrated National Board Dental Examination.

(p)~~(t)~~ "NBDHE" means National Board Dental Hygiene Examination.

~~(u) "PBIS" means Professional Background Information Service.~~

~~(v) "SRTA" means Southern Regional Testing Agency.~~

(q)~~(w)~~ "Supervision" of dental auxiliary means the act of overseeing or directing duties performed by a dental auxiliary. Types of supervision may include:

(i) "General Supervision" of a dental auxiliary means that a dentist has diagnosed and authorized the procedures which are being carried out; however, a dentist need not be present when the authorized procedures are being performed;

(ii) "Direct Supervision" of a dental auxiliary means that a dentist is physically present in the dental office, a dentist has diagnosed the condition to be treated, a dentist has authorized the procedure to be performed, and before dismissal of the patient, a dentist has approved the work performed by the auxiliary; or

(iii) "Indirect Supervision" of a dental auxiliary means that a dentist is physically present in the dental office, a dentist has diagnosed the condition to be treated, and a dentist has authorized the procedure to be performed.

(r) "Teledentistry" means the use of data transmitted through interactive audio/video or data communications either by synchronous or asynchronous technology for the purposes of examination, diagnosis, treatment planning, consultation or directing the delivery of treatment by dentists and dental auxiliary in settings permissible and consistent with the rules of supervision. Teledentistry service may include telephone, electronic mail message, or facsimile transmitting, or online tool.

(i) Synchronous technology: secure two-way audio/visual technology that allows a dentist and dental auxiliary to see and communicate in real time with a patient who is located in a different physical location.

(ii) Asynchronous technology: the transmission of recorded health information (radiographs, photographs, video and other digital media) through a secure electronic communications system to a dentist and dental auxiliary who uses the information to evaluate a patient's condition or render a service outside of a real-time or live interaction.

(s)~~(x)~~ "WAPA" means Wyoming Administrative Procedure Act, W.S. 16-3-101 through 115.

~~(y) "WREB" means Western Regional Examining Board.~~

Section 4. Board Office. The Board Office shall be located at 2001 Capitol Avenue, Cheyenne, Wyoming.

Section 5. Board Meetings. The Board shall set its regular meetings by resolution.

Section 6. Reference by Incorporation.

(a) Each rule and code incorporated by reference is further identified as follows:

(i) Principles of Ethics and Code of Professional Conduct, excluding Principles 5.H. and 5.I., adopted by the ADA and revised November ~~2016~~2018, found at: ~~http://dental.wyo.gov/board/rules~~https://dental.wyo.gov/rules.

(ii) Bylaws and Code of Ethics, adopted by the ADHA and effective on ~~June 13, 2016~~June 2020, found at: ~~http://dental.wyo.gov/board/rules~~https://dental.wyo.gov/rules.

(iii) Dental Assisting National Board's Code of Professional Conduct, adopted by the DANB and revised ~~April 2015~~February 2018, found at: ~~http://dental.wyo.gov/board/rules~~https://dental.wyo.gov/rules.

(iv) Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care, adopted by the Centers for Disease Control and Prevention and revised ~~March 2016~~October 2016, found at: ~~http://dental.wyo.gov/board/rules~~https://dental.wyo.gov/rules.

(v) Centers for Disease Control Guideline for Prescribing Opioids for Chronic Pain - United States, 2016, adopted by the Centers for Disease Control and Prevention and effective March 18, 2016, found at: http://dental.wyo.gov/rules.

(vi)~~(v)~~ Chapter 2 - Uniform Rules for Contested Case Practice and Procedure, adopted by the Office of Administrative Hearings and effective on ~~October 17, 2014~~July 20, 2017, found at: ~~http://dental.wyo.gov/board/rules~~https://dental.wyo.gov/rules.

(vii)~~(vi)~~ Chapter 2 - Uniform Procedures, Fees, Costs, and Charges for Inspection, Copying, and Producing Public Records, adopted by the Department of Administration and Information and effective on September 6, 2016, found at ~~http://dental.wyo.gov/board/rules~~https://dental.wyo.gov/rules.

(b) For these rules incorporated by reference:

(i) The Board has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules;

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (a) of this section; and

(iii) The incorporated rules are maintained at the Board Office and are available for public inspection and copying at cost at the same location.

Section 7. Public Records Inspection. Public records inspections shall be conducted pursuant to the Department of Administration and Information's rules concerning public records.

Section 8. Change of Name, Address, or Telephone Number. Each applicant and licensee shall notify the Board in writing of any change to their legal name, home address, business address, e-mail address, or telephone number within thirty (30) days of the change.

CHAPTER 3

REQUIREMENTS FOR LICENSURE AND RENEWAL

Section 1. Authority. The Board is authorized under Wyoming Statute 33-15-108(g) and 33-15-120(e) to promulgate rules and regulations related to the application, licensure, and renewal procedures to dentistry and dental hygiene in Wyoming.

Section 21. Statement of Purpose. These Board Rules are adopted to implement the Board's authority to establish the requirements for licensure, annual license renewal, and volunteer licensescertificates.

Section 32. Application Status.

(a) For those applicants seeking licensure, competency shall be met during the timeframe identified immediately prior to submitting a completed application.

(b) Applications shall be deemed "complete" when all necessary documentation has been received by the Board office.

(c) Applications shall expire one (1) year after submission. If an application expires, an applicant shall submit a new application, including payment of fee.

Section 43. ARC Review of Applications.

(a) An applicant for licensure or certification shall have committed no acts that are grounds for disciplinary action, or if an act was committed, the ARC has found after investigation that sufficient restitution has been made and the applicant no longer presents a threat to the public safety.

(b) If the ARC questions an applicant's competency, the ARC may request an applicant complete a regional clinical examination or other program.

Section 54. Jurisprudence Examination.

(a) The Board shall issue a dental or dental hygiene license to any applicant who meets the qualifications for licensure identified in Sections 5, 6, 7, 8, 9, and 1314 and successfully passes the jurisprudence examination.

(b) The ARC shall recommend eligibility to sit for the jurisprudence examination.

(b)(c) To successfully pass the jurisprudence examination, the applicant shall score at least an 75%80% on the exam.

(c) Applicants that fail the examination shall wait one (1) week to retest.

Section 6~~5~~. Dental Licensure by Examination.

(a) Eligibility. ~~An applicant may seek dental licensure by examination if the applicant graduated from a CODA accredited U.S. or Canadian Dental School within twelve (12) months.~~ An applicant may seek initial licensure if the applicant is not licensed to practice in another jurisdiction, or if licensed in another jurisdiction but that jurisdiction's licensure requirements are not equivalent to Wyoming, or if the applicant fails to meet other licensure methods.

(b) Application Requirements. Applicant shall:

(i) Submit a completed application and payment of fee;

(ii) Submit current certification in BLS;

(iii) Request official transcripts from a CODA accredited dental program;

(iv)~~(ii)~~ Request score reports documenting successful passage of~~Successfully pass~~ the INDBE~~NBDE~~;

(v)~~(iii)~~ Request score reports documenting successful passage of~~Successfully pass~~ a regional clinical examination that indicates competency in:

(A) Endodontics, including access opening of a posterior tooth and access, canal instrumentation and obturation of an anterior tooth;

(B) Fixed Prosthodontics, including ~~one of the following:~~

~~(I) A~~a full crown procedure~~;~~ and a separate bridge with two (2) abutment preparations.

~~(II) An indirect cast class II inlay;~~

~~(III) An indirect cast class II onlay; or~~

~~(IV) Cast 3/4 crown.~~

(C) Periodontics, including scaling ~~and root planing~~ on a patient in a clinical setting; and

(D) Restorative Dentistry, including a class II amalgam or composite preparation and restoration and a class III composite preparation and restoration on a patient in a clinical setting.

~~(I)~~ Slot preps shall not be accepted.

~~(II) If an indirect inlay, onlay, or 3/4 crown procedure is done on a patient, the applicant shall be required to perform one (1) additional restorative procedure as listed above.~~

(vi) If an applicant has been out of clinical practice for more than one (1) year, the applicant shall submit the following evidence to demonstrate competency:

(A) Graduation from a CODA accredited dental program in the preceding twelve (12) months; or

(B) Successful completion of a regional clinical examination that meets the criteria in Section 6(b)(v) within the preceding five (5) years and completion of eight (8) hours hands-on clinical CE for each year out of clinical practice. The CE must be earned from a CODA accredited dental program or pre-approved by the ARC prior to completion.

Section 7~~6~~. Dental Licensure by Endorsement.

(a) Eligibility. An applicant may seek dental licensure by endorsement if the applicant has a license in good standing in another jurisdiction with licensure requirements equivalent to~~as stringent as~~ Wyoming's requirements.

(b) Application Requirements. Applicant shall:

(i) Submit a completed application and payment of fee;

(ii) Submit current certification in BLS;

(iii)~~(ii)~~ Submit evidence demonstrating completion of ~~Complete~~ requirements identified in Section 6(b)(iv) and (v)~~5(b)(ii) and (iii)~~. If applicant successfully passed a regional clinical examination as identified in Section 6(b)(v)~~5(b)(iii)~~ which did not include a fixed prosthodontics component, applicant shall submit evidence of active clinical practice of 5,000 hours in the last five (5) years or verification of completion of a general practice residency (GPR), advanced education in general dentistry (AEGD), or other specialty practice residency as identified in Chapter 6;

~~(iii) Submit a completed application to PBIS and authorize PBIS to report to the Board; and~~

(iv) Request verification of an active license in another jurisdiction;

(v) Submit a copy of the diploma from a CODA accredited program; and

(vi)~~(iv)~~ If an applicant has been out of clinical practice for less than five (5) years, the applicant shall submit the following evidence to demonstrate competency:

(A) Active clinical practice of 1,000 hours in the last twelve (12) months;

(B) Successful completion of a regional clinical examination that meets the criteria in Section 6(b)(v) within twelve (12) months; or

(C) Completion of eight (8)~~ten (10)~~ hours of hands-on clinical continuing education for each year not actively practicing. The CE must be earned from a CODA accredited dental program or pre-approved by the ARC prior to completion.

(vii)~~(v)~~ If an applicant has been out of active clinical practice for more than five (5) years, the applicant shall submit the following evidence to demonstrate competency:

(A) Successful completion of a regional clinical examination within twelve (12) months; and

(B) Completion of eight (8)~~ten (10)~~ hours of hands-on clinical continuing education for each year not actively practicing. The CE must be earned from a CODA accredited dental program or pre-approved by the ARC prior to completion.

Section 8~~7~~. Dental Hygiene Licensure by Examination.

(a) Eligibility. ~~An applicant may seek dental hygiene licensure by examination if the applicant graduated from a CODA accredited U.S. or Canadian Dental Hygiene School or program within twelve (12) months.~~ An applicant may seek initial licensure if the applicant is not licensed to practice in another jurisdiction, or if licensed in another jurisdiction but that jurisdiction's licensure requirements are not equivalent to Wyoming, or if the applicant fails to meet other licensure methods.

(b) Application Requirements. Applicant shall:

(i) Submit a completed application and payment of fee~~s~~;

(ii) Submit current certification in BLS;

(iii) Request official transcripts from a CODA accredited program;

(iv)~~(ii)~~ Request score reports documenting successful passage of~~Successfully pass~~ the NBDHE; and

(v)~~(iii)~~ Request score reports documenting successful passage of a patient-based clinical licensure examination~~Successfully pass the CRDTS, WREB, CDCA, CITA, or SRTA exam~~.

(vi) If an applicant has been out of clinical practice for more than one (1) year, the applicant shall submit the following evidence to demonstrate competency:

(A) Graduation from a CODA accredited program in the preceding twelve (12) months; or

(B) Successful completion of a regional clinical examination that meets the criteria in Section 8(b)(v) within the preceding five (5) years and completion of eight (8) hours hands-on clinical CE for each year out of clinical practice. The CE must be earned from a CODA accredited dental hygiene program or pre-approved by the ARC prior to completion.

Section 9~~8~~. Dental Hygiene Licensure by Endorsement.

(a) Eligibility. An applicant may seek dental hygiene licensure by endorsement if the applicant has a license in good standing in another jurisdiction with licensure requirements equivalent to~~as stringent as~~ Wyoming's requirements.

(b) Application Requirements. Applicant shall:

(i) Submit a completed application and payment of fee;

(ii) Submit current certification in BLS;

~~(ii) Submit a completed application to PBIS and authorize PBIS to report to the Board; and~~

(iii) Submit evidence demonstrating completion of requirements identified in Section 8(b)(iv) and (v);

(iv) Submit verification of an active license in another jurisdiction;

(v) Submit a copy of the diploma from a CODA accredited program; and

(vi)~~(iii)~~If an applicant has been out of active clinical practice for less than five (5) years, the applicant shall submit the following evidence to demonstrate competency:

(A) Active clinical practice of 800 hours in the last twelve (12) months;

(B) Successful completion of a regional clinical examination that meets the criteria in Section 8(b)(v) within twelve (12) months; or

(C) Completion of eight (8)~~ten (10)~~ hours of hands-on continuing education for each year not actively practicing. The CE must be earned from a CODA accredited dental hygiene program or pre-approved by the ARC prior to completion.

(vii)~~(iv)~~ If an applicant has been out of clinical practice for more than five (5) years, the applicant shall submit the following evidence to demonstrate competency:

(A) Successful completion of a regional clinical examination that meets the criteria in Section 8(b)(v) within twelve (12) months; and

(B) Completion of eight (8)~~ten (10)~~ hours of hands-on clinical continuing education for each year not actively practicing. The CE must be earned from a CODA accredited dental hygiene program or pre-approved by the ARC prior to completion.

Section 10~~9~~. Annual Licensure Renewal.

(a) Expiration.

(i) All dental and dental hygiene licenses shall expire December 31 of every second~~each~~ year.

(ii) Unless a licensee timely renews their license, the licensee shall not practice after their expiration date~~December 31~~.

(b) Renewal Application. A dental or dental hygiene licensee seeking renewal shall:

(i) Submit a completed renewal application and payment of fee;

(ii) Verify current certification in BLS; and

(iii) Acquire sixteen (16) hours of CE that complies with Section 11~~10~~.

(iv) Verify active clinical practice within the preceding five (5) years.

(c) Competency Requirement. After five (5) years of inactive clinical practice, an applicant shall demonstrate competency by successful completion of regional clinical examination that meets the requirements in Section 6(b)(v) for dentists and Section 8(b)(v) for dental hygienists ~~or apply for a non-clinical license~~.

Section 11~~10~~. Continuing Education Requirements.

(a) Renewal Period. CE shall be obtained January 1 of even years through December 31 of odd years. The first CE period begins on January 1st following the date the license was issued.

(i) For a new hygienist with a license issued in an even year, the licensee shall submit eight (8) hours of CE.

(ii) For a new dentist with a license issued in an even year, the licensee shall submit eight (8) hours of CE, three (3) of which must be related to the responsible prescribing of controlled substances.

(b) CE Content.

(i) The subject matter shall relate directly to the professional competence of the licensee or patient care rendered by the licensee. Acceptable CE subjects include, but are not limited to, the following clinical subjects relating to the dental profession: oral surgery, operative dentistry, oral pathology, preventive dentistry, orthodontics, clinical patient management, pediatric dentistry, oral biology, periodontics, prosthodontics, dental materials, implantology, radiology, infection control, endodontics, management of medical emergencies, dental anesthesiology, professional ethics, and pharmacology.

(ii) Unacceptable subjects include, but are not limited to, practice building and business management courses.

(iii) CE may be acquired in any jurisdiction.

(iv) CE earned in excess of the sixteen (16) hours required for renewal may not be carried forward to apply toward the next renewal period.

(c) Of the required sixteen (16) hours, a dentist shall obtain three (3) hours of CE related to the responsible prescribing of controlled substances every two (2) years. This requirement shall not apply to dental hygienists.

(d) Waiver. The Board may grant a waiver for CE requirements to licensees who have petitioned and demonstrated just cause based on extenuating circumstances.

(e) CE Audit.

(i) The licensee shall maintain evidence of CE compliance for at least four (4) years after the renewal period in which the course was applied.

(ii) Failure to provide the documents requested for audit within thirty (30) days may subject the licensee to disciplinary action.

(iii) If the Board disallows any CE, the licensee shall have one hundred twenty (120) days from notice of such disallowance to:

(A) Provide evidence that the disallowed CE meet the criteria established by these rules;

(B) Provide documentation of having acquired additional CE during the required time frame; or

(C) Resolve~~Cure~~ the disallowance by acquiring the required number of CE.

(D) Any CE activity completed past the renewal date to resolve~~cure~~ a disallowance may not be reported on subsequent applications for license renewal.

(iv) If a licensee fails to complete the required number of CE, the licensee shall be subject to disciplinary action.

Section 12~~11~~. Failure to Timely Renew.

(a) Unlicensed Practice. Failure to timely renew may subject the licensee to disciplinary action for unlicensed practice.

(b) Administrative Grace Period.

(i) The administrative grace period shall be from January 1st to March 31st following the renewal period~~annually~~.

(ii) Licensees who failed to timely renew may apply for renewal during the administrative grace period. However, licensees shall not practice until the Board approves their license.

(iii) Licensees who failed to timely renew shall:

(A) Submit a completed renewal application and payment of fee; ~~and~~

(B) Verify current certification in BLS~~.~~; and

(C) Complete CE that meets the requirements in Section 11.

(iv) On April 1st following the renewal period, any license not renewed shall lapse.

Section 13~~12~~. Lapsed License.

(a) If a dental license lapses, the dentist shall apply for relicensure.

(b) If a dental hygiene license lapses, the dental hygienist may restore their lapsed license until December 31st of the year the license lapsed. After December 31st, the dental hygienist shall apply for relicensure.

Section 14~~13~~. Dental and Dental Hygiene Relicensure.

(a) Eligibility. An applicant may seek dental or dental hygiene relicensure if the applicant has been licensed in Wyoming and allowed his or her license to lapse.

(b) Application Requirements. Applicant shall:

(i) Submit a completed relicensure application and payment of fee;

(ii) Verify current certification in BLS; ~~and~~

(iii) Submit eight (8) hours CE for each year the license has lapsed; and

(iv) Successfully pass the jurisprudence examination.

(c) Competency Requirement for Return to Practice. An applicant applying for relicensure who has not actively practiced in five (5) years shall also demonstrate competency by:

(i) Successful completion of a regional clinical examination per Section 6(b)(v) for dentists and Section 8(b)(v) for hygienists within twelve (12) months; and

(ii) Submitting evidence of completion of eight (8)~~ten (10)~~ hours of hands-on clinical continuing education for each year not actively practicing. The CE must be earned from a CODA accredited dental program or pre-approved by the ARC prior to completion.

Section 15~~14~~. Reinstatement.

(a) Eligibility. An applicant may seek to have his or her dental or dental hygiene license reinstated if the applicant's Wyoming dental or dental hygiene license has been revoked, surrendered, suspended, conditioned, or restricted.

(b) Application Requirements. Applicant shall:

(i) Submit a completed application and payment of fee;

(ii) Verify current certification in BLS;

(iii) Submit evidence of complying with the requirements of a previous Board order;

(iv) Submit evidence of applicant's ability to safely and competently practice; and

(v) Submit evidence demonstrating just cause for reinstatement.

~~**Section 15. Non-Clinical Licensure.**~~

~~(a) Eligibility. An applicant that currently holds or has previously held a license in good standing to practice dentistry may seek a non-clinical license if the applicant does not engage in active clinical practice. This limited license is intended for those applicants teaching, examining, consulting, reviewing, engaging in administrative oversight, or those who do not intend to practice clinical dentistry.~~

~~(b) Application Requirements. Applicant shall:~~

~~(i) Submit a completed application and payment of fee; and~~

~~(ii) Submit a personal statement describing applicant's intended non-clinical practice.~~

~~(c) Renewal Application. A non-clinical licensee seeking renewal shall submit a completed renewal application and payment of fee.~~

~~(d) Reactivation. To reactivate a non-clinical license, the licensee shall:~~

~~(i) Submit a completed application and payment of fee;~~

~~(ii) Verify current certification in BLS;~~

~~(iii) Successfully pass the jurisprudence examination; and~~

~~(iv) Demonstrate competency by:~~

~~(A) Successful completion of a regional clinical examination within twelve (12) months; and~~

~~(B) Submitting evidence of completion of ten (10) hours of hands-on clinical continuing education for each year not actively practicing.~~

Section 16. Volunteer's License~~Certificate~~. Any applicant that meets the qualifications under W.~~yoming~~ S.~~tatute~~ 33-15-131 shall submit a completed application.

Section 17. Temporary Educator's License. Any applicant that meets the qualifications under W.S. 33-15-133 shall submit a completed application.

CHAPTER 4

DENTAL PRACTICE

Section 1. Authority. The Board is authorized under Wyoming Statutes 33-1-303(a)(iv), 33-15-108(h), and 33-15-130 to promulgate rules and regulations related to telemedicine and x-ray machine inspection procedures in Wyoming.

Section 2~~1~~. Statement of Purpose. These Board Rules are adopted to implement the Board's authority to regulate the practice of dentistry in Wyoming.

Section 3~~2~~. ~~Practice of Dentistry~~Teledentistry.

~~(a) The dentist shall:~~

~~(i) Be responsible for the quality of dentistry performed in his or her office, regardless of whether it is performed by him or her personally or by auxiliaries working under his or her supervision;~~

~~(ii) Be responsible for maintaining a high level of proficiency in the practice of dentistry and for keeping up with current educational standards of the profession;~~

~~(iii) Report gross and/or recurring improprieties to the proper board or agency; and~~

~~(iv) Notify the Board of any disease or condition that adversely affects his or her practice.~~

(a)~~(b)~~ The practice of dentistry occurs where the patient is located ~~or receives services~~. Where an existing dentist-patient relationship is not present, a licensee must take appropriate steps to establish a dentist-patient relationship in utilizing teledentistry services that is consistent with the prevailing standard of care.

(b) Before rendering dental advice or care using teledentistry services, the licensee shall:

(i) Verify and authenticate the location and to the extent possible, confirm the identity and contact information of the requesting patient.

(ii) Disclose and validate the licensee's identity, credentials and contact information.

(iii) Obtain appropriate written treatment consent from the requesting patient.

(iv) Obtain patient's medical and dental health history.

(v) Detail security measures taken as well as potential risks to privacy and the loss of information due to technical failures.

(vi) Determine if the condition being diagnosed or treated is appropriate for teledentistry.

(vii) Determine appropriate treatment and follow up care if needed.

(c) Dental Records. Any dental record made through the use of teledentistry shall be consistent with the same record retention standards as a record made through a traditional, in person dental encounter.

(d) Confidentiality. The licensee shall ensure that any electronic and digital communication used in the practice of teledentistry is secure to maintain the confidentiality of the patient's medical/dental information as required by the Health Insurance Portability and Accountability Act of 1996 including the retention and disposal of electronic and digital equipment and data.

(e) Violation of any provision above shall be considered "unprofessional conduct" within the meaning of Chapter 9 and shall constitute grounds for disciplinary action by the Board.

Section 4~~3~~. Satellite Offices. ~~A dentist shall designate his or her main office. All other offices shall be deemed satellite offices and shall abide by the same rules and regulations as the main office.~~ Licensees using satellite offices shall ensure all offices maintain the appropriate standard of care.

Section 5~~4~~. Radiograph Use. Inspections of ~~dental~~ x-ray machines are required as follows:

~~(a) Inspector shall submit a completed application.~~

~~(b) All dental x-ray machines shall be inspected by a Board approved inspector every five (5) years. The dentist shall be responsible to contract directly with an approved inspector.~~

~~(c) The inspector shall submit to the Board the pass/fail results of all equipment inspected. The Board shall issue a dated sticker for units have passed the safety inspection. The dentist shall provide the Board a copy of the work order showing satisfactory repair completed on any equipment failing inspection.~~

(a) Inspectors. Any individual who performs x-ray machine assembly, installation or service shall meet the following educational and experience requirements:

(i) Completion of a structured educational program that includes training in radiation machine safety, assembly, installation and service, including, but not limited to:

(A) A baccalaureate degree in electrical engineering with specialized training in radiation producing devices;

(B) A one-year associate degree in biomedical equipment repair;

(C) Equivalent manufacturer, military or other technical school training; and

(ii) At least six (6) months of supervised, documented training on inspection and calibration of the applicable x-ray machine.

(b) Inspections. Inspections of x-ray equipment shall be conducted in accordance with relevant national standards. All machines shall be inspected at the time of installation and thereafter every five (5) years for x-ray machines and every three (3) years for computed tomography machines.

(c) Waiver. Licensees may be granted a six (6) month waiver to the inspection requirement at the discretion of the Board.

(d) Compliance and Documentation. Failure to abide with the requirements of this section shall be considered "unprofessional conduct" within the meaning of Chapter 9 and shall constitute grounds for disciplinary action by the Board.

(i) Inspector should provide evidence for dentists to place on machines indicating the last inspection date and next inspection due date.

(ii) Evidence of compliance to the Board is not required unless specifically requested.

CHAPTER 5

ANESTHESIA ADMINISTRATION AND SEDATION PERMIT PROCEDURES

Section 1. Authority. The Board is authorized under Wyoming Statute 33-15-130 to promulgate rules and regulations related to the application and licensure procedures to administer sedation and provide for sedation inspection in Wyoming.

Section 2~~1~~. Statement of Purpose. These Board Rules are adopted to implement the Board's authority to establish a regulatory framework for issuance of a sedation permit pursuant to ~~Wyoming Statute~~W.S. 33-15-130.

Section 3~~2~~. Definitions. For the purpose of this chapter, the following definitions shall apply:

(a) "ACLS" means advanced cardiac life support.

(b) "Anxiolysis" is minimal sedation~~means the diminution or elimination of anxiety. The relief of patient anxiety or fear should produce minimum somnolence. The technique should be appropriately chosen to render the patient relaxed but have an adequate margin of safety so that excessive somnolence/unconsciousness is not likely~~.

(c) "Applicant" means a Wyoming licensed dentist applying for a sedation permit.

(d) "ASA" means American Society of Anesthesiology classification.

(e) "Combination inhalation" means using an inhalation agent and a sedative agent at the same time.

(f) "Competent" means displaying special skill or knowledge derived from training and experience.

(g) "Deep sedation" means a drug-induced depression of consciousness during which the patient cannot be easily aroused but responds purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. The patient may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

(h) "Dental hygienist" means a Wyoming licensed dental hygienist holding an appropriate expanded duties permit including local anesthesia and/or nitrous oxide anxiolysis.

~~(i) "Dentist" means a Wyoming licensed dentist that does not hold an operating dentist sedation permit or sedation permit.~~

(i)~~(j)~~ "Enteral" means a route of administration in which the agent is absorbed through

the gastrointestinal tract or mucosa [i.e., oral, rectal, nasal, or sublingual].

(j)~~(k)~~ "Facility Permit" means a permit issued to any location where sedation is being performed~~a permit holder's facility~~ that has been inspected and approved by the Board.

(k) "Facility Permit Holder" means a Wyoming licensed dentist designated as the responsible dentist for a facility permit.

(l) "General anesthesia" means a drug-induced loss of consciousness during which the patient is not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. The patient often requires assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

(m) "Inhalation" means a route of administration in which a gaseous or volatile agent is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed.

(n) "Local anesthesia" means the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

(o) "Minimal sedation" (previously known as anxiolysis) means a minimally depressed level of consciousness produced by a pharmacological method that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory, and cardiovascular functions are unaffected. Minimal sedation includes administration of oral medication and/or nitrous oxide.

(p) "Moderate sedation" previously known as "conscious sedation and/or twilight sedation or parenteral sedation" means a drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. The drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the sedation permit holder. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

(q) "MRD" means maximum recommended dose of a drug as printed on Food and Drug Administration approved labeling for unmonitored home use.

(r) "Nitrous oxide anxiolysis" means the administration by inhalation of a combination of nitrous oxide and oxygen producing an altered level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond

appropriately to physical stimulation or verbal command.

~~(s) "Operating dentist" means a non-board eligible dentist that has been issued an operating dentist permit by the Board to allow the operating dentist to perform procedures where sedation services are provided by a qualified anesthesia provider.~~

(s)~~(t)~~ "PALS" means Pediatric Advanced Life Support.

(t)~~(u)~~ "Parenteral" means a route of administration in which the drug bypasses the gastrointestinal tract [i.e., intramuscular, intravenous, intranasal, submucosal, subcutaneous, or intraosseous].

~~(v) "Permit holder" means a Wyoming licensed dentist that has been issued a sedation permit from the Board.~~

(u)~~(w)~~ "Qualified anesthesia provider" means a licensed anesthesiologist, certified registered nurse anesthetist, or sedation permit holder with appropriate sedation level permit.

(v) "Responsible dentist" means a licensed dentist who assumes responsibility for a facility permit.

(w) "Sedation Inspector" means a Board-approved inspector of sedation facilities and sedation permit applicant's surgical/anesthetic technique cases.

(x) "Sedation permit" means a permit issued by the Board for administration of moderate sedation or deep sedation and/or general anesthesia by a sedation permit holder.

(y) "Titration" means administration of multiple or incremental doses of a drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response, and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

Section 4~~3~~. Standard of Care.

(a) For all levels of sedation, a dentist~~, operating dentist,~~ or sedation permit holder shall have the training, skills, drugs, and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical services) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

(b) A dentist~~, operating dentist,~~ or sedation permit holder shall be responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation, deep sedation, and/or general anesthesia and providing the equipment, drugs, and protocol for patient rescue.

(c) Because sedation and general anesthesia are a continuum, it is not always possible

to predict how an individual patient will respond. Hence, a dentist~~, operating dentist,~~ or sedation permit holder intending to produce a given level of sedation shall be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.

(d) The concept of rescue is essential to safe sedation. A dentist~~, operating dentist,~~ or sedation permit holder shall have the skills to rescue the patient from a deeper level than that intended for the procedure. The ability to rescue means that a dentist or sedation permit holder shall be able to recognize the various levels of sedation and have the skills necessary to provide appropriate cardiopulmonary support if needed.

(i) If the intended level of sedation is "minimal," a dentist~~, operating dentist,~~ or sedation permit holder shall be able to rescue from "moderate sedation."

(ii) If the intended level of sedation is "moderate," ~~an operating dentist or~~ a sedation permit holder shall have the skills to rescue from "deep sedation."

(iii) If the intended level of sedation is "deep sedation," ~~an operating dentist or~~ a sedation permit holder shall have the skills to rescue from a state of "general anesthesia."

(e) If a patient enters a deeper level of sedation than the dentist~~, operating dentist,~~ or sedation permit holder is qualified to provide, the dentist~~, operating dentist,~~ or sedation permit holder shall stop the dental procedure until the patient returns to the intended level of sedation.

(f) Children (under the age of 12) may become moderately sedated despite the intended level of minimal sedation; if this occurs, the requirements for moderate sedation shall apply.

(g) Except in extraordinary situations, the dentist~~, operating dentist,~~ or sedation permit holder shall not use preoperative sedatives for children prior to arrival in the dental office due to the risk of unobserved respiratory obstruction during transport by untrained individuals.

(h) All local anesthetic agents are cardiac depressants and may cause central nervous system excitation or depression. Particular attention shall be paid to dosage in children. To ensure that the patient will not receive an excessive dose, the maximum allowable safe dosage (i.e., mg/kg) shall be calculated before administration. There may be enhanced sedative effects when the highest recommended doses of local anesthetic drugs are used in combination with other sedatives or narcotics.

(i) Patients considered for minimal sedation, moderate sedation, and/or general anesthesia must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this may consist of a review of their current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

(j) Pre-operative preparation shall include:

(i) Consideration of dietary restrictions based on the sedative technique prescribed; and

(ii) Verbal and written instructions shall be given to the patient, parent, escort, guardian or care giver.

(k) An appropriate scavenging system shall be available if gases other than oxygen or air are used.

~~**Section 4. Requirements for Administering Local Anesthesia, Oral, and/or Nitrous Oxide Anxiolysis.**~~

~~(a) An operating sedation permit or sedation permit shall not be required for a dentist to administer local anesthesia, oral, and/or nitrous oxide anxiolysis.~~

~~(b) A dentist, operating dentist, or permit holder who administers local anesthesia, oral, and/or nitrous oxide anxiolysis shall comply with the other sections of this chapter.~~

~~(c) A dental hygienist that administers local anesthesia and/or nitrous oxide anxiolysis shall comply with the other sections of this chapter.~~

~~(d) Local Anesthesia and Oral Anxiolysis. To administer local anesthesia or oral anxiolysis, a dentist or dental hygienist shall be certified in administering BLS.~~

~~(e) Nitrous Oxide Anxiolysis. To administer nitrous oxide anxiolysis, a dentist or dental hygienist shall:~~

~~(i) Be certified in administering BLS;~~

~~(ii) Have adequate equipment with fail-safe features and 25% minimum oxygen flow; and~~

~~(iii) Demonstrate competency and/or training in administering nitrous oxide anxiolysis by:~~

~~(A) Completion of CODA recognized program; or~~

~~(B) Completion of a Board-approved course.~~

Section 5. Requirements for Administering Minimal Sedation.

(a) A sedation permit ~~or operating dentist sedation permit~~ shall not be required for a dentist to administer minimal sedation.

(b) A dentist shall only administer minimal sedation by an enteral route.

(c) To administer minimal sedation, a dentist or dental hygienist shall:

(i) Have adequate equipment with fail-safe features and 25% minimum oxygen flow; and

(ii) Demonstrate competency and/or training in administering minimal sedation by:

(A) Completion of CODA recognized program; or

(B) Completion of a Board-approved course.

(d) Office Equipment Requirements. Any dentist who administers minimal sedation shall provide the following equipment, which shall be functional and available at all times:

(i) A continuous pulse oximeter;

(ii) A blood pressure cuff of appropriate size;

(iii) Stethoscope or equivalent blood pressure monitoring devices;

(iv) An appropriate size bag-valve-mask apparatus or equivalent with an oxygen hook-up; and

(v) A manual or automatic external defibrillator.

(e) A dentist or sedation permit holder shall document every administration of minimal sedation. Documentation for administration of minimal sedation shall include, but is not limited to, the following:

(i) Pertinent medical history including, but not limited to:

(A) Previous medication(s);

(B) Allergies; and

(C) Sensitivities;

(ii) Weight (nitrous oxide excluded);

(iii) Vital Signs, including, but not limited to:

(A) Baseline heart rate; and

(B) Blood pressure.

(iv) Beginning and ending oxygen saturation levels; and

(v) Medication(s) administered and dosage(s).

(f) All dental personnel shall be certified in administering BLS. A dentist or sedation permit holder may delegate patient monitoring to qualified dental personnel. During a procedure where nitrous oxide anxiolysis or minimal sedation is administered, at least one (1) dental personnel shall be present.

(g)~~(c)~~ When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the MRD dose of a drug that can be prescribed for unmonitored home use.

(h)~~(d)~~ Nitrous oxide administration~~anxiolysis~~ may be used in combination with a single enteral drug in minimal sedation.

(i)~~(e)~~ Nitrous oxide administration~~anxiolysis~~ when used in combination with a sedative agent(s) may produce moderate sedation, deep sedation, and/or general anesthesia which requires ~~an operating sedation permit or~~ a sedation permit.

Section 6. Requirements for Administering Moderate Sedation, Deep Sedation, and/or General Anesthesia.

(a) A sedation permit shall be required for a sedation permit holder to administer moderate sedation, deep sedation, and/or general anesthesia.

(b) Office Equipment Requirements.

(i) Any sedation permit holder who administers moderate sedation, deep sedation, and/or general anesthesia shall have available the required equipment in Section 5(d) and the following additional equipment and faculties, which shall be functional and available at all times:

(A) Suitable operating suite;

(B) Recovery area;

(C) Gas storage facilities with back up tanks and mobile back-up oxygen, which generally meet accepted safety standards;

(D) Suction system;

(E) Back-up suction equipment;

(F) Back-up lighting equipment;

(G) Parenteral access or the ability to gain parenteral access, if clinically indicated;

(H) Capnograph (end tidal carbon dioxide monitor);

(I) EKG;

(J) Appropriate emergency medications;

(K) Endotracheal tubes suitable for patients being treated;

(L) Endotracheal tube forceps (i.e., magill);

(M) A laryngoscope with reserve batteries and bulbs;

(N) Oropharyngeal airways;

(O) Nasopharyngeal airways; and

(P) At least one (1) additional airway device.

(ii) Volatile Anesthesia Delivery Systems. Any sedation permit holder who administers volatile anesthesia shall provide the required equipment listed in Section 5(d) and Section 6(b)(i) and the following additional equipment and facilities, which shall be functional and available at all times:

(A) Capability to deliver oxygen to a patient under positive pressure, including a back-up oxygen system;

(B) Gas outlets that meet generally accepted safety standards preventing accidental administration of inappropriate gases or gas mixture;

(C) Fail-safe mechanisms for inhalation of nitrous oxide anxiolysis;

(D) The inhalation equipment must have an appropriate scavenging system if volatile anesthetics are used; and

(E) Gas storage facilities, which meet generally accepted safety standards.

(c) A sedation permit holder shall document every administration of moderate sedation, deep sedation, and/or general anesthesia. Documentation for administration of moderate sedation, deep sedation, and/or general anesthesia shall include the required documents listed in Section 5(e) and the following additional documentation:

(i) Current and comprehensive medical history, including:

(A) Medical conditions; and

(B) Age;

(ii) Physical examination, including:

(A) Airway assessment;

(B) Respiratory rate; and

(C) Temperature;

(iii) ASA Classification;

(iv) Procedure(s);

(v) Informed Consent;

(vi) Anesthesia Record, which shall include:

(A) Vital signs before and after anesthesia is utilized;

(B) Parenteral access site and method, if utilized;

(C) Medication(s) administered;

(D) Time anesthesia commenced and ended;

(E) Monitor blood pressure, heart rate, and oxygen saturation at least every five (5) minutes;

(F) EKG;

(G) Capnograph (end tidal carbon dioxide monitor);

(H) Ventilation status (spontaneous, assisted, or controlled);

(I) Intravenous fluids, if utilized;

(J) Response to anesthesia, including any complications;

(K) Starting time of recovery and time of discharge; and

(L) Condition of patient at discharge and authorization of sedation permit holder.

(d) All dental personnel shall be certified in administering BLS. A dentist or sedation permit holder may delegate patient monitoring to qualified dental personnel.

(i) Moderate Sedation. During a procedure where moderate sedation is administered, the sedation permit holder and at least one (1) other dental personnel shall be present.

(ii) Deep Sedation and/or General Anesthesia. During a procedure where deep sedation and/or general anesthesia is administered, the sedation permit holder and at least two (2) other dental personnel shall be present and at least one (1) shall be experienced in patient monitoring and documentation.

~~(b) An operating dentist sedation permit shall be required for an operating dentist to perform procedures where sedation services are provided by a qualified anesthesia provider.~~

(e)~~(c)~~ A dentist~~, operating dentist,~~ or sedation permit holder shall be subject to disciplinary action if:

(i) A dentist administers moderate sedation, deep sedation, and/or general anesthesia without a sedation permit; or

~~(ii) A dentist performs procedures where sedation services are provided by a qualified anesthesia provider without an operating dentist sedation permit;~~

(iii) A permit holder administers deep sedation and/or general anesthesia with a sedation permit for moderate sedation~~;~~.

~~(iv) An operating dentist performs procedures where sedation services are provided by a qualified anesthesia provider on an expired, revoked, or encumbered operating dentist sedation permit; or~~

~~(v) A permit holder administers moderate sedation, deep sedation, and/or general anesthesia on an expired, revoked, or encumbered sedation permit or temporary sedation permit.~~

~~(d) A permit holder may achieve moderate sedation by administration of combination inhalation, parenteral and/or enteral routes.~~

Section 7. Application Process for Administering Moderate Sedation.

(a) The applicant shall submit a completed application, including fees, and provide evidence of:

(i) Current certification in ACLS or PALS; and

(ii) Demonstrating competency and/or training in administering moderate sedation within two (2) years immediately preceding the application as follows:

(A) Completion of a specialty residency recognized by CODA;

(B) Completion of a general practice residency recognized by CODA that meets the minimal training requirements identified in subsection (D);

(C) Submit proof that applicant has administered moderate sedation, deep sedation and/or general anesthesia in another jurisdiction within generally accepted standards of dental practice and provide documentation of at least 40 moderate sedation cases; or

(D) Completion of a training course to administer and manage moderate sedation within twelve (12) months prior to application. For moderate sedation, such training shall include a minimum:

(I) 60 hours of didactic instruction;

(II) 20 solo intubations (patient-based and/or acceptable electronic simulated manikin);

(III) 20 moderate sedation cases;

(IV) Physical diagnosis rotation; and

(V) Advance Airways and Emergency Management.

(b) While reviewing a completed application, the ARC shall consider any pending complaints before the Board against the applicant. ~~The ARC may grant applicant approval to proceed with onsite clinical inspection as defined in Section 11.~~

(c) Surgical/Anesthetic Techniques. Each sedation inspector shall review at least three (3) separate cases in which the applicant administered anesthesia. The sedation inspector may require additional cases to observe at his/her discretion. If no cases are available (i.e. the applicant has just completed a residency program), three (3) separate standardized cases shall be reviewed.

(d) Simulated Emergencies. The applicant and his/her team shall be able to demonstrate their expertise in managing the following emergencies:

(i) Laryngospasm;

(ii) Bronchospasm;

(iii) Emesis and aspirator of vomitus;

(iv) Management of foreign bodies in the airway;

(v) Angina Pectoris;

(vi) Myocardial Infarction;

(vii) Cardiopulmonary Resuscitation;

(viii) Hypotension;

(ix) Hypertensive crisis;

(x) Acute allergic reaction;

(xi) Convulsions; and

(xii) Hyperventilation syndrome.

(e) Discussion Period. The applicant may be required to answer additional questions by the sedation inspector.

~~(c) Applicant shall be responsible for payment of inspection fee to inspectors.~~

~~(d) After successfully passing an onsite clinical inspection, the Board shall issue a sedation permit to applicant.~~

Section 8. Application Process for Administering Deep Sedation and/or General Anesthesia.

(a) The applicant shall submit a completed application, including fees, and provide evidence of:

(i) Current certification in ACLS or PALS;

(ii) Demonstrating competency and/or training in administering deep sedation and/or general anesthesia within two (2) years immediately preceding the application as follows:

(A) Completion of a residency program that includes training in sedation and/or general anesthesia that is approved by CODA, the American Dental Society of Anesthesiology, the Accreditation Council for Graduate Medical Education, the American Osteopathic Association or any successor organization to any of the foregoing; or

(B) Completion of a post-doctoral training program (e.g., oral and maxillofacial surgery) that affords comprehensive and appropriate training necessary to

administer and manage deep sedation and/or general anesthesia that is approved by CODA or other program approved by the Board.

(b) While reviewing a completed application, the ARC shall consider any pending complaints before the Board against the applicant. ~~The ARC may grant applicant approval to proceed with onsite clinical inspection as defined in Section 11.~~

(c) Surgical/Anesthetic Techniques. Each sedation inspector shall review at least three (3) separate cases in which the applicant administered anesthesia. The sedation inspector may require additional cases to observe at his/her discretion. If no cases are available (i.e. the applicant has just completed a residency program), three (3) separate standardized cases shall be reviewed.

(d) Simulated Emergencies. The applicant and his/her team shall be able to demonstrate their expertise in managing the following emergencies:

(i) Laryngospasm;

(ii) Bronchospasm;

(iii) Emesis and aspirator of vomitus;

(iv) Management of foreign bodies in the airway;

(v) Angina Pectoris;

(vi) Myocardial Infarction;

(vii) Cardiopulmonary Resuscitation;

(viii) Hypotension;

(ix) Hypertensive crisis;

(x) Acute allergic reaction;

(xi) Convulsions; and

(xii) Hyperventilation syndrome.

(e) Discussion Period. The applicant may be required to answer additional questions by the sedation inspector.

~~(c) Applicant shall be responsible for payment of inspection fee to inspectors.~~

~~(d) After successfully passing an onsite clinical inspection, the Board shall issue a~~

~~sedation permit to applicant.~~

~~**Section 9. Temporary Sedation Permit for Administration of Deep Sedation and/or General Anesthesia.**~~

~~(a) The Board shall not issue a temporary sedation permit for moderate sedation.~~

~~(b) The Board shall issue a temporary sedation permit for deep sedation and/or general anesthesia to a qualified applicant after receiving a completed application, including fees, and prior to onsite clinical inspection.~~

~~(c) Temporary sedation permit shall expire:~~

~~(i) Ninety (90) days from date issued; or~~

~~(ii) If applicant does not successfully pass the clinical onsite inspection.~~

~~(d) The Board may revoke a temporary sedation permit.~~

Section 9. Sedation Permit Renewal and Expiration.

(a) Sedation permits shall be renewed on or before December 31 every second year.

(b) A sedation permit holder shall submit a completed sedation permit renewal application, including fees, and provide evidence of:

(i) Current certification in ACLS or PALS; and

(ii) Sixteen (16) hours sedation continued education renewal course every two (2) years with requirements that the course contain medical emergencies and airway management skills training with a hands on component.

(iii) The Board may request more documentation if necessary.

Section 10. Reinstatement of Expired and Revoked Sedation Permits.

(a) A dentist may apply for reinstatement of their expired sedation permit by meeting the application requirements established in Section 7 and/or Section 8.

(b) A dentist may apply for reinstatement of their revoked sedation permit by meeting the application requirements established in Section 7 and/or Section 8 and submit evidence of:

(i) Meeting requirements of previous Board order; and

(ii) Demonstrating just cause for reinstatement.

Section 11~~10~~. Sedation ~~Onsite Clinical~~ Inspector Qualifications and Duties.

(a) Sedation Inspector Qualifications. The inspector shall:

(i) Submit a completed application;

(ii) Actively practice as a dental anesthesiologist, oral maxillofacial surgeon,~~dental specialist,~~ anesthesiologist, or certified nurse anesthetist; and

(iii) Hold a current and unencumbered Wyoming license in their field.~~; and~~

~~(iv) Hold a sedation permit to administer deep sedation and/or general anesthesia.~~

(b) Sedation Inspector Duties. A Board-approved sedation inspector shall:

(i) Be considered an agent for the Board;

(ii)~~(i)~~ Comply with the Board Rules for inspecting sedation facilities~~clinical locations~~ within Wyoming;

(iii)~~(ii)~~ Not have a conflict of interest with an applicant. ~~An~~A sedation inspector's receipt of payment from the applicant for services as ~~an~~a sedation inspector is acceptable and does not constitute a conflict of interest; and

(iv) Review a sedation permit applicant's surgical/anesthetic techniques required in Section 7(c) and Section 8(c).

~~(iii) Be considered an agent for the Board.~~

~~**Section 11. Onsite Clinical Inspection Process for Sedation Permits for Administration of Moderate Sedation, Deep Sedation, and/or General Anesthesia.**~~

~~(a) Office Inspection. Each office location where sedation is intended to be administered shall be inspected.~~

~~(b) Initial Onsite Clinical Inspection Process.~~

~~(i) The initial inspection shall be performed by two (2) inspectors.~~

~~(ii) The onsite clinical inspection process for sedation permits shall consist of four (4) parts:~~

~~(A) Review. The inspector shall review the office equipment, documentation, and emergency medications as required in Sections 12 and 13.~~

~~(B) Surgical/Anesthetic Techniques. Each inspector shall review at least three (3) separate cases in which the applicant administered anesthesia. The inspector may require additional cases to observe at his/her discretion. If no cases are available (i.e. the applicant has just completed a residency program), three (3) separate standard cases shall be reviewed.~~

~~(C) Simulated Emergencies. The applicant and his/her team shall be able to demonstrate their expertise in managing emergencies.~~

~~(D) Discussion Period. The applicant may be required to answer additional questions by the inspector.~~

~~(iii) After an inspector has completed the onsite clinical inspection, the inspector shall submit his/her findings and necessary documentation to the Board for approval.~~

~~(c) Re-Inspection Process.~~

~~(i) Permit holder's onsite clinical location(s) shall be re-inspected every five (5) years. Permit holder bears the burden of ensuring that their onsite clinical location(s) are re-inspected no later than sixty (60) months from the previous inspection.~~

~~(ii) Permit holder shall submit a completed onsite clinical re-inspection application, including fees, and provide evidence of attending ten (10) continuing medical or dental education credit hours in anesthesia in the five (5) years preceding the onsite clinical location re-inspection.~~

~~(iii) Each re-inspection of an onsite clinical location may be inspected by one (1) inspector with approval by the Board.~~

~~(iv) The Board may require re-inspection of an onsite clinical location(s) as part of the process for renewal or reinstatement of the permit.~~

Section 12. Initial Facility Permit Application Process.

(a) Application Requirements. Applicant shall:

(i) Submit a completed application and payment of fee; and

(ii) Have two (2) approved sedation inspectors submit sedation facility inspection reports for each location where sedation is intended to be administered.

(iii) Applicant shall be responsible for payment of sedation facility inspection fee to sedation inspectors.

(b) Renewal Requirements.

(i) Facility permits shall be renewed on or before December 31 every second year.

(ii) A facility permit holder shall submit a completed facility permit renewal application, including fees. The facility permit holder shall provide evidence of re-inspection every five (5) years.

Section 13. Sedation Facility Inspection Process.

(a) Initial Inspection Process.

(i) Each sedation inspector shall review the office equipment, documentation, and emergency medications as required in Section 6.

(ii) After a sedation inspector has completed the onsite sedation facility inspection, the sedation inspector shall submit his/her findings and necessary documentation.

(b) Re-Inspection Process.

(i) Permitted sedation facilities shall be re-inspected every five (5) years. Responsible dentist bears the burden of ensuring that their permitted sedation facilities are re-inspected no later than five (5) years from the previous inspection.

(ii) Each re-inspection of a permitted sedation facility may be inspected by one (1) Board approved sedation inspector.

(iii) The Board may require re-inspection of a permitted sedation facility.

~~**Section 12. Office Faculties and Equipment Requirements for Minimal Sedation, Moderate Sedation, Deep Sedation and/or General Anesthesia.**~~

~~(a) Minimal Sedation. Any dentist that administers minimal sedation shall provide the following equipment, which shall be functional and available at all times:~~

~~(i) A continuous pulse oximeter;~~

~~(ii) A blood pressure cuff of appropriate size;~~

~~(iii) Stethoscope or equivalent blood pressure monitoring devices;~~

~~(iv) An appropriate size bag-valve-mask apparatus or equivalent with an oxygen hook-up; and~~

~~(v) A manual or automatic external defibrillator.~~

~~(b) Moderate Sedation, Deep Sedation and/or General Anesthesia. Any permit holder~~

who administers moderate sedation, deep sedation, and/or general anesthesia shall provide the required equipment listed in subsection (a) and the following additional equipment and faculties, which shall to be functional and available at all times:

(i) Suitable operating suite;

(ii) Recovery area;

(iii) Gas storage facilities with back up tanks and mobile back-up oxygen, which generally meet accepted safety standards;

(iv) Suction system;

(v) Back-up suction equipment;

(vi) Back-up lighting equipment;

(vii) Parenteral access or the ability to gain parenteral access, if clinically indicated;

(viii) Capnograph (end tidal carbon dioxide monitor);

(ix) EKG;

(x) Appropriate emergency medications;

(xi) Endotracheal tubes suitable for patients being treated;

(xii) Endotracheal tube forceps (i.e., magill);

(xiii) A laryngoscope with reserve batteries and bulbs;

(xiv) Oropharyngeal airways;

(xv) Nasopharyngeal airways; and

(xvi) At least one (1) additional airway device.

(c) Volatile Anesthesia Delivery Systems. Any permit holder that administers volatile anesthesia shall provide the required equipment listed in subsections (a) and (b) and the following additional equipment and facilities, which shall to be functional and available at all times:

(i) Capability to deliver oxygen to a patient under positive pressure, including a back-up oxygen system;

(ii) Gas outlets that meet generally accepted safety standards preventing accidental administration of inappropriate gases or gas mixture;

(iii) Fail-safe mechanisms for inhalation of nitrous oxide anxiolysis;

(iv) The inhalation equipment must have an appropriate scavenging system if volatile anesthetics are used; and

(v) Gas storage facilities, which meet generally accepted safety standards.

Section 13. Patient Monitoring and Necessary Documentation.

(a) A dentist or permit holder shall document every administration of anxiolysis, minimal sedation, deep sedation, and/or general anesthesia.

(b) Anxiolysis and Minimal Sedation. Documentation for administration of anxiolysis (oral and nitrous oxide) and minimal sedation shall include, but not limited to, the following:

(i) Pertinent medical history including, but not limited to:

(A) Previous medication(s);

(B) Allergies; and

(C) Sensitivities;

(ii) Weight (nitrous oxide excluded);

(iii) Vital Signs, including, but not limited to:

(A) Baseline heart rate; and

(B) Blood pressure.

(iv) Beginning and ending oxygen saturation levels; and

(v) Medication(s) administered and dosage(s).

(c) Moderate Sedation, Deep Sedation and/or General Anesthesia. Documentation for administration of moderate sedation, deep sedation, and/or general anesthesia shall include the required documents listed in subsection (b) and the following additional documentation:

(i) Current and comprehensive medical history, including:

(A) Medical conditions; and

(B) Age;

(ii) Physical examination, including:

(A) Airway assessment;

(B) Respiratory rate; and

(C) Temperature;

(iii) ASA Classification;

(iv) Procedure(s);

(v) Informed Consent;

(vi) Anesthesia Record, which shall include:

(A) Vital signs before and after anesthesia is utilized;

(B) Parenteral access site and method, if utilized;

(C) Medication(s) administered;

(D) Time anesthesia commenced and ended;

(E) Monitor blood pressure, heart rate, and oxygen saturation at least every five (5) minutes;

(F) EKG;

(G) Capnograph (end tidal carbon dioxide monitor);

(H) Ventilation status (spontaneous, assisted, or controlled);

(I) Intravenous fluids, if utilized;

(J) Response to anesthesia, including any complications;

(K) Starting time of recovery and time of discharge; and

(L) Condition of patient at discharge and authorization of permit holder.

Section 14. Dental Personnel Requirements.

(a) All dental personnel shall be certified in administering BLS. A dentist, operating dentist, or permit holder may delegate patient monitoring to qualified dental personnel.

(b) Nitrous Oxide Anxiolysis and Minimal Sedation. During a procedure where nitrous oxide anxiolysis or minimal sedation is administered, at least one (1) dental personnel shall be present.

(c) Moderate Sedation. During a procedure where moderate sedation is administered, the operating dentist or permit holder and at least one (1) other dental personnel shall be present.

(d) Deep Sedation and/or General Anesthesia. During a procedure where deep sedation and/or general anesthesia is administered, the operating dentist or permit holder and at least two (2) other dental personnel shall be present and at least one (1) shall be experienced in patient monitoring and documentation.

Section 15. Application Process for Facility Permit and Operating Dentist Sedation Permit.

(a) If a permit holder allows an operating dentist to utilize their facilities to perform dental procedures, then the permit holder shall apply for a facility permit.

(b) The permit holder seeking a facility permit shall submit a completed application.

(c) The operating dentist shall submit a completed operating dentist sedation permit application, including fees, and provide evidence of:

(i) Current certification in BLS; and

(ii) Agreement between operating dentist and the facility where the sedation is being provided.

(d) While reviewing a completed application, the ARC shall consider any pending complaints before the Board against operating dentist.

(e) Based on the ARC's recommendation, the Board shall approve an operating dentist sedation permit or facility permit.

Section 16. Sedation Permit Renewal and Expiration.

(a) Sedation permit, operating dentist sedation permit, and facility permit shall be renewed on or before December 31 each year.

(b) Permit holder shall submit a completed moderate sedation, deep sedation and/or general anesthesia sedation permit renewal application, including fees, and provide evidence of:

(i) Current certification in ACLS or PALS; and

(ii) Non-board eligible dentists shall complete an additional sixteen (16) hours sedation continued education renewal course every two (2) years with requirements that the course contain medical emergencies and airway management skills training with a hands on component.

(c) Permit holder shall submit a completed facility permit renewal application.

(d) An operating dentist shall submit a completed operating dentist sedation permit renewal application, including fees, and provide evidence of BLS annually.

(e) The Board may request more documentation if necessary.

(f) A sedation permit, operating dentist sedation permit, or facility permit shall expire for:

(i) Failure to renew permit;

(ii) Failure to renew Wyoming dental license; or

(iii) Failure to obtain onsite clinical reinspection within required five (5) year period.

Section 17. Reinstatement of Expired and Revoked Sedation Permits.

(a) A dentist may apply for reinstatement of their expired sedation permit by meeting the application requirements established in Section 7 and/or Section 8.

(b) A dentist may apply for reinstatement of their revoked sedation permit by meeting the application requirements established in Section 7 and/or Section 8 and submit evidence of:

(i) Meeting requirements of previous Board order; and

(ii) Demonstrating just cause for reinstatement.

(c) A dentist may apply for reinstatement of their expired operating dentist sedation permit by meeting the application requirements established in Section 15.

(d) A dentist may apply for reinstatement of their revoked operating dentist sedation permit by meeting the application requirements established in Section 15 and submit evidence of:

(i) Meeting requirements of previous Board order; and

(ii) Demonstrating just cause for reinstatement.

~~**Section 18. Anesthesia Morbidity/Mortality Reporting Requirements.**~~

~~(a) Operating dentist and permit holder shall report any morbidity, mortality, or other incident that results in temporary or permanent physical or mental injury requiring hospitalization to the Board within thirty (30) days.~~

~~(b) Operating dentist and permit holder shall submit documentation as prescribed by the Board.~~

CHAPTER 7

DENTAL AUXILIARIES

Section 1. Authority. The Board is authorized under Wyoming Statute 33-15-119, 33-15-129(a), 33-15-123, and the WAPA to promulgate rules and regulations related to the application and licensure procedures to practice of dental hygiene and dental auxiliaries in Wyoming.

Section 2~~1~~. Statement of Purpose. These Board Rules are adopted to implement the Board's authority to regulate the practice of dental hygiene and other dental auxiliaries.

Section 3~~2~~. Dental Auxiliary Personnel. Except as otherwise provided, dental auxiliary personnel shall not perform irreversible procedures.

Section 4~~3~~. Practice of Dental Hygiene.

(a) The dental hygienist shall:

(i) Work under the supervision of a ~~qualified,~~ Wyoming licensed dentist; and

(ii) Be responsible for maintaining a high degree of proficiency in the practice of dental hygiene that is consistent with current educational standards of the profession.

(b) Dental hygienists may work in the private office of a licensed dentist, in the Armed Forces of the United States, in federal or state institutions, in public health settings, and nursing or retirement facilities.

(c) Dental hygienists are encouraged to promote oral health. They may accomplish this through presentations to schools, institutions, groups, or individuals. In no event should these presentations be used for the purpose of advertising or soliciting patients for himself/herself or a dentist.

Section 5~~4~~. Supervision of Procedures Performed by the Dental Hygienist.

(a) General Supervision. The following procedures require general supervision:

(i) Community dental health activities~~;~~ which includes public health services at federally funded health centers and clinics; nursing homes; extended care facilities; home health agencies; group homes for the elderly, disabled and youth; public health offices; Women, Infants, and Children; Head Start programs; child development programs; early intervention programs; migrant work facilities; free clinics; health fairs; public and private schools; state and county correctional institutions; community school-based prevention programs; and public health vans.

(A) Public health services solely consist of prophylaxis, topical fluoride applications, oral health education, and dental screenings. These services can be provided by the hygienist without prior authorization of the dentist. All patients seen shall be referred to a dentist annually.

(B) The hygienist shall maintain a Collaboration Agreement with a Wyoming licensed dentist. The hygienist must have a current Wyoming dental hygienist license with a minimum of two (2) years clinical experience.

(ii) ~~Functions~~Duties authorized for dental assistants set forth in the Board Rules;

(iii) Root plane, scale and polish teeth;

(iv) Polish amalgams and composites;

(v) Screen the oral cavity for disease;

(vi) Place temporary fillings that require no removal of tooth structure;

(vii) Place, expose, and process radiographic images;

(viii) Place pit and fissure sealants and silver diamine fluoride; and

(ix) Apply subgingival anesthetic (i.e. Oraqix) if the dental hygienist holds a local anesthetic expanded ~~functions~~duties permit.

(b) Direct Supervision. The following procedures require direct supervision:

(i) Prepare, place, and remove periodontal packs;

(ii) Remove overhanging margins;

(iii) Treat diagnosed dry sockets;

(iv) Treat diagnosed pericoronitis;

(v) Perform whitening procedures; and

(vi) Perform expanded dental ~~functions~~duties.

Section 6~~5~~. Expanded ~~Functions~~Duties Permits.

(a) Permit. To obtain an expanded ~~functions~~duties permit, a dental hygienist shall meet educational standards, or pass an examination approved by the Board, or both. Applicant shall submit a completed application for each ~~function~~duty.

(b) Training Course Approval.

(i) Training programs shall be approved in advance in writing by the Board. Due to the varied programs, individual courses shall require individual approval after course content is reviewed by the Board.

(ii) Applicant shall provide evidence of satisfactory completion of each expanded ~~functions~~duties course.

(iii) In the case of use of lasers, the applicant shall provide proof of certification from the Academy of Laser Dentistry or completion of a laser course through a CODA accredited dental hygiene program.

(iv) An in-person evaluation for an expanded ~~functions~~duties permit may be required by the Board to ascertain the applicant's knowledge of the expanded ~~functions~~duties that the applicant wishes to be permitted to perform.

(c) Expanded ~~Functions~~Duties. The following may be performed by a dental hygienist with an appropriate expanded ~~functions~~duties permit:

(i) Administer local anesthetics;

(ii) Administer and monitor nitrous oxide/oxygen; or

(iii) Use lasers to provide soft tissue therapy within the dental hygienists scope of practice. Dental hygienists shall NOT use lasers at settings intended to cut/remove hard tissue or tooth structure~~; or~~.

~~(iv) Provide public health services at facilities to include, but not limited to: federally funded health centers and clinics; nursing homes; extended care facilities; home health agencies; group homes for the elderly, disabled and youth; public health offices; Women, Infants, and Children; Head Start programs; child development programs; early intervention programs; migrant work facilities; free clinics; health fairs; public and private schools; state and county correctional institutions; community school-based prevention programs; and public health vans.~~

~~(A) Public health services solely consist of prophylaxis, fluoride varnishes, oral health education, and dental screenings. These services can be provided by the hygienist without prior authorization of the dentist. All patients seen shall be referred to a dentist annually.~~

~~(B) The public health hygienist must submit a Collaboration Agreement with a Wyoming licensed dentist. The hygienist must have a current Wyoming dental hygienist license with a minimum of two (2) years clinical experience. The hygienist must carry liability insurance.~~

Section 7~~6~~. Dental Assistants. The following applies to all dental assistants:

(a) Dental Assistant. A dentist holding a current Wyoming license may employ persons designated as "Dental Assistants." They may be trained by their employer or by an accredited or Board approved program for dental assistants.

(b) General Supervision. The following procedures require general supervision:

(i) Take vital statistics and health histories;

(ii) Instruct patients in proper dental health care;

(iii) Process radiographs;

(iv) Fabricate and cement temporary crowns;

(v) Replace ligature wires and/or place elastic ties;

(vi) Remove ligature wire and/or elastic ties;

(vii) Place and remove orthodontic separators; ~~and~~

(viii) Remove broken bands, brackets, wires and appliances in emergency situations or as needed for operative or prophylactic purposes~~.~~; and

(ix) Place and expose x-ray image receptors (either film or digital) with a dentist's order, either verbal or written.

(c) Indirect Supervision. The following procedures require indirect supervision:

(i) Take impressions other than final or master impressions and/or digital scan impressions;

(ii) Apply topical medications, excluding pit and fissure sealants and silver diamine fluoride;

(iii) Mix dental materials to be used by the dentist; and

~~(iv) Place and expose x-ray image receptors (either film or digital); and~~

(iv)~~(v)~~ Insert arch wires that have been adjusted by the dentist into the brackets or attachments and secured in place~~;~~.

(d) Direct Supervision. The following procedures require direct supervision:

(i) Remove sutures;

(ii) Assist the dentist in all operative and surgical procedures;

(iii) Place and remove rubber dams;

(iv) Place and remove matrices;

(v) Remove excess cement from the coronal surfaces of the teeth;

(vi) Prepare and remove periodontal packs;

(vii) Polish the coronal surfaces of the teeth, rubber cup only, but not for the purpose of prophylaxis. ~~A procedure performed by a dental assistant under this subsection may not be billed as a prophylaxis;~~

(viii) Perform whitening procedures;

(ix) Place and remove orthodontic wires and/or appliances that have been activated by the dentist;

(x) Take impressions for orthodontic procedures, i.e. retainers and removable appliances;

(xi) Remove direct bond attachments and bands;

(xii) Place pit and fissure sealants; and

(xiii) Treat diagnosed dry socket.

(e) Prohibitions. The following procedures may not be performed by dental assistants:

(i) Remove tooth structure;

(ii) Diagnose for treatment;

(iii) Take final impressions either digital or conventional or deliver a permanent prosthesis of any type; ~~or~~

(iv) Any procedure billed as a dental prophylaxis~~.~~;

(v) Use high speed handpiece intraorally; or

(vi) Use low speed handpiece intraorally, except for coronal polishing.

Section 8~~7~~. Exposure of Radiographic Images by Dental Assistants.

(a) Eligibility. An applicant may seek a permit to expose dental radiographs under the indirect supervision of a dentist, if the applicant demonstrates competency.

(b) Application Requirements. Applicant shall:

(i) Submit a completed application and payment of fee; and

(ii) Demonstrate competency by submitting evidence the applicant has:~~completion of a course or examination in dental radiography approved by the Board.~~

(A) Completed a course or examination in dental radiography approved by the Board within one (1) year immediately prior to the date of application; or

(B) Been authorized to expose dental radiographs in another jurisdiction within the last five (5) years.

(c) Renewal. A permit to expose radiographs shall expire December 31 every second year~~annually~~, unless renewed.

(d) Late Renewal. A permit to expose radiographs that was not timely renewed may be renewed within five (5) years of the date the permit expired by submitting a late renewal application and the late fee. After five (5) years, the assistant must reapply and document completion of a new radiography course within one (1) year immediately prior to the date of application.

Section 9~~8~~. Placement of Pit and Fissure Sealants by Dental Assistants.

(a) Eligibility. An applicant may apply for a pit and fissure sealant permit if the applicant has successfully completed a Board approved course which may include:

(i) Board approved course meeting the requirements identified in subsection (c); or

(ii) CODA accredited dental hygiene program or a dental assisting program.

(b) Application Requirements. Applicant shall submit:

(i) Completed application and payment of fee; and

(ii) Completed checklist demonstrating competency and completion of course within one (1) year immediately prior to the date of application.

(c) Education. The education program shall include:

(i) Didactic Education including:

(A) Infection Control;

(B) Microbiology;

(C) Chemistry;

(D) Dental anatomy;

(E) Ethics related to pit and fissure sealant application;

(F) Jurisprudence related to pit and fissure sealant application; and

(ii) Clinical Instruction including supervised application of sealants.

(d) Renewal. A permit to place pit and fissure sealants shall expire December 31 every second year~~annually~~, unless renewed.

(e) Late Renewal. A permit to place pit and fissure sealants that was not timely renewed may be renewed within five (5) years of the date the permit expired by submitting a late renewal application and the late fee. After five (5) years, the assistant must reapply and document completion of a new pit and fissure training course within one (1) year immediately prior to the date of application.

Section 10~~9~~. Code of Ethics for Dental Hygienists and Dental Assistants. Each dental hygienist and dental assistant practicing in the state of Wyoming shall:

(a) Provide oral health care utilizing highest professional knowledge, judgment, and ability;

(b) Serve all patients without discrimination;

(c) Hold professional patient relationships in confidence;

(d) Utilize every opportunity to increase public understanding of oral health practices;

(e) Generate public confidence in members of the dental health profession;

(f) Cooperate with all health professions in meeting the health needs of the public;

(g) Recognize and uphold the laws and regulations governing this profession;

(h) Maintain professional competence through continuing education;

(i) Exchange professional knowledge with other health professions;

(j) Represent dental hygiene and/or dental assisting with high standards of personal conduct; and

(k) Comply with the provisions of ADHA's Code of Ethics or Dental Assisting National Board's Code of Professional Conduct as referenced in Chapter 1.

CHAPTER 9

PRACTICE AND PROCEDURES FOR DISCIPLINARY, APPLICATION, AND LICENSURE MATTERS

Section 1. Authority. The Board is authorized under Wyoming Statute 33-15-112, 33-15-121, and the WAPA to promulgate rules and regulations related to the discipline of dentists and dental hygienists in Wyoming.

Section 21. Statement of Purpose. These Board Rules are adopted to implement the Board's authority to:

(a) Conduct investigations, hearings, and proceedings concerning:

(i) Alleged violations of the Act or the Board Rules; or

(ii) Actions relating to an application for a licensure including granting or denying.

(b) Determine and administer appropriate disciplinary action against licensee.

(c) For the purposes of this chapter, "licensee" means a dentist or dental hygienist.

Section 32. Grounds for Discipline. The Board may take disciplinary action or refuse to issue or renew a license for the any one (1) or more of the following acts or conduct:

(a) Violations of the Act or Board Rules;

(b) Unprofessional conduct. Unprofessional conduct relates to the practice of dentistry or any dental auxiliary occupation that constitutes a departure from or failure to conform to the standards of acceptable and professional practices, including, but not limited to:

(i) Conduct that indicates the licensee or applicant is grossly ignorant of health care and dental related standards and protocols;

(ii) Conduct that indicates the licensee or applicant is inefficient by failing to provide timely care to a patient or by failing to refer the patient when circumstances indicate referral is appropriate;

(iii) Conduct or factors that indicate the licensee's or applicant's competency is compromised;

(iv) Impairment due to drug abuse, alcohol abuse, or a physical or mental condition, which may have compromised, or may compromise, patient safety;

(v) Employing directly or indirectly any unlicensed person to perform operations of any kind of treatment for human teeth or jaws, or to perform any task which constitutes the practice of dentistry;

(vi) Betraying patient confidences;

(vii) Failing to make and maintain complete patient records that conform to prevailing record-keeping standards within the licensee holder's profession;

(viii) Failing to provide a patient, or the Board, with a full and complete copy of all patient records, x-rays, molds, or any other item kept in the course of treatment or services rendered by the license holder, for any patient, if either the patient, the patient's legal guardian, or the Board requests said copies;

(ix) Providing false, deceptive, or misrepresented information to the Board, committees or staff:

(A) In procuring or attempting to procure a license to practice dentistry;

(B) In filing or reporting any health care information, including but not limited to client documentation, agency records or other essential health documents;

(C) In signing any report or record as a dentist; or

(D) In submitting any information to the Board;

(x) Failure of a dentist to verify that all staff employed by the dentist or individuals contracted with the dentists, are licensed or certified by the Board to perform all tasks requiring licensure or certification before such tasks are performed at the direction of the dentist;

(xi) Directing or permitting any staff member to perform any procedure for which they are not licensed, certified, or competent;

(xii) Performing any act or gesture which, from the standpoint of the patient, exploits the patient's trust between the patient and the patient's dentist. Such acts may include intimate or sexual advances, intimate or sexual contact, or the use of any unnecessary sedative substance without explicit written consent by the patient;

(xiii) Performing any study or research without following standardized protocols for the research, including obtaining written and informed consent by the patient for any study;

(xiv) Failure to maintain current BLS~~CPR~~ certification;

(xv) Reprimand or other disciplinary action imposed by any academic institution or professional organization for cheating or plagiarizing;

(xvi) Financial insolvency which may jeopardize the efficacy of treatment or appropriate standard of care provided to patients;

(xvii) Violation of any order, term, restriction, or condition imposed by the Board; or

(xviii) Failure to conform with any provision of the ADA Principles of Ethics and Code of Professional Conduct, ADHA Bylaws and Code of Ethics, Dental Assisting National Board's Code of Professional Conduct, ~~or~~ the Centers for Disease Control's Summary of Infection Prevention Practices in Dental Settings, or the Centers for Disease Control's Guideline for Prescribing Opioids for Chronic Pain as referenced in Chapter 1.

Section 4~~3~~. Application Review and Investigation Process.

(a) Application Review.

(i) Every application for a license or permit issued by the Board shall be subject to investigation to determine whether the requirements set forth in the Act and Board Rules are satisfied.

(ii) If any application, including renewals, reveals any information that ~~which~~ merits further investigation, the matter shall be assigned to the ARC.

(b) ARC Action. The ARC may recommend:

(i) ~~Recommend a~~A license or permit be issued, ~~or~~ renewed, relicensed, or reinstated;

(ii) ~~Recommend a~~A license be issued, renewed, relicensed, or reinstated subject to conditions, restrictions, or other disciplinary action;

(iii) ~~Recommend~~Approval of a settlement agreement, which may include the issuance of a license or renewal with the imposition of restrictions, conditions, reprimand, or a combination thereof; or

(iv) ~~Recommend d~~Denial of the application.

(c) Notice of Intent. The ARC shall notify the applicant of its intent to recommend ~~approval subject to conditions, restrictions, other disciplinary action, or denial. Such notification shall contain~~:

(i) Issuance of a license subject to conditions, restrictions, other disciplinary action; or

(ii) Denial of a license.

(d) The Notice of Intent shall contain:

(i) A brief description of the facts or conduct that warrant denial or issuance of a licensethe approval subject to conditions, restrictions, other disciplinary action, or denial of licensure;

(ii) A statement of the nature of the actions which warrant denial or issuance of a licensethe approval subject to conditions, restrictions, other disciplinary action, or denial, the facts upon which the action is based, the specificand a citation to the applicable statutory provisions or the specific Board Rules involved; and

(iii) An opportunity to show compliance with all lawful requirements for retention of the license or respond within fifteen (15) days from the date of mailing; and

(iv)(iii)Notice of the right to a hearing if a written request is received in the Board office within thirty (30) days of the date of mailing the notice of intent.

(d) Applicant's Request for Hearing. If the ARC recommends approval subject to conditions, restrictions, other disciplinary action, or denial of an application, the applicant may request a contested case hearing in writing within thirty (30) days of the mailing of the notification.

(e) Applicant's Response to Notice of Intent. Within thirty (30) days of the date of the Notice of Intent, the applicant shall submit a written request to the Board office to:

(i) Hold a hearing on the ARC's recommendation;

(ii) Table consideration of the application; or

(iii) Withdraw the application.

(f) Applicant's Failure to Respond to Notice of Intent. If the applicant fails to timely respond to the Notice of Intent, the Board shall dismiss the application.

Section 5. Petition for Modification of Conditions or Restrictions.

(a) Petition for Modification of Conditions or Restrictions.

(i) A licensee may petition the Board for modification of the conditions or restrictions imposed upon their license.

(ii) A licensee shall submit a written petition for modification to the Board office. The petition for modification shall include documentation demonstrating:

(A) Compliance with a previously entered Board order;

(B) That the modification is consistent with their treatment place, if applicable; and

(C) That the modification is sufficient to ensure the public is adequately protected.

(b) Investigative Committee Action. A petition for modification shall be reviewed by the IC.

(i) If the IC agrees with the requested modification, the parties may file a stipulated motion with the Board.

(ii) If the IC does not agree with the requested modification, the IC shall notify the licensee of its intent to recommend denial of the petition.

(c) Board Consideration.

(i) The Board shall consider the petition, the IC's recommendation, and/or a stipulated motion at its earliest convenience.

(ii) The Board may approve or deny the petition for modification.

Section 64. Complaint Review and Disciplinary Investigation Process.

(a) Complaint Review. Every complaint submitted to the Board or initiated on behalf of the Board shall be investigated by an IDC.

(b) InvestigativeDisciplinary Committee Action. The IDC may recommend:

(i) Recommend dDismissal of a complaint;

(ii) Recommend iIssuance of an advisory letter;

(iii) RecommendApproval of a settlement agreement, which may include voluntary surrender, suspension, imposition of restrictions or conditions, reprimand, or other discipline;

(iv) Recommend dDisciplinary action against the licensee including revocation, suspension, reprimand, restrictions or conditions, or other discipline; or

(v) Recommend sSummary suspension.; or

(vi) Approval of a voluntary surrender.

~~(c) Summary Suspension. The Board may conduct an expedited hearing if the DC believes that the licensee's continued practice presents a danger to the public health, safety or welfare and recommends summary suspension.~~

Section 7~~5~~. Summary Suspension.

(a) Recommendation. If the I~~D~~C recommends summary suspension, the Board shall conduct an expedited proceeding to determine whether the licensee's continued practice imperatively requires emergency action to protect the~~presents a clear and imminent danger to~~ public health, safety or welfare.

(b) Notice of Intent to Recommend Summary Suspension.

(i) The I~~D~~C shall notify the licensee of its intent to recommend summary suspension;

(ii) The Notice of Intent shall contain:

(A) Copy of the complaint; and

(B) Notice that an expedited summary suspension proceeding shall be set at the earliest opportunity a quorum of Board members may be assembled;

(c) Notice of Expedited Proceeding. Upon confirmation of the date and time of the expedited proceeding, the I~~D~~C shall notify the licensee in writing of the date and time of the proceeding.

(d) Scope of Expedited Proceeding. The scope of the expedited summary suspension proceeding shall be limited to a presentation of the evidence the IC believes warrants summary suspension and any information the licensee may present on his or her behalf. The board shall order summary suspension if it concludes probable cause exists that the allegations, if proven, would imperatively require emergency action to protect the public health, safety, or welfare. The board shall incorporate a finding to that effect in its order granting summary suspension.

Section 8. Voluntary Surrender.

(a) A licensee may petition the Board, in writing, to voluntarily surrender their license in lieu of discipline.

(b) The Board shall consider the petition at its earliest convenience.

(c) The Board may consider whether the licensee is under investigation and may approve or deny the petition.

Section 9. Formal Proceedings for Disciplinary Action.

(a) Notice of Intent to Recommend Disciplinary Action.

(i) The IC shall notify the licensee of its intent to recommend disciplinary action.

(ii) The Notice of Intent shall:

(A) Include a brief description of the facts or conduct that warrants the intended action; and

(B) Provide the licensee an opportunity to show compliance or respond to the allegations for disciplinary action within fifteen (15) days of the date of mailing.

~~**Section 6. Petition and Complaint and Notice of Hearing.**~~

~~(a) Petition and Complaint. Formal proceedings for disciplinary action against a licensee shall be commenced by serving a petition and complaint and notice of hearing by certified or regular mail at least thirty (30) days prior to the date set for hearing.~~

~~(b) Notice of Hearing. The notice of hearing shall contain:~~

~~(i) The name and last known address of the licensee;~~

~~(ii) A statement in ordinary and concise language of the matters asserted, which shall contain the nature of the complaint filed with the Board, the facts upon which the complaint is based, the specific statutory provisions, and the specific Board Rules that the licensee is alleged to have violated;~~

~~(iii) The time, place, and nature of the hearing;~~

~~(iv) The legal authority and jurisdiction; and~~

~~(v) A statement indicating that failure to respond to the petition and complaint within twenty (20) days of its receipt may result in a default judgment.~~

Section 10. Petition.

(a) The IC shall initiate formal proceedings for disciplinary action by filing a Petition with the Board office and serving a copy upon the licensee to the last known address of the licensee by regular U.S. mail.

(b) Failure to respond to the Petition within twenty (20) days of the filing with the Board office may result in a default judgment.

Section 11. Notice of Hearing.

(a) Timing of Hearing. Upon receipt of a written request for hearing from an applicant or filing of a Petition, the Board shall conduct a hearing. Board staff shall serve a Notice of Hearing on the applicant or licensee at least thirty (30) days prior to the hearing.

(b) Notice of Hearing. The notice of hearing shall contain:

(i) The name and last known address of the applicant or licensee;

(ii) A brief statement of the matters asserted:

(A) In application matters, the recommendation, the facts upon which the recommendation is based, and the statutory provisions or Board Rules the applicant is alleged to have violated; or

(B) In disciplinary matters, the nature of the Petition, the facts upon which the Petition is based, and the statutory provisions or Board Rules the licensee is alleged to have violated.

(iii) The time, place, and nature of the hearing;

(iv) The legal authority and jurisdiction; and

(v) A statement indicating that:

(A) The applicant's failure to appear at a noticed hearing or pursue proceedings may result in a dismissal; or

(B) The licensee's failure to answer the allegations contained in the Petition within twenty (20) days of the date of mailing and failure to appear at a noticed hearing may result in a default judgment.

Section 12~~7~~. Lawful Service. There shall be a presumption of lawful service of a petition ~~and complaint~~, notice of hearing, or any other communication required by these Board Rules if sent to the last known address ~~of the licensee or applicant by certified mail, regular mail, or electronic mail to the e-mail address indicated to be the preferred method of communication~~.

Section 13~~8~~. Dismissal or Default. ~~The Board may enter an order of default judgment based on the allegations contained in the petition and complaint in any case where the licensee or the licensee's representative has not responded nor appeared at a scheduled noticed hearing.~~

(a) The Board may dismiss an application where the applicant or the applicant's representative has not requested a hearing or appeared at a noticed hearing.

(b) The Board may enter an order of default judgment based on the allegations contained in the Petition in any case where the licensee or the licensee's representative has not answered the Petition and has not appeared at a noticed hearing.

Section 14~~9~~. Contested Case. The hearing officer shall preside over the formal contested case hearing which shall be conducted pursuant to the WAPA and the Office of Administrative Hearings' rules concerning contested case proceedings as referenced in Chapter 1.

Section 15. Burden and Standard of Proof.

(a) Application Matters. The applicant shall bear the burden to prove by a preponderance of the evidence, that he or she meets the qualifications for licensure. The burden shall shift to the ARC to prove by clear and convincing evidence, that the applicant should be denied a license. The burden shall shift back to the applicant to persuade the Board that the ARC's grounds for denial or issuance of a license subject to conditions or restrictions are insufficient.

(b) Disciplinary Matters. The IC shall bear the burden to prove by clear and convincing evidence that the licensee violated the Act, Board Rules, or both.

(c) Petition for Modification Matters. The Board shall grant petitions for modification of conditions in its own discretion.

Section 16~~10~~. Board Decision and Order.

(a) Board Action. The Board may resolve an application matter, complaint, or Petition by:

(i) Approving the recommendations of the I~~D~~C or ARC;

(ii) Dismissing a complaint;

(iii) Issuing an advisory letter;

(iv) Ruling in favor of a party on a dispositive motion;

(v)~~(ii)~~ Conducting a contested case hearing. Following the hearing and deliberation of all evidence admitted at a contested case hearing, the Board may:

~~(A) Dismiss the complaint due to lack of clear and convincing evidence;~~

~~(B) Issue, renew, relicense, or reinstate a license;~~

~~(C) Issue an advisory letter;~~

~~(D) Issue, renew, relicense, or reinstate a license with conditions, restrictions, or other disciplinary action;~~

~~(E) Impose discipline by revocation, suspension, reprimand, restrictions, conditions, non-renewal, or a combination thereof, for a violation of any provision of the Act or the Board Rules; or~~

~~(F) Deny a license, renewal, reactivation, or reinstatement.~~

(A) Issue, renew, relicense, or reinstate a license;

(B) Issue, renew, relicense, or reinstate a license with conditions, restrictions, or other disciplinary action;

(C) Deny a license, renewal, relicense, or reinstatement;

(D) Dismiss the complaint or Petition;

(E) Dismiss the complaint or Petition with an advisory letter; or

(F) Impose a reprimand, conditions, restrictions, suspension, revocation, other discipline, or a combination thereof.

(b) Board Order. The Board shall issue a written decision and order. The decision and order shall be sent to the applicant, licensee, or their representatives~~attorneys~~ by ~~certified or~~ regular mail.

Section 12~~11~~. Appeals.

(a) Appeals from decisions of the Board are governed by the WAPA and the Wyoming Rules of Appellate Procedure.

(b) Costs of transcripts and any reasonable costs assessed by the Board regarding the record on appeal shall be borne by the party making the appeal.

CHAPTER 10

FEES

Section 1. Authority. The Board is authorized under Wyoming Statute 33-15-106 and the WAPA to promulgate rules and regulations related to the establishment of fees for issuance of licenses and administration of examinations in Wyoming.

Section 2~~1~~. Statement of Purpose. These Board Rules are adopted to implement the Board's authority to determine and collect reasonable fees.

Section 3~~2~~. General Information.

(a) Fees shall be payable in the exact amount ~~by credit card, money order, or check~~and shall be paid in advance of the services rendered.

(b) All fees collected by the Board are non-refundable.

(c) Fees related to public records requests shall be assessed pursuant to the Department of Administration and Information's rules concerning public records.

Section 4~~3~~. Fees. Services for which the Board charges a fee shall include, but not be limited to, the following fee schedule:

(a) Dentists:

(i)	Application for Licensure by Examination	$300
(ii)	Application for Licensure by Endorsement	$750
~~(iii)~~	~~Application for Non-Clinical Licensure~~	~~$50~~
(iii)~~(iv)~~	Biennial License Renewal	$~~185~~350
(iv)~~(v)~~	Late License Renewal (Jan 1 – Mar 31)	$370
~~(vi)~~	~~Non-Clinical License Renewal~~	~~$25~~
(v)~~(vii)~~	Relicensure	$370
(vi)~~(viii)~~	Reinstatement	$750

(b) Sedation Permit Holders:

(i)	Application for Moderate Sedation Permit	$500

(ii) Application for Deep Sedation/General Anesthesia Permit $500

~~(iii) Application for Operating Dentist Permit $25~~

(iii)~~(iv)~~ Application for Facility Permit $25

~~(v) Office Inspector Fee (paid directly to each inspector) $250~~

(iv)~~(vi)~~ Biennial Moderate or Deep Sedation/General Anesthesia Permit Renewal $~~250~~475

~~(vii) Operating Dentist Permit Renewal $15~~

(v)~~(viii)~~ Biennial Facility Permit Renewal $~~25~~50

(vi)~~(ix)~~ Sedation Permit Reinstatement $500

(c) Dental Hygienists:

(i) Application for Licensure by Examination $150

(ii) Application for Licensure by Endorsement $200

~~(iii) Application for Non-Clinical Licensure $50~~

(iii)~~(iv)~~ Applications for Dental Hygiene Expanded Functions $30

(iv) Biennial License Renewal (including functions) $~~95~~170

(v) Late License Renewal (Jan 1 – Mar 31) $190

~~(vi) Non-Clinical License Renewal $25~~

(vi)~~(vii)~~ Relicensure $190

(vii)~~(viiii)~~ Reinstatement $200

(d) Dental Assistants:

(i) Application for Radiograph Permit $30

(ii) Application for Pit and Fissure Permit $30

(iii) Biennial Radiograph ~~and Pit and Fissure~~ Permit Renewal $~~15~~20

	(iv)	Biennial Pit and Fissure Permit Renewal	$20
	(v)	Late Permit Renewal	$15
(e)	Other Fees:		
	(i)	License or Permit Verification	$25
	(ii)	Replacement Document	$25
	~~(iii)~~	~~Roster~~	~~$25~~
	(iii)~~(iv)~~	Non-Sufficient Fund Fee	$30