South Dakota State Board of Dentistry

Board Meeting Agenda

10:00 a.m. Central – Friday, October 23, 2026

Red Rossa Highlands Conference Room – 808 West Sioux Avenue, Pierre, SD 57501

Public Agenda

1) **Call to Order**
2) **Open Forum:** 5 Minutes Per Person: 20 Minute Maximum
3) **Approval of Minutes:** May 29, 2026 Board Meeting, July 29, 2026 Virtual Board Meeting, and August 10, 2026 Virtual Board Meeting.
4) **Adoption of Agenda**
5) **Financial Report**
6) **Office Updates**
7) **Organization and Program Updates**
    - **a.** SD Dental Association, Dental Wellness Program, Oral Health Coalition and related Subgroups: *Kellie Yackley*
    - **b.** SD Dental Hygienists' Association: *Caitlyn Lint*
    - **c.** Health Professionals Assistance Program: *Amanda McKnelly- (Written Report Submitted)*
    - **d.** Dental Assisting and Dental Hygiene Programs:
        - i. Southeast Technical College: *Marcia Jensen – (Written Report Submitted)*
        - ii. Western Dakota Technical College: *Chanin Hughes- (Written Report Submitted)*
        - iii. Lake Area Technical College: *Nicole Pahl – (Written Report Submitted)*
        - iv. University of South Dakota: *Miranda Drake*
    - **e.** Clinical Exam Testing Agency Updates
        - i. CRDTS Update
            1. Steering Committee Member Request- (1) In-Person and (1) Zoom Per Year
        - ii. ADEX Update
8) **Executive Session - SDCL 1-25-2(3 & 7) Consulting with Legal Counsel**
9) **License Applications**
    - **a.** Application Approval
    - **b.** Dr. Bechtold- Motion Under 36-6A-25
10) **Compliance/Legal**
    - **a.** 20:43:04:01 Representation of or Advertising Specialty Practice: *Hilary Williamson*
11) **Old Business**
    - **a.** Teledentistry Draft Regulations
12) **New Business:**
    - **a.** Anesthesia Review Project
        - i. Revised ADA Guidelines
            1. Update Previous 2016 Guidelines
            2. Clarify Nitrous Course Requirements
        - ii. Letter from South Dakota Society of Pediatric Dentistry and American Board of Pediatric Dentistry Diplomates
        - iii. Application and Process Review
    - **b.** Nitrous Oxide Course Approval Request
    - **c.** Radiography Course Approval Request

d. Open Meeting Laws Training: *Beverly Katz*
e. Exhibit Hour Clarification
f. CE Approval Form
g. 2027 Clinical Competency Examinations
h. CE Honorarium Application
i. Board Member Appointment(s)

13) Next Meetings:

- Scheduled: February 5, 2027 and June 4, 2027- Location TBD
- Need to schedule October 2027 Meeting

14) Adjourn

Individuals needing assistance, pursuant to the Americans with Disabilities Act, should contact the Board of Dentistry at least 48 hours in advance of the meeting to make any necessary arrangements.

SD State Board of Dentistry
Board Meeting
Red Rossa Event Center – Ft. Pierre, SD
Friday May 29, 2026

President Van Dam called the meeting to order at 10:03 a.m. Central.

Board Members Present: Dr. Scott Van Dam, Dr. Brian Prouty, Dr. Don Massa, Dr. Harold Doerr, Dr. Jon Schaack, and Amy Perry.

Board Members Present via Video/Audio Conferencing: Ashley Flynn.

Board Staff Present: Brittany Novotny, Lisa Harsma, Dusti Palecek, Beverly Katz (General Counsel), and Elizabeth Cave (General Counsel), and Deni Martin.

Board Staff Present via Video/Audio Conferencing: Shelly Munson (Prosecutor), Dr. Randy Sachau (Investigator), Dr. Monty Bechtold (Investigator).

Others Present: Paul Knecht (SDDA), Katie Pudwill, and Dr. Michael Lee.

Van Dam called for public testimony during the open forum. There was no public testimony.

Motion to approve the minutes of the February 6, March 25, April 13, and May 12, 2026 board meetings by Perry. Second by Prouty. Motion carried.

Motion to move adopt the agenda by Doerr. Second by Perry. Motion carried.

Motion to approve the financial report by Massa. Second by Perry. Motion carried.

Novotny provided an office update.

Paul Knecht presented an update on the South Dakota Dental Association, the Dental Wellness Program, and the Oral Health Coalition.

Katie Pudwill presented an update on the South Dakota Dental Hygienists' Association.

Motion to move into Executive Session pursuant to SDCL 1-25-2 (3) and (4) by Perry. Second by Schaack. Motion carried. The Board went into Executive Session at 10:26 a.m.

Motion to move out of Executive Session by Perry. Second by Doerr. Motion carried. The Board moved out of Executive Session at 12:30 p.m.

Motion to approve the dentist credential verification applications of Emillie Claire Brandt, Michael Todd Grooms, Matthew Anthony Lucero, Eric Eugene Martin, Anita Marie Masaitis, Jennifer Kathryn Anne Rose, and Andrew Michael Vostad by Schaack. Second by Doerr. Motion carried.

Motion to approve the dentist applications of Ian Daniel Ailts, Camryn Paige Blackwell, Andrew Clayton Christiansen, Alyse Marie Dockter-Wulf, Katherine Anne Erickson, Catherine Renee Franco,

Mason Lee Jensen, Blake Christopher Peterson, Jack Edward Schoenfelder, Mari-Alina Igorevna Timoshchuk, and John Robert Zent by Perry. Second by Schaack. Motion carried.

Motion to approve the dental hygienist credential verification applications of Emily Marie Rasmussen and Lori Dee Toohey by Perry. Second by Doerr. Motion carried.

Motion to approve the dental hygienist applications of Adriauna Rae Alexander, Brennan Hope Backmann, Andrea Mai DeReu, Haley Anne Eichacker, Mia Jane Glanzer, Dayani Paola Gonzalez, Jennifer Gonzalez-Villalobos, Sydney Elizabeth Grasma, Katie Marie Gretschmann, Morgyn Joan Grotewold, Ashley Lynn Humpal, Kensington Olivia Klock, Kendal Nicole Kostenbauer, Hailey Ann Larson, Elizabeth Ann Mentele, Kathleen Lorraine Nash, Jazmyn Marie Nelson, Hanah Marie Neuschwander, Katelyn Kimberly Richarson, Danielle Rae Richer, Mera Shenouda, Emilee Lynn Small, Kyra Elizabeth Utecht, Rylie Marie Van Rooyen, Lexie Renae VanderPol, Abby Elizabeth Walth and Sara Louise Wieman by Schaack. Second by Massa. Motion carried.

Motion to approve the dentist military application of Elizabeth Grace Linder by Schaack. Second by Doerr. Motion carried.

Motion to approve the dental hygienist military application of Amanda Ann Spaulding by Perry. Second by Schaack. Motion carried.

Motion to approve the agreed upon disposition, as presented, and direct the order be signed and entered for case 18.2526 by Doerr. Second by Massa. Motion carried.

Motion to approve the agreed upon disposition, as presented, and direct the order be signed and entered for case 21.2526 by Perry. Second by Schaack. Motion carried.

Motion to approve an extension to the Emeritus Status Agreement of Dr. Harold Doerr, license number M678, until July 1, 2027 and direct an Order be signed and entered, by Perry. Second by Schaack. Doerr abstained. Motion carried.

Motion to approve the management contract, as proposed, with DM Management Services, LLC by Doerr. Second by Prouty. Motion carried.

Motion to rescind the Protective Restorations Advisory Opinion adopted June 17, 2016 by Schaack. Second by Massa. Motion carried.

Motion to approve the Board Policies, as presented, by Perry. Second by Doerr. Motion carried.

Motion to approve the Continuing Education Guidelines, as presented, by Doerr. Second by Massa. Motion carried.

Motion to approve the Board Courses, as presented, by Perry. Second Doerr. Motion carried.

Prouty provided an update from the Anesthesia Credentials Committee meeting.

Novotny provided an overview of appointment opportunities with the American Board of Dental Examiners and the Central Regional Dental Testing Services.

Van Dam nominated Dr. Brian Prouty as President, Dr. Jon Schaack as Vice President, and Amy Perry as Secretary/ Treasurer. Motion to cease nominations and cast a unanimous ballot for Dr. Brian Prouty as President, Dr. Jon Schaack as Vice President, and Amy Perry as Secretary/ Treasurer by Van Dam. Second by Doerr. Motion carried.

Motion to approve the annual membership in the American Association of Dental Boards (AADB) and the American Association of Dental Administrators (AADA) and to approve travel to attend the meetings associated with each organization by Massa. Second by Schaack. Motion carried.

The Board announced meeting dates of October 23, 2026, February 5, 2027 and June 4, 2027.

Dr. Harold Doerr and Dr. Scott Van Dam were recognized and thanked for their outstanding service to the Board, having served since 2016 and 2017, respectively. The Board highlighted that their leadership, expertise, and dedication were instrumental in numerous statutory and regulatory initiatives, and that their professionalism, integrity, and collaborative approach strengthened the Board and elevated the profession throughout their years of service.

The Board recognized and expressed its appreciation to Brittany Novotny and the team at Midwest Solutions, Inc. for 17 years of exemplary service. The Board acknowledged the significant contributions made by Brittany and her team over the years and expressed sincere gratitude for their dedication, professionalism, and skill. The Board noted that Brittany and her team will be missed and extended their warmest wishes.

Motion to move into Executive Session pursuant to SDCL 1-25-2 (3) by Doerr. Second by Massa. Motion carried. The Board went into Executive Session at 1:25 p.m.

Motion to move out of Executive Session by Doerr. Second by Schaack. Motion carried. The Board moved out of Executive Session at 1:28 p.m.

Motion to adjourn by Doerr. Second by Perry. Motion carried.

There being no further business, the meeting was adjourned at 1:28 p.m.

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Amy Perry, Secretary

SD State Board of Dentistry
Board Meeting
Zoom
Wednesday, July 29, 2026
5:30pmMST/6:30pmCST

Draft Minutes Have Not Been Approved by the Board

President Dr. Brian Prouty called the meeting to order at 6:30pm CST.

Board Members Present: Dr. Scott Van Dam, Dr. Brian Prouty, Dr. Don Massa, Dr. Harold Doerr, Dr. Jon Schaack, Ashley Flynn, and Amy Perry.

Board Staff Present: Deni Martin and Kayla Bolstad, and Brittany Novotny (Management Transition Support)

Legal Counsel Present: Beverly Katz, Elizabeth Cave, Hillary Williamson, and Andy Fick

Others Present: None.

Motion to adopt the agenda by Doerr, seconded by Van Dam. All in favor, motion carried.

Motion to move into executive session pursuant to SDCL 1-25-2(3) to consult with legal counsel about proposed pending litigation or contractual matters by Schaak, seconded by Doerr. All in favor, motion carried.

Board entered executive session at 6:34pm CST

The Board moved out of executive session at 8:07pm CST.

Motion to adjourn by Prouty, seconded by Perry. All in favor, motion carried.

Meeting adjourned at 8:10pm CST.

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Amy Perry, Secretary

SD State Board of Dentistry
Board Meeting
Zoom
Monday, August 10, 2026
5:30pmMST/6:30pmCST

Draft Minutes Have Not Been Approved by the Board

President Dr. Brian Prouty called the meeting to order at 6:31pm CST.

Board Members Present: Dr. Scott Van Dam, Dr. Brian Prouty, Dr. Don Massa, Dr. Harold Doerr, Dr. Jon Schaack, Ashley Flynn, and Amy Perry.

Board Staff Present: Deni Martin, Kayla Bolstad, and Brittany Novotny (Management Transition Support)

Legal Counsel Present: Beverly Katz, Elizabeth Cave, Hillary Williamson, and Andy Fick

Others Present: Anita Masaitis and Ann Schwartz.

Motion to adopt the agenda by Van Dam, seconded by Perry. All in favor, motion carried.

Motion to move into executive session pursuant to SDCL 1-25-2(3) to consult with legal counsel about proposed pending litigation or contractual matters by Perry, seconded by Van Dam. All in favor, motion carried.

Board entered executive session at 6:34pm CST

The Board moved out of executive session at 7:32 pm CST.

Motion to adjourn by Perry, seconded by Schaack. All in favor, motion carried.

Meeting adjourned at 7:32pm CST.

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Amy Perry, Secretary

SD State Board of Dentistry		Renewals/Reinstatement FY 26	
Categories	**FY 26**	Dentist	660
Licenses/Registrations - Renewed	3965	Dental Hygienist	968
Permits - Renewed	2631	RDA	978
Licenses/Registrations - New	445	Radiology	1355
Permits - New	214	Corporations	260
Temporary Registrations (Excluding new graduates)	9	**Licensing/Registration FY 26**	
Collaborative Supervision Agreements	4	Dentist	24
Continuing Education Audits	144	Dental Hygienist	45
Complaints Received	48	Radiology	199
Financials FY 26		RDA	114
Revenue	$ 576,438.89	Corporations	3
Expense	$ 566,119.00	Cred Verification - Dentist	19
Cash Center Balance - Year End	$ 473,807.74	Cred Verification - Hygienist	14

Remaining Authority by Object/Subobject

Expenditures current through 07/04/2026 01:19:30 PM
HEALTH -- Summary
FY 2026 Version -- AS -- Budgeted and Informational
FY Remaining: 0%

09202 Board of Dentistry - Info

Subobject		Operating	Expenditures	Encumbrances	Commitments	Remaining	PCT AVL
EMPLOYEE SALARIES							
5101030	Board & Comm Mbrs Fees	13,797	5,644	0	0	8,153	59.1
Subtotal		**13,797**	**5,644**	**0**	**0**	**8,153**	59.1
EMPLOYEE BENEFITS							
5102010	Oasi-employer's Share	1,252	435	0	0	817	65.3
Subtotal		**1,252**	**435**	**0**	**0**	**817**	65.3
51 Personal Services							
Subtotal		**15,049**	**6,079**	**0**	**0**	**8,970**	59.6
TRAVEL							
5203010	Auto-state Owned-in State	0	592	0	0	-592	0.0
5203030	Auto-priv (in-st.) H/rte	1,772	965	0	0	807	45.5
5203070	Air-charter-in State	22,000	2,185	0	0	19,815	90.1
5203100	Lodging/in-state	1,637	224	0	0	1,413	86.3
5203130	Non-employ. Travel-in St.	2,500	0	0	0	2,500	100.0
5203140	Meals/taxable/in-state	305	40	0	0	265	86.9
5203150	Non-taxable Meals/in-st	200	100	0	0	100	50.0
5203260	Air-comm-out-of-state	1,000	0	0	0	1,000	100.0
5203330	Non-employ Travel-out-st.	3,000	0	0	0	3,000	100.0
Subtotal		**32,414**	**4,106**	**0**	**0**	**28,308**	87.3
CONTRACTUAL SERVICES							
5204010	Subscriptions	300	0	0	0	300	100.0
5204020	Dues & Membership Fees	5,000	900	0	0	4,100	82.0
5204050	Computer Consultant	34,400	42,854	0	0	-8,454	0.0
5204060	Ed & Training Consultant	3,307	0	0	0	3,307	100.0
5204080	Legal Consultant	38,616	123,878	0	0	-85,262	0.0
5204090	Management Consultant	363,481	293,223	0	0	70,258	19.3
5204100	Medical Consultant	40,000	47,592	0	0	-7,592	0.0
5204130	Other Consulting	7,000	10,070	0	0	-3,070	0.0
5204160	Workshop Registration Fee	2,000	0	0	0	2,000	100.0
5204181	Computer Services-state	316	215	0	0	101	32.0
5204190	Computer Services-private	500	2,222	0	0	-1,722	0.0
5204200	Central Services	3,549	5,317	0	0	-1,768	0.0
5204203	Central Services	203	7	0	0	196	96.6
5204204	Central Services	1,211	1,683	0	0	-472	0.0
5204207	Central Services	1,016	677	0	0	339	33.4

Remaining Authority by Object/Subobject

Expenditures current through 07/04/2026 01:19:30 PM
HEALTH -- Summary
FY 2026 Version -- AS -- Budgeted and Informational
FY Remaining: 0%

09202 Board of Dentistry - Info

Subobject		Operating	Expenditures	Encumbrances	Commitments	Remaining	PCT AVL
5204360	Advertising-newspaper	400	0	0	0	400	100.0
5204460	Equipment Rental	0	150	0	0	-150	0.0
5204480	Microfilm & Photography	500	0	0	0	500	100.0
5204510	Rents-other	725	595	0	0	130	17.9
5204530	Telecommunications Srvcs	4,000	0	0	0	4,000	100.0
5204550	Garbage & Sewer	0	78	0	0	-78	0.0
5204590	Ins Premiums & Surety Bds	1,500	1,120	0	0	380	25.3
5204960	Other Contractual Service	12,000	16,036	0	0	-4,036	0.0
Subtotal		**520,024**	**546,617**	**0**	**0**	**-26,593**	0.0
	SUPPLIES & MATERIALS						
5205020	Office Supplies	1,100	1,766	0	0	-666	0.0
5205310	Printing-state	1,000	640	0	0	360	36.0
5205350	Postage	4,500	6,911	0	0	-2,411	0.0
5205390	Food Stuffs	500	0	0	0	500	100.0
Subtotal		**7,100**	**9,317**	**0**	**0**	**-2,217**	0.0
	OTHER						
5208010	Other	500	0	0	0	500	100.0
Subtotal		**500**	**0**	**0**	**0**	**500**	100.0
52 Operating Subtotal		**560,038**	**560,040**	**0**	**0**	**-2**	0.0
Total		**575,087**	**566,119**	**0**	**0**	**8,968**	1.6

Remaining Authority by Object/Subobject

Expenditures current through 10/03/2026 11:50:36 AM
HEALTH -- Summary
FY 2027 Version -- AS -- Budgeted and Informational
FY Remaining: 74.2%

09202 Board of Dentistry - Info

Subobject		Operating	Expenditures	Encumbrances	Commitments	Remaining	PCT AVL
EMPLOYEE SALARIES							
5101030	Board & Comm Mbrs Fees	13,990	1,992	0	0	11,998	85.8
Subtotal		**13,990**	**1,992**	**0**	**0**	**11,998**	85.8
EMPLOYEE BENEFITS							
5102010	Oasi-employer's Share	1,279	153	0	0	1,126	88.0
Subtotal		**1,279**	**153**	**0**	**0**	**1,126**	88.0
51 Personal Services							
Subtotal		**15,269**	**2,145**	**0**	**0**	**13,124**	86.0
TRAVEL							
5203030	Auto-priv (in-st.) H/rte	1,772	1,065	0	0	707	39.9
5203070	Air-charter-in State	3,000	0	0	0	3,000	100.0
5203100	Lodging/in-state	1,637	112	0	0	1,525	93.2
5203130	Non-employ. Travel-in St.	2,500	354	0	0	2,146	85.8
5203140	Meals/taxable/in-state	305	6	0	0	299	98.0
5203150	Non-taxable Meals/in-st	200	26	0	0	174	87.0
5203260	Air-comm-out-of-state	1,000	0	0	0	1,000	100.0
5203330	Non-employ Travel-out-st.	3,000	0	0	0	3,000	100.0
Subtotal		**13,414**	**1,563**	**0**	**0**	**11,851**	88.3
CONTRACTUAL SERVICES							
5204010	Subscriptions	300	0	0	0	300	100.0
5204020	Dues & Membership Fees	5,000	4,600	0	0	400	8.0
5204050	Computer Consultant	44,400	75,000	0	0	-30,600	0.0
5204060	Ed & Training Consultant	3,307	0	0	0	3,307	100.0
5204080	Legal Consultant	47,616	14,743	0	0	32,873	69.0
5204090	Management Consultant	295,140	288,586	186,216	0	-179,662	0.0
5204100	Medical Consultant	40,000	19,080	210,327	0	-189,407	0.0
5204130	Other Consulting	7,000	17,120	75,400	0	-85,520	0.0
5204160	Workshop Registration Fee	2,000	0	0	0	2,000	100.0
5204181	Computer Services-state	316	0	0	0	316	100.0
5204190	Computer Services-private	500	113	0	0	387	77.4
5204200	Central Services	3,569	2,225	0	0	1,344	37.7
5204202	Central Services	0	10	0	0	-10	0.0
5204203	Central Services	203	9	0	0	194	95.6
5204204	Central Services	1,211	132	0	0	1,079	89.1
5204207	Central Services	1,016	624	0	0	392	38.6

Remaining Authority by Object/Subobject

Expenditures current through 10/03/2026 11:50:36 AM
HEALTH -- Summary
FY 2027 Version -- AS -- Budgeted and Informational
FY Remaining: 74.2%

09202 Board of Dentistry - Info

Subobject		Operating	Expenditures	Encumbrances	Commitments	Remaining	PCT AVL
5204360	Advertising-newspaper	400	0	0	0	400	100.0
5204480	Microfilm & Photography	500	0	0	0	500	100.0
5204510	Rents-other	725	840	0	0	-115	0.0
5204530	Telecommunications Srvcs	4,000	0	0	0	4,000	100.0
5204590	Ins Premiums & Surety Bds	1,500	0	0	0	1,500	100.0
5204960	Other Contractual Service	12,000	852	0	0	11,148	92.9
Subtotal		**470,703**	**423,934**	**471,943**	**0**	**-425,174**	0.0
	SUPPLIES & MATERIALS						
5205020	Office Supplies	1,100	1,517	0	0	-417	0.0
5205310	Printing-state	1,000	578	0	0	422	42.2
5205320	Printing-commercial	0	1,046	0	0	-1,046	0.0
5205350	Postage	4,500	2,649	0	0	1,851	41.1
5205390	Food Stuffs	500	0	0	0	500	100.0
Subtotal		**7,100**	**5,790**	**0**	**0**	**1,310**	18.5
	CAPITAL OUTLAY						
5207451	Office Furn & Fixtures	0	1,512	0	0	-1,512	0.0
5207901	Computer Hardware	0	33	0	0	-33	0.0
Subtotal		**0**	**1,545**	**0**	**0**	**-1,545**	0.0
	OTHER						
5208010	Other	500	0	0	0	500	100.0
Subtotal		**500**	**0**	**0**	**0**	**500**	100.0
52 Operating Subtotal		**491,717**	**432,832**	**471,943**	**0**	**-413,058**	0.0
Total		**506,986**	**434,977**	**471,943**	**0**	**-399,934**	0.0

AGENCY: 09 HEALTH
BUDGET UNIT: 09202 BOARD OF DENTISTRY - INFO

COMPANY	CENTER	ACCOUNT	BALANCE	DR/CR	CENTER DESCRIPTION
6503	092000061807	1140000	97,686.32	DR	BOARD OF DENTISTRY
COMPANY/SOURCE TOTAL 6503 618			97,686.32	DR *	
COMP/BUDG UNIT TOTAL 6503 09202			97,686.32	DR **	
BUDGET UNIT TOTAL 09202			97,686.32	DR ***	

REVENUE SUMMARY BY BUDGET UNIT
FOR PERIOD ENDING: 09/30/2026

AGENCY 09 HEALTH
BUDGET UNIT 09202 BOARD OF DENTISTRY - INFO

CENTER	COMP	ACCOUNT	DESCRIPTION	CURRENT MONTH	YEAR-TO-DATE
COMPANY NO	6503				
COMPANY NAME	PROFESSIONAL & LICENSING BOARDS				
092020061807	6503	4293005	DENTIST CREDENTIAL	1,800.00	3,000.00
092020061807	6503	4293015	HYGIENIST CREDENTIAL	.00	600.00
092020061807	6503	4293105	DENTIST NEW LICENSE	200.00	600.00
092020061807	6503	4293110	DENTIST LICENSE RENEWAL	.00	3,960.00
092020061807	6503	4293115	DENTIST JP EXAM	1,200.00	2,400.00
092020061807	6503	4293125	DENTIST REINSTATE LICENSE	.00	900.00
092020061807	6503	4293135	DENTIST NITROUS OXIDE	150.00	350.00
092020061807	6503	4293137	DENTIST NITROUS RENEW	.00	100.00
092020061807	6503	4293147	DENTIST MOD SED AD RENEW	.00	50.00
092020061807	6503	4293152	DENTIST GA/DEEP SED RENEW	.00	50.00
092020061807	6503	4293205	HYGIENIST NEW LICENSE	150.00	450.00
092020061807	6503	4293210	HYGIENIST RENEWAL LICENSE	.00	4,715.00
092020061807	6503	4293215	HYGIENIST JP EXAM	135.00	675.00
092020061807	6503	4293220	HYGIENIST ANESTH RENEW	.00	1,505.00
092020061807	6503	4293222	HYGIENIST ANESTHESIA	135.00	405.00
092020061807	6503	4293225	HYGIENIST REINSTATE	.00	1,350.00
092020061807	6503	4293235	HYGIENIST NITRIOUS OXIDE	135.00	360.00
092020061807	6503	4293237	HYGIENIST NIT OXIDE RENEW	.00	1,225.00
092020061807	6503	4293305	RADIOLOGY NEW	1,980.00	3,420.00
092020061807	6503	4293307	RADIOLOGY RENEWAL	.00	3,220.00
092020061807	6503	4293315	RADIOLOGY REINSTATE	.00	1,170.00
092020061807	6503	4293405	ADA EXPANDED FUNCTION NEW	1,845.00	2,880.00
092020061807	6503	4293410	ADA EXPAND FUNCTION RENEW	.00	2,625.00
092020061807	6503	4293415	ADA EXPAND FUNCT REINSTAT	.00	675.00

REVENUE SUMMARY BY BUDGET UNIT
FOR PERIOD ENDING: 09/30/2026

AGENCY 09 HEALTH
BUDGET UNIT 09202 BOARD OF DENTISTRY - INFO

CENTER	COMP	ACCOUNT	DESCRIPTION	CURRENT MONTH	YEAR-TO-DATE	
092020061807	6503	4293420	ADA EXPAND FUNC ADMIN NIT	1,485.00	2,295.00	
092020061807	6503	4293422	ADA EXPAND FUNC NIT RENEW	.00	1,750.00	
092020061807	6503	4293505	CORPORATE NEW LICENSE	.00	100.00	
092020061807	6503	4293510	CORPORATE RENEWAL	.00	425.00	
092020061807	6503	4293600	TEMP LICENSE	700.00	1,300.00	
092020061807	6503	4293850	COLLABORATIVE SUPERVISION	.00	20.00	
ACCT:	4293	BUSINESS & OCCUP LICENSING (NON-GOVERNMENTAL)		9,915.00	42,575.00	*
ACCT:	42	LICENSES, PERMITS & FEES		9,915.00	42,575.00	**
092020061807	6503	4595000	VERIFICATION LETTERS	100.00	225.00	
092020061807	6503	4595800	LIST OF PRACTITIONERS	750.00	3,150.00	
ACCT:	4595			850.00	3,375.00	*
ACCT:	45	CHARGES FOR SALES & SERVICES		850.00	3,375.00	**
092020061807	6503	4920045	NONOPERATING REVENUES	.00	11,321.43	
ACCT:	4920	NONOPERATING REVENUE		.00	11,321.43	*
ACCT:	49	OTHER REVENUE		.00	11,321.43	**
CNTR:	092020061807			10,765.00	57,271.43	***
CNTR:	092020061			10,765.00	57,271.43	****
CNTR:	0920200			10,765.00	57,271.43	*****
COMP:	6503			10,765.00	57,271.43	******
B UNIT:	09202			10,765.00	57,271.43	*******

Subobject	Description	FY22 Actual	FY23 Actual	FY24 Actual	FY25 Actual	FY26 Actual	FY27 10/1/2026
5101030	Board & Comm Members	1,320	660	540	1,992	5,644	1,992
5102010	OASI-Employer's	101	50	42	152	435	153
5203010	Auto-State	15450	25562	7508	19978	4106	1563
	Board Member Travel						
	*Includes: Auto, Meals, Lodging						
5204010	Subscriptions	872		1200	2191		0
5204020	Dues & Memberships	5,920	2,585	375	625	900	4,600
5204030	Legal Document Fees	634	22				
5204050	Computer Consultant (database)	6,035	23,765	32,593	28,079	42,854	75,000
5204060	Ed & Training			7,500	7,875	-	
5204080	Legal Consultant	47,398	10,999	68,609	155,877	123,878	14,743
5204090	Management Consultant	265,080	273,964	312,118	315,100	293,223	288,586
5204100	Medical Consultant (investigator)	24,457	28,191	33,283	73,608	47,592	19,080
5204130	Other Consulting	1,795	23,071	9,732	10,459	10,070	17,120
5204160	Workshop Registration Fee	475	1,120			-	
5204181	Central Services- Computer Services	125		176	196	215	
520190	Computer Services- Private	872	1938	135	133	2222	113
5204200	Central Services: Accounting	4,074	3,649	5,270	5,814	5,317	2,225
5204202	Central Services				8		10
5204203	Central Services: Purchasing Services				6	7	9
5204204	Central Services: Records	1,821	906	1,505	1,178	1,683	132
5204207	Central Services: HR	415	333	117	483	677	624
5204220	Equipment Serv & Maint	390					
5204360	Advertising- Newspaper	257				-	
5204430	Publishing		196	458			
5204460	Equipment Rental			200		150	
5204480	Microfilm & Photography				50	0	
5204510	Rents-Other	900	1,641	2,102	334	595	840
5204530	Telecommunications Services	34				0	
5204550	Garbage & Sewer	60	66	92	50	78	
5204590	Ins Premiums & Surety Bds	1155	1393	1197	1204	1120	
5204960	Other Contractual Service	10346	10081	13447	14756	16036	852
5205020	Office Supplies	955	1578	2099	1461	1766	1517
5205300	Trophies & Awards				62		
5205310	Printing-State	1125	803	1020	1021	640	578
5205320	Printing- Commercial				1030		1046
5205330	Supp Public & Ref Mat		48				
5205350	Postage	4624	5457	6667	6943	6911	2649
5205390	Food Stuffs	541	484	885	168	0	
5207451	Office Furniture & Fixtures						1512
5207901	Computer Hardware						33
	TOTAL EXPENSES	**397,231.00**	**418,562.00**	**508,870.00**	**650,833.00**	**566,119.00**	**434,977.00**
	TOTAL REVENUE	**366,776.74**	**348,532.52**	**462,763.81**	**623,115.56**	**576,438.89**	**57,271.43**
	REVENUE - EXPENSES	-30,454.26	-70,029.48	-46,106.19	-27,717.44	10,319.89	-377,705.57

	CASH CENTER BALANCE	**596,516.74**	**398,642.31**	**491,202.07**	**463,484.93**	**473,807.74**	**97,866.32**

MIDWEST HEALTH MANAGEMENT SERVICES, LLC

SD Health Professionals Assistance Program

Annual Health Professionals Assistance Program Update

Dear Members of the South Dakota Board of Dentistry,

We are pleased to provide an update on our program and its current participants.

Our program continues to operate under SDCL Chapter 36-2A, and we currently have two participants enrolled. Both participants continue to do well and remain actively engaged in the program. We are encouraged by their continued progress and appreciate the opportunity to support them through this process. Both participants are voluntary. One has a mental health diagnosis, and the second one has a mental health and substance use diagnosis.

For the upcoming fiscal year, we are requesting continued funding of $5,000 per year. We are not requesting an increase or change to the current annual amount.

We appreciate the Board of Dentistry's continued support of the program. This funding allows us to maintain the resources necessary to provide appropriate support and monitoring for participants while continuing to fulfill the goals of the program.

Thank you for your consideration and for your ongoing partnership. We look forward to continuing this work and providing another update as appropriate.

Sincerely,

Amanda McKnelly
Executive Director

4109 S. Carnegie Circle
Sioux Falls, SD 57106

605-275-4711
Fax: 605-275-4715
www.MWHMS.com

Southeast Technical College

Dental Assisting Program Update

October 2026

Purpose:

To provide the South Dakota State Board of Dentistry with an update on the dental assisting program.

Updates:

- The sixth class (2025-2026 cohort) of the program successfully graduated thirty-two students. 100% of the students have secured employment in South Dakota, Minnesota, and Wisconsin.

- Currently students have either concluded or in the process of sitting for the DANB Examination. At present, twelve students have successfully completed the DANB Examination. We provide comprehensive support for students pursuing the DANB credential. We strongly suggest all the students take the DANB Examination.

- The current class has an enrollment of thirty-three students. The students represent the home state of South Dakota, Minnesota, and Iowa.

- The program has hired an additional adjunct to support the increase in enrollment from 30 to 36 students. Currently, the program has two full-time faculty and six adjunct instructors.

- The program has added a dentist to the team to provide clinical support for students during chairside training.

Regarding the new dental assisting program being established in Summerset as we are a RDA program and accredited by CODA, I am aware of the program; however, based on my current understanding, Western Dakota Technical College is not planning any changes to our program at this time. We do not anticipate a significant impact on our enrollment, and we will continue to monitor developments as the program moves forward.

As an update on Western Dakota Technical College's Registered Dental Assisting (RDA) Program, we currently have 20 students enrolled. The program continues to provide students with the knowledge, clinical experiences, and hands-on training necessary to meet South Dakota's workforce needs.

As for the Dental Hygiene Program, I would recommend contacting Erik Mutterer (Erik.Mutterer@wdt.edu), who would be the best resource to provide an update on the status and timeline of that program.

Please let me know if there is any additional information I can provide regarding the Registered Dental Assisting Program.

Chanin Hughes| BA, CDA, RDA

Registered Dental Assisting Program Director

T: 605.718.3057

Chanin.Hughes@wdt.edu

Western Dakota Technical College prepares students to be highly-skilled professionals through accessible, career-focused programs to improve their lives, while adapting to community workforce needs and positively impacting our economy.

LATC Report:

Lake Area Technical College's Dental Assisting program graduated 50 students last spring: 42 from the campus program and 8 from the online program. This fall, 43 students entered the campus program, and all 5 online students who began in January 2026 remain enrolled. Enrollment for fall 2027 has reached the program's maximum capacity of 48 students, and we have begun filling seats for fall 2028.

The launch of our Dental Hygiene program has contributed to dental assisting enrollment, as interest in dental hygiene remains high. Many students initially enter with limited awareness of the dental assistant's role. As they progress, they discover that they enjoy the variety dental assisting offers and are surprised by the rigor of the coursework. Many have decided to remain in dental assisting, while keeping dental hygiene as an option for future education and professional growth.

Our Dental Hygiene program completed its initial CODA site visit in March 2026 and was granted initial accreditation in August. The program welcomed its first class of 13 students this fall and is preparing for another CODA site visit in spring 2027.

Dental hygiene students will have full use of the LATC dental clinic for most of the spring semester and throughout the summer semester to complete required clinical competencies and hours. We have added a dedicated radiography room to support instruction and free up clinic space. We continue to evaluate ways to strengthen both programs and meet the needs of the dental profession.

We are seeking dentists to provide part-time clinical oversight for dental hygiene students. Although some hours are covered, additional participation would be welcome. Dentists interested in contributing to the education of future members of the dental workforce are encouraged to contact Dr. Darlene Bogenpohl, Dental Hygiene Program Director, at Darlene.Bogenpohl@lakeareatech.edu.

Central Regional Dental Testing Service, Inc.
CRDTS+SRTA - *Better Together*
1725 SW Gage Blvd.
Topeka, KS 66604-3333
www.crdts.org

Ph: 785-273-0380
FX: 785-273-5015
info@crdts.org

January 2026 – Post Meeting Summary

TO: CRDTS Steering Committee Members and State Dental Board Executive Directors
CC: Executive Committee
FROM: Richael Cobler, Executive Director

Subject: Recap and Update: CRDTS Steering Committee Meeting (August 28, 2026)

Dear State Dental Board Members and Executive Directors,

Thank you to everyone who was able to travel to Omaha for our recent CRDTS Annual Meeting at the Embassy Suites. Your time, insights, and engagement are deeply appreciated as we work together to advance our testing and education standards. For those who were unable to attend, you were greatly missed, and we hope to see you at our next gathering. Your voice is important!

To keep everyone informed, here is a comprehensive recap of the actions, approvals, and reports from the August 28 session:

Administrative & Officer Actions

- **Meeting Governance:** The committee officially established a quorum, adopted the meeting agenda, reviewed the organizational charter, and approved the minutes from the January 24, 2026, regular meeting.
- **Compliance Reminder:** President, Dr. Deena Kuempel led a review of the Code of Conduct and Confidentiality rules. Committee members are reminded that the annual questionnaire must be completed and signed online via the Examiners tab under "CRDTS Docs".
- **Leadership Updates:** The committee approved the Standing Committee Membership slate following the President & Executive Committee Report from Dr. Kuempel. Financial updates, leadership summaries, and strategic outlooks were also delivered by President-Elect Dr. Sean Ellis, Vice-President Rebecca Ficken, and Secretary/Treasurer Linda Jorgenson.

Exam Review Committee Reports

- **Dental Exam Review (Dr. Rodney Hill):** The committee formally approved a summary of examination changes and welcomed nine new dental exam testing sites.
- **Dental Hygiene Exam Review (Lisa Kucera, RDH):** Five new dental hygiene testing sites were approved. Additionally, Suzanne Luken was approved to fill the South Dakota seat on the DH ERC, Mara Gordon was appointed as a Restorative Auxiliary Consultant/Subject Matter Expert, and Abby Rennau was appointed as the Faculty/Educator Representative.

Committee & Staff Briefings

- **Leadership Slate:** The Nominating Committee (Dr. Dohm) presented a slate of officers, which was approved to be forwarded to the General Assembly.
    - **Congratulations to Dr. Bryon Killpack** on his election to the Dental ERC Chair position and thank you to all of the incumbents for agreeing to continue in your position.
- **EEAC Changes:** The Examiner Evaluation and Assignment Committee (Dr. Wright) secured approval for attached charter changes. The committee also approved Dr. Dohm to fill the EEAC seat vacated by Dr. Wright.

- **Operations & Finance:** Operational updates were provided by the professional staff directors covering dental exams, dental hygiene exams, special programs, marketing, and business strategies. Executive Director Richael Cobler concluded the briefings with an executive presentation.

Budgeting: The committee officially reviewed and approved the 2025–2026 financials, adopted the 2026–2027 budget, and set the meeting calendar for 2027.

Upcoming Events & Save the Dates

- **Next CRDTS Steering Committee Meeting:** January 23, 2027. This will be a hybrid meeting held at the Marriott Kansas City Airport.
- **Next Annual Meeting:** August 27, 2027 – San Antonio on the Riverwalk

Thank you again for your continued dedication to CRDTS and the dental regulatory community. Please reach out if you have any questions regarding these updates.

Warm regards,

Sheli Cobler

Richael "Sheli" Cobler
Executive Director
www.crdts.org

Date: October 2026
Prepared by: Stephen Prisby, ADEX Regulatory and Educational Affairs Director
Prepared for: South Dakota Board of Dentistry

ADEX News & Updates

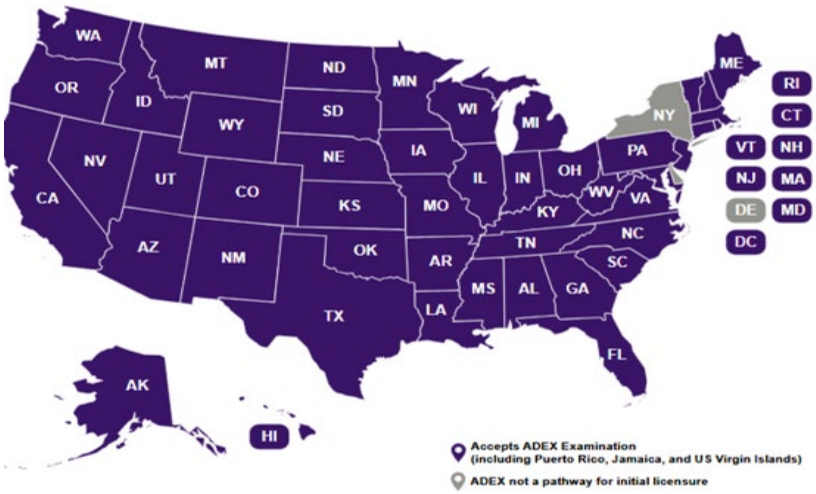
The American Board of Dental Examiners (ADEX) is a national, non-profit examination organization dedicated to supporting state dental boards' mission to protect the public. ADEX administers fair, valid, reliable, and standardized national licensure examinations in the oral health professions. Its examination system is built around regulator collaboration, trained and calibrated examiners, nationally coordinated scoring, quality assurance, and a governance model that includes state board and educator-examiner participation.
ADEX supports the licensure needs of state dental boards and commissions across more than 50 U.S. states and jurisdictions. In 2025, ADEX offered more than 570 examination dates at 312 testing locations and served more than 466 dental education programs nationwide. ADEX continues to support boards in all jurisdictions where its examinations are accepted through direct outreach, board meeting engagement, secure score reporting, and regulator-informed examination updates.

- **Board-centered expertise:** ADEX's regulatory collaboration is grounded in direct experience with state dental board mandates and operations. Current and former state dental board members serve throughout ADEX's leadership, examiner network, and advisory structure, giving ADEX a practical and continuous connection to the boards it supports. That board-level experience strengthens ADEX's ability to develop and administer examinations that reflect real regulatory expectations and help ensure entry-level oral health practitioners are prepared to practice safely.

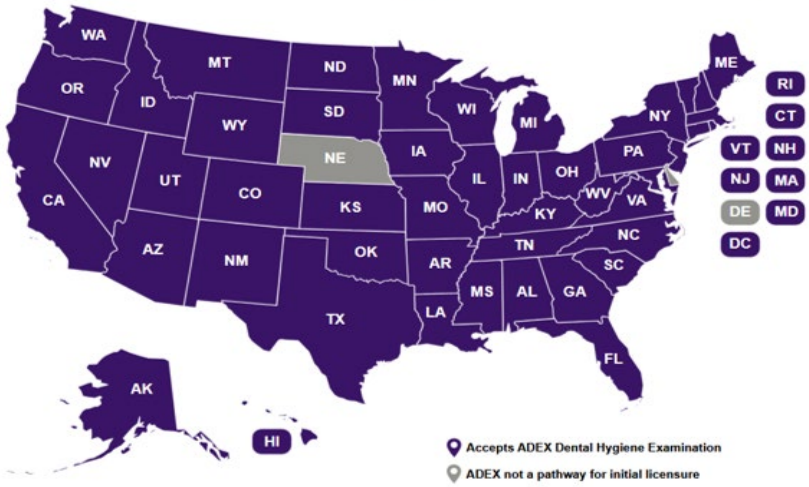
- **National reach and regulatory visibility:** ADEX has established direct engagement across all 50 states and Washington, DC, creating a strong foundation for consistent communication with boards, administrators, and regulatory stakeholders.

- **Portability and consistency:** A national standard should reduce unnecessary barriers for qualified candidates while preserving the authority of state boards. The American Board of Dental Examiners gives boards a pathway to support mobility without weakening public protection. The ADEX Exams are the most widely accepted dental and dental hygiene exams for initial licensure in the United States.

National Dental Portability



National Dental Hygiene Portability



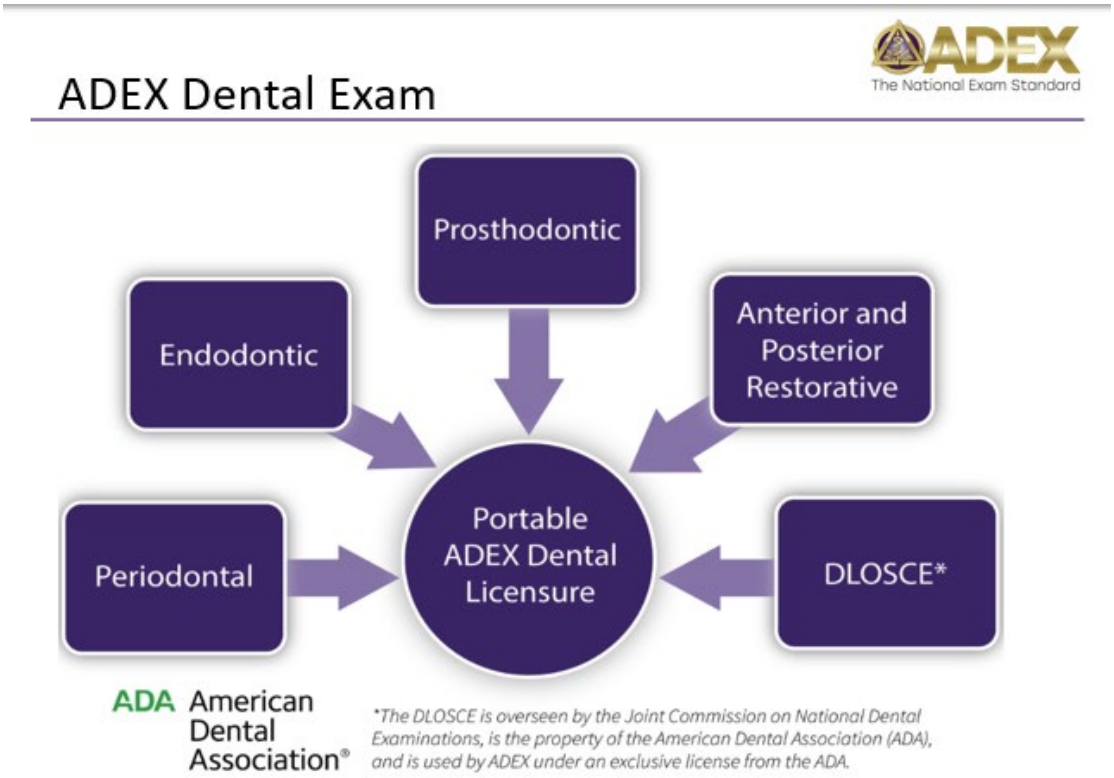
Council on Examinations & Examiner Participation Opportunity

Through the ADEX Council on Examinations, each ADEX Member state appoints a dentist and dental hygienist to serve three-year terms. Current state dental board members, or individuals who have served within the past five years, are eligible for appointment. Council and committee participation gives state regulators a direct voice in exam development, policy discussion, professional calibration, and the continuing refinement of licensure assessments.

State dental board members have multiple opportunities to contribute to the ADEX examination process. In addition to overseeing licensure decisions within their jurisdictions, board members may serve as ADEX examiners, gaining firsthand experience with candidate assessment, calibration, scoring, and the safeguards that support fair and standardized examinations. This involvement helps promote national consistency while providing valuable insight into examination quality and administration.

- **Examine:** Former and current state board members, along with educators, participate directly in examination administration and gain firsthand insight into the public-protection framework behind ADEX licensure assessments. **The ADEX examining team includes more than 1,400 calibrated & trained professionals committed to maintaining the highest testing standards and supporting safe, competent practice.**
- **Develop:** Receive training, calibration, and professional development connected to contemporary licensure assessment.
- **Lead:** Represent the state board perspective in national examination policy and governance discussions on the Council on Examinations.

The integration of the ADA's Dental Licensure Objective Structured Clinical Examination (DLOSCE) as the cognitive assessment component within the ADEX Dental Examination is complete as of August 2026. This collaboration is designed to simplify pathways, reduce redundancy, and better align dental licensure with national models used across other health professions.



The ADA's DLOSCE was developed by the **Joint Commission on National Dental Examinations (JCNDE)**. It is a unique nationally standardized, case-based examination that evaluates clinical judgment, diagnosis, treatment planning, patient management, and readiness for independent practice. The examination consists of 150 multiple-choice questions based on realistic patient cases and incorporates interactive 3-D images that candidates can rotate, zoom, and manipulate to simulate the evaluation of clinical findings. The DLOSCE assesses the critical thinking and decision-making skills required for safe, competent, and independent dental practice using a valid, reliable, and modern examination format. The Exam is timed and candidates have up to 6 hours and 45 minutes to complete it (with breaks).

The JCNDE is governed by an independent 16-member commission representing a broad range of stakeholders, including dental education, dental practice, state dental boards, dental hygiene, dental students, and public members. These members come from organizations such as ADEA, ASDA, ADHA, AADB and the ADA.

The ADEX Clinical Local Anesthesia Exam has evolved

The updated ADEX Clinical Local Anesthesia Exam removes the need for a patient and uses simulated technology to evaluate candidate readiness in a more standardized, consistent, and accessible format. ADEX has developed a comprehensive clinical assessment model using simulation-based methodology. Created through 12 months of innovation and collaboration with Acadental. It delivers a level of realism and clinical fidelity not previously available for licensure assessment. It advances ADEX's commitment to modern, competency-based examination standards.

Simulation-based testing provides several important advantages:

- Elimination of patient risk associated with administering anesthesia solely for examination purposes.
- Standardization of testing conditions, ensuring that each candidate is evaluated under the same clinical parameters.
- Improved reliability and objectivity in scoring, as examiners can assess clearly defined competencies and technique without variability introduced by individual patient factors.

This approach supports patient safety, reduces ethical & logistical barriers for candidates and programs, and allows state boards to rely on a modern assessment model that continues to measure the knowledge, judgement and clinical decision-making required for safe local anesthesia administration.



The Annual Testing & Regulatory Summit will take place October 14-18, 2026, at the Gaylord National Harbor just outside Washington, DC. This annual regulatory and testing meeting brings together state dental board leaders, administrators, educators, exam leaders, and national stakeholders for focused discussion on licensure, examination modernization, public protection, license portability and emerging regulatory issues. The Summit includes the Annual Meetings for the American Board of Dental Examiners, the American Association of Dental Administrators, the American Association of Dental Boards and the Educators' Conference.

ADEX continues to strengthen its relationship-focused outreach with the South Dakota Board of Dentistry. I will continue sharing updates with your Board's Executive Secretary, Deni Martin, and remain available for future board meeting presentations and questions. These national updates may support the Board as it considers licensure policy, examination acceptance, workforce mobility, and public protection priorities.

Stephen Prisby
Regulatory and Educational Affairs Director
sprisby@adextesting.org

Frequently Asked Questions (FAQ) regarding the updates to the ADEX Clinical Local Anesthesia Exam incorporating new SimLA simulated technology

1. Why is ADEX replacing the patient-based local anesthesia examination with the updated local anesthesia exam utilizing the SimLA product?

Educators and students have voiced concerns for years about the ethical challenges of conducting a clinical local anesthesia examination on patients. These concerns include asking patients to receive unnecessary injections primarily for examination purposes and the difficulty of ensuring a consistent testing experience to meet examination requirements. Moving to a simulation-based model allows ADEX to preserve the rigor of the clinical assessment while reducing unnecessary patient involvement and creating a safer, more standardized environment for evaluating candidate competency.

2. Does ADEX still offer the computer based didactic local anesthesia exam?

Yes. ADEX offers the computer based didactic exam in tandem with the clinical local anesthesia exam. Five states require both components. Twenty-five states require only the computer-based didactic examination. The didactic assessment remains a secure, standardized, computer-based examination delivered through a national testing network. Candidates must demonstrate critical competencies required for safe local anesthesia administration, including proper patient assessment, armamentarium selection, infection control, anatomical landmark identification, injection technique, aspiration, and management of potential complications.

3. How do you know the candidate has successfully anesthetized the patient if no patient is used?

The examination never tested to determine if a patient was anesthetized or numb. It uses a validated simulation model that objectively measures proper needle placement (insertion, angulation, depth), and procedural technique. Candidates are evaluated on the accuracy of the procedure rather than patient sensation, providing a standardized and objective assessment of clinical competency. The target candidates for this exam are in school or finishing a rigorous CODA accredited dental hygiene program, which involves patient based clinical skills assessment. In addition, they will still be taking the computer-based didactic Local Anesthesia Exam in tandem with this clinical local anesthesia exam.

4. Is the examination easier on the SimLA than the previous patient-based examination?

No. The examination measures the same competencies expected of entry-level dental hygienists. The format has changed, but the performance expectations and standards for safe, competent practice remain rigorous. All established critical criteria that were historically evaluated on the patient-based exam have been maintained.

5. Has the examination been validated?

Yes. The updated exam with the SimLA product was developed over twelve months and rigorously tested with multiple groups of Subject Matter Experts and ADEX Staff clinicians prior to determining it acceptable for pilot testing. At multiple events, participant clinicians, educators, and dental hygiene students with no prior exposure to or knowledge of the product took a mock exam following the established criteria of the patient-based examination. Psychometric analysis of the results demonstrated that the simulated examination effectively measures the competencies necessary for safe local anesthesia administration while providing consistent outcomes in validated errors and pass rates as the patient-based exam.

6. Will state dental boards continue to accept the examination for licensure?

The updated clinical exam incorporating SimLA is designed to satisfy state licensure requirements while reflecting current best practices in simulated competency assessment. Individual state acceptance remains determined by each state's statutes and regulations.

7. How is the examination scored?

Candidates are evaluated using standardized scoring criteria that measure each critical step of the procedure. Examiners assess Contaminated Needle, Site of Insertion, Needle Depth and Angle, Aspiration, Rate of Deposition, Recapping, and Sharps Disposal and overall competency using established objective evaluation standards.

8. Will candidates still need to understand patient management and emergency procedures?

Absolutely. Candidates are expected to follow all CDC guidelines and patient management practices with a simulated patient and are required to take the computer-based didactic Local Anesthesia Exam. In that exam, candidates must show knowledge of patient assessment, medical history review, pharmacology of anesthetic agents, contraindications, informed consent, recognition of complications, and appropriate emergency management. Safe clinical judgment remains an essential component of the examination.

9. What are the primary benefits of administering the Local Anesthesia Clinical Examination using the SimLA simulated patient?

The SimLA examination offers several significant advantages:

- Eliminates unnecessary injections on patients and resolves ethical dilemmas.
- Provides a standardized testing experience for every candidate.
- Maintains rigorous competency standards while utilizing current assessment technology.
- Produces more objective and consistent scoring.
- Aligns with modern simulation practices used throughout healthcare education.

Dentist Credential		
First Name	**Middle Name**	**Last Name**
Hunter	Allen	Watson
Parham		Akhavan
Brian	Bradley	Bursick
Peter	Anthony	Balacky

Dentist New		
First Name	**Middle Name**	**Last Name**
Reese	Alan	Blacker
Samuel	Jeffery	Derner
Anne	Elizabeth	Wittrock
Ashley	Kay	Solano

Dentist Military		
First Name	**Middle Name**	**Last Name**
None		

Hygienist Military		
First Name	**Middle Name**	**Last Name**
None		

Hygienist Credential		
First Name	**Middle Name**	**Last Name**
Cheyenne	Christian Robertson	Atkins
Catherine	Antonia	Cotsilis
Erin	Ashley	Fine
Adrianna	Michelle	Junch
Eliza	Claire	Pharis
Pamela	Jo	Schoon
Elaine	Noel	Vogel
Bailey	JoAnn	Johanson
Codi	Rayann	Southard

Hygienist New		
First Name	**Middle Name**	**Last Name**
Mya	Noel	Boomsma
Riley	Marie	Draper
Maria	Isabel	Garcia Perales
Sage	Makay	Graham
Parmila		Khapangi Magar
Lilli	Aaron	Molitor
Kenadi	Faye	Morgan
Theadora	Faye	Norman
Kaira	Joy	Packard
Marie	Ann	Peckosh
Kayla	Marie	Senn
Brenda	Yadira	Torres
Megan	Rene	Lyon

Monty Bechtold- Reinstatement Motion under 36-6A-25

20:43:04:01. Representation of or advertising specialty practice. A dentist may advertise or represent oneself as a specialist or use the terms specializes, specializing, or another variation of either term, for any specialty in which the dentist has completed a post-doctoral program that:

(1) Consists of at least two full-time years; and

(2) Is accredited by an accreditation agency recognized by the United States Department of Education or is administered by a dental school accredited by an organization recognized by the United States Department of Education.

A dentist advertising or representing oneself as a specialist or using the term specializes, specializing, or another variation of either term, must avoid any implication that another dentist associated with the same practice or entity is a specialist, unless that dentist meets the requirements of this section.

Declaration to the public of a specialty practice or the inference of specialty status not authorized by this section is engaging in false or misleading advertising.

Source: SL 1975, ch 16, § 1; 6 SDR 87, effective March 2, 1980; 11 SDR 73, effective November 27, 1984; 12 SDR 151, 12 SDR 155, effective July 1, 1986; 18 SDR 132, effective February 17, 1992; 37 SDR 131, effective January 6, 2011; 50 SDR 12, effective August 8, 2023.

General Authority: SDCL 36-6A-14(20).

Law Implemented: SDCL 36-6A-14(1)(22), 36-6A-28, 36-6A-29, 26-6A-59.1(13).

STATUTES

36-6A-1. Definitions.

Terms used in this chapter mean:

.....

(18) "Direct supervision," the supervision of a dental hygienist or registered dental assistant requiring that a dentist diagnose the condition to be treated, a dentist authorize the procedure to be performed, a dentist remain in the dental clinic while the procedure is performed, and before dismissal of the patient a dentist approve the work performed by the dental hygienist or registered dental assistant. A dentist may provide direct supervision via live video. A dentist must appear upon request using live video with a response time similar to what would be expected if the dentist were present in the dental clinic;

...

(21) "Indirect supervision," the supervision of a dental hygienist or registered dental assistant requiring that a dentist authorize the procedures and a dentist be in the dental clinic while the procedures are performed by the registered dental assistant or dental hygienist. A dentist may provide indirect supervision via live video. A dentist must appear upon request using live video with a response time similar to what would be expected if the dentist were present in the dental clinic;

...

(31) "Teledentistry," the practice of dentistry via telehealth as outlined in SDCL 34-52 ~~where the patient and the dentist are not in the same physical location, and which utilizes the exchange of clinical information and images over remote distances~~.

Source: SL 2015, ch 199, § 1; SL 2016, ch 193, § 1.

36-6A-49.4. Teledentistry ~~services to comply with chapter as if services provided in person~~ standards.

Any services provided by a licensee or registrant through teledentistry ~~or electronic means~~ shall comply with the provisions of this chapter to the same standard of competence as if the services were provided in person by a licensee or registrant. A dentist shall not conduct an evaluation using teledentistry if the standard of competence or the evidence based standards of practice to sufficiently establish an informed diagnosis necessitates an in person evaluation. A licensee or registrant utilizing teledentistry shall:

(1) Establish protocols for technological failures.

(2) Ensure appropriate follow up care for a patient in a reasonable timeframe following a teledentistry encounter; and

(3) Refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in the case of emergency.

Source: SL 2015, ch 199, § 61.

ADMINISTRATIVE RULES

20:43:11:01. Content. A dentist who treats patients shall maintain legible, complete, and accurate medical records. The medical record must contain the patient's clinical and financial record. The clinical record must contain the following information:

(1) For each clinical record entry note:

(a) The signature, initials, or electronic verification of the individual that made the entry note; and

(b) If treatment was provided, the name and the signature, initials, or electronic verification of the individual that provided treatment and the name of the supervising dentist;

(2) The date of each patient record entry, document, radiograph or model;

(3) The examination findings documented by subjective complaints, objective findings, an assessment or diagnosis of the patient's condition, and proposed treatment options;

(4) Current dental and medical history that may affect dental treatment;

(5) Any images, radiographs, test results or other diagnostic aid used to aid in the diagnosis. All film or digital radiographs must be of diagnostic quality. Retention of molds or study models is at the discretion of the dentist, except for molds or study models for orthodontia or full mouth reconstruction that must be retained as part of the clinical record;

(6) An agreed upon treatment plan based on the assessment or diagnosis of the patient's condition;

(7) A complete description of all treatment or procedures administered to the patient at each visit;

(8) A record of any medication administered or dispensed in office, or prescribed, including:

(a) The date administered, dispensed, or prescribed;

(b) The name of the patient to which the medication was administered, dispensed, or prescribed;

(c) The name of the medication; and

(d) The dosage and amount of the medication administered, dispensed, or prescribed, including refills;

(9) Referrals, patient response to referrals, and any communication to and from any health care provider regarding the patient;

(10) Notation of communication to and from the patient or patient's parent or guardian, including:

(a) Notation of informed consent, including communication of potential risks and benefits of proposed treatment, recommended tests, and alternatives to treatment, including no treatment or tests;

(b) Notation of post-treatment instructions or reference to an instruction pamphlet given to the patient;

(c) Notation regarding patient complaints or concerns associated with treatment, including complaints or concerns obtained in person, by phone call, mail, electronic communication, or digital communication; and

(d) Termination of the doctor-patient relationship; ~~and~~

(11) A copy of, or notation regarding, each laboratory order~~.~~; and

(12) A dentist who provides dental services via teledentistry must also:

(a) Ensure that a teledentistry encounter is clearly characterized as such in the patient's clinical record; and

(b) Include the following in the informed consent:

(i) Consent from the patient to receive teledentistry services, including a statement that patients may decline teledentistry services;

(ii) The types of dental services provided via teledentistry and methods of teledentistry delivery, including limitations on services and how privacy will be protected;

(iii) The identity, contact information, practice location, licensure or registration, and credentials of all licensees and registrants involved in the patient's care;

(iv) Instructions outlining how medical records can be accessed;

(v) Protocol for technological failures or emergency situations; and

(vi) Protocol for referral for appropriate follow up care with a dentist pursuant to an established treatment plan.

April 21, 2026

Dear South Dakota State Board of Dentistry and Anesthesia Credentials Committee,

We are writing to respectfully request consideration of an Administrative Rule that establishes a separate host permit specifically for dental providers treating pediatric patients (age 12 and under) under general anesthesia in a dental office setting. The primary purpose of this proposed distinction is to strengthen pediatric patient safety.

Hospital systems grant privileges for treating patients under general anesthesia only after a rigorous and comprehensive credentialing process. A similar level of scrutiny is necessary at the state level to ensure that dental providers possess the appropriate training, experience, and clinical judgment required to safely treat pediatric patients under general anesthesia in outpatient dental settings.

The level of training required for this type of care is uniquely provided through CODA-accredited pediatric dental residency programs. Treating pediatric patients under general anesthesia involves a complex combination of clinical decision-making, technical skill, and medical awareness that extends beyond the scope of predoctoral dental education.

Providers must be able to appropriately treatment plan within the context of general anesthesia, where definitive care is critical to avoid subjecting the child to additional sedation events. This includes determining appropriate restorative choices based on patient age, caries risk, and health history—such as when to use composite or amalgam restorations versus stainless steel crowns, when to perform a pulpotomy/pulpectomy versus extraction, and when space maintenance is indicated or contraindicated. All providers planning pediatric cases for general anesthesia must have the training to be able to discern which pediatric patients can be safely treated in an office-based general anesthesia setting versus those who would be best and safest treated in a hospital-based general anesthesia setting. This is crucial to reducing the risk of adverse events. In addition, the treating dentist must understand and actively manage airway safety during procedures. This includes assessing for loose teeth and aspiration risk, utilizing throat packs, implementing proper isolation and suction protocols, reducing airway fire risk, continuously monitoring the patient, and effectively communicating with the anesthesia provider throughout the procedure.

There must also be a clear understanding of the differences between open airway (IV sedation) and secure airway (intubation) techniques, and how dental treatment approaches vary between these modalities. The dentist must be prepared to assist in

managing the patient in the event of a medical emergency, including situations where the patient decompensates or if the anesthesia provider becomes incapacitated. The ability to manage the patient under general anesthesia until emergency medical services arrive is critical.

Pediatric dental residency programs include extensive anesthesia training, including a dedicated rotation in a medical setting. During this time, residents gain hands-on experience in airway management, IV placement, pharmacology of anesthetic agents, and techniques such as oral, nasopharyngeal, and LMA placement, as well as oral and nasal intubation.

Equally important is the ability to provide efficient, high-quality dental care under general anesthesia. Treating multiple teeth—often 12 or more—in a single session should be completed efficiently to minimize anesthesia time, which is a significant safety consideration. This level of efficiency is developed through repeated clinical exposure. CODA-accredited pediatric programs require a minimum of 25 independent general anesthesia cases for graduation, though many residents complete over 100 cases during training.

Prolonged anesthesia time increases risk, making efficiency not simply a matter of convenience but of patient safety. Additionally, providers must be capable of managing post-operative complications in a clinical setting and providing follow-up care without necessitating additional sedation. This may include re-cementing crowns, repairing restorations, or extracting teeth in an awake patient when appropriate.

Given the complexity and risks involved, it is essential that only dentists with formal, specialized training in pediatric dentistry—specifically those who have completed CODA-accredited pediatric dental residencies—are permitted to provide dental treatment to pediatric patients under general anesthesia in dental office settings. We also acknowledge that Oral Maxillofacial Surgeons are well equipped to also render any needed treatment under general anesthesia in a dental office setting. These specialists would also qualify for a pediatric host permit if necessary. We are also aware some general dentists may have received pediatric training as well via a General Practice Residency or Advanced Education in General Dentistry, the conversation to draft an Administrative Rule should consider the training of these providers as well; however, training needs to meet appropriate standards.

General dentists, while highly trained in many aspects of care, do not receive the depth or breadth of training required to safely and effectively manage these cases without increased risk to pediatric patients. It should be noted that pediatric dentists will also

treat adolescent patients and/or patients with special health care needs when appropriate over the age of 12 under general anesthesia in the dental office setting. Pediatric dentists should not be restricted to serving patients under the age of 12.

For these reasons, we strongly urge the Board to consider implementing an Administrative Rule that creates a distinct host permit for pediatric general anesthesia cases, with credentialing standards aligned to the level of training provided in pediatric dental residency programs.

Thank you for your time and consideration of this important patient safety issue.

Sincerely,

South Dakota Society of Pediatric Dentistry and to include the following individuals:

Allie J. Koth, DDS
Diplomate of the American Board of Pediatric Dentistry
ABC Pediatric Dentistry
Sioux Falls, SD
605-275-5771

Conner Christensen, DDS
Diplomate of the American Board of Pediatric Dentistry
ABC Pediatric Dentistry
Sioux Falls, SD
605-275-5771

Kalee Abu-Ghazaleh, DDS
Diplomate of the American Board of Pediatric Dentistry
ABC Pediatric Dentistry
Sioux Falls, SD
605-275-5771

Jeffrey Brownstein, DDS
Diplomate of the American Board of Pediatric Dentistry
American Dental Board of Anesthesiology
National Dental Board of Anesthesiology
South Dakota Dental Anesthesia
(531) 333-2241

Joseph Skibinski, DDS
Diplomate of the American Board of Pediatric Dentistry
Children's Dental Center
Sioux Falls, SD
(605) 332-1095

John Taggart, DDS
Diplomate of the American Board of Pediatric Dentistry
Children's Dental Center
Sioux Falls, SD
(605) 332-1095

Scott Weyers, DDS
Diplomate of the American Board of Pediatric Dentistry
Children's Dental Center
Sioux Falls, SD
(605) 332-1095

Cory Peterson, DDS
Diplomate of the American Board of Pediatric Dentistry
Children's Dental Center
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(605) 332-1095

Miranda Lommen-Mielke, DDS
Diplomate of the American Board of Pediatric Dentistry
Children's Dental Center
Sioux Falls, SD
(605) 332-1095

Kate Reeves, DDS
Diplomate of the American Board of Pediatric Dentistry
Dunes Dental 4 Kids
Dakota Dunes, SD
(605) 242-4700

Karli Williams, DDS
Diplomate of the American Board of Pediatric Dentistry

Black Hills Pediatric Dentistry
Rapid City, SD
(605) 341-3068

Brent Bradley, DDS
Diplomate of the American Board of Pediatric Dentistry
Black Hills Pediatric Dentistry
Rapid City, SD
(605) 341-3068

Andrew Wilson, DDS
Diplomate of the American Board of Pediatric Dentistry
Black Hills Pediatric Dentistry
Rapid City, SD
(605) 341-3068

SOUTH DAKOTA
STATE BOARD OF DENTISTRY

MAILING ADDRESS: PO Box 42 Black Hawk, SD 57718 | PHYSICAL ADDRESS: 1760 Rand Road Ste B Rapid City, SD 57702 | PHONE: 605-791-3650 | EMAIL: contactus@sdboardofdentistry.com

NITROUS OXIDE COURSE APPLICATION

Name of Person Requesting Approval: Leslie K Greager. RDH, BSDH
Address: 4701 Feather Ridge Ct
City, State, Zip Code: Rapid City, SD 57702
Phone: 605-389-1211 Email: lkgbrushnfloss@hotmail.com
Name of Course: Nitrous Oxide / Oxygen Sedation

Notification regarding approval of the course will be sent to this email address.

NITROUS OXIDE SEDATION AND ANALGESIA PERMIT REQUIREMENTS:

ARSD 20:43:09:05(2)-Dentists
Has successfully completed a board-approved course that meets the objectives and content as described in Part 4 of the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students or a course in nitrous oxide sedation and analgesia through an accredited dental school.

ARSD 20:43:09:06(2)- Dental Hygienists and Registered Dental Assistants
Has successfully completed a State Board of Dentistry-approved educational course that substantially meets the objectives and content as described in Part 4 of the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students.

Is this course offered through an accredited dental school? ☐ Yes ☑ No

If yes, you may stop here. If no, please continue.

Has this course met all of the requirements for Part 4 of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students? (A copy of the complete document can be found at the end of this application.)

INHALATION SEDATION (NITROUS OXIDE/OXYGEN)

Please select yes or no to indicate whether the course meets each of the following requirements.

General Objectives 1-10:	☑ Yes	☐ No
A. Inhalation Sedation Course Objectives 1-8:	☑ Yes	☐ No
B. Inhalation Sedation Course Content 1-15:	☑ Yes	☐ No
C. Inhalation Sedation Course Duration: Minimum 14 hours	☑ Yes	☐ No
D. Participant Evaluation and Documentation of Inhalation Sedation Instruction:	☑ Yes	☐ No

E. Faculty:

Name of Dentist: On site / participant's employer

Dentist Qualifications:
**You must submit documentation of instructor's postdoctoral training in anxiety and pain control with this application.*

- Active permit or license to administer moderate sedation: ☑ Yes ☐ No

License Number: _____ State: SD

- At least 3 years of experience in moderate sedation: ☑ Yes ☐ No

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

Does this course meet this requirement? ☒ Yes ☐ No

Location of Training Facility:

Practice Name: Will be each participant's office

Address: _____

City, State, Zip Code: _____

ENTERAL AND/OR COMBINATION INHALATION-ENTERAL MINIMAL SEDATION

A. Enteral and/or Combination Inhalation-Enteral Minimal Sedation
Course Objectives 1-13: ☐ Yes ☐ No NA

B. Enteral and/or Combination Inhalation- Enteral Minimal Sedation
Course Content 1-15: ☐ Yes ☐ No NA

C. Enteral and/or Combination Inhalation-Enteral Minimal Course
Duration- Minimum 16 hours: ☐ Yes ☐ No NA

D. Participant Evaluation and Documentation of Instruction: ☐ Yes ☐ No NA

Please note: A complete course outline must be submitted with this application.

Applicant Attestation

By signing below, I certify that the information provided in this application and all supporting documentation is true, accurate, and complete to the best of my knowledge. I understand that submission of this application does not constitute approval of the course by the South Dakota State Board of Dentistry and that the course may not be represented as Board-approved unless and until written approval is issued by the Board.

I further understand that course approval is based upon the information and documentation submitted with this application. Any material change to the course content, duration, faculty, instructor qualifications, or training facility may require additional review and approval by the Board.

Person Requesting Course Approval

Printed Name: Lester B. Granger

Signature: _____ Date: 9/4/2024

Dentist Instructor Attestation

I certify that the information provided regarding my education, training, licensure/permit status, and experience is true and accurate. I further certify that I will provide instruction consistent with the course curriculum and supporting materials submitted with this application.

Dentist Instructor Name: _____

Signature: _____ Date: _____

South Dakota State Board of Dentistry
P.O. Box 1079
1351 N. Harrison Ave.
Pierre, SD 57501

Leslie K. Greager
4701 Feather Ridge Court
Rapid City, SD 57701

Dear members of the South Dakota State Board of Dentistry.

My name is Leslie Greager. I have worked as a clinical Registered Dental Hygienist in the State of South Dakota for over thirty-five years, taught the Nitrous Oxide/ Oxygen Sedation Certification Course for over eight years, the Radiology Certification Course for over twelve years, and have taught multiple continuing education courses most specific to radiology for over ten years. I am writing to you in request for your approval to teach the Nitrous Oxide/ Oxygen Sedation Certification Course as myself as the sponsor organization.

In approximately 2015, it was brought to my attention that dental professionals on the west side of the State of South Dakota had one option within the state for Nitrous Oxide/ Oxygen Sedation training, which was in Vermillion, SD. This caused great concern regarding the cost of the course, time away from work and/ or home, and travel expenses. In an effort to accommodate these concerns, I constructed a sixteen-hour, board approved Nitrous Oxide/ Oxygen Sedation Certification Course while working as an instructor at Western Dakota Technical Institute.

In October of 2025, the South Dakota State Board of Dentistry approved of my teaching the Radiology Certification Course as myself as the sponsor organization, independent of a third party entity. My goal was to present the course utilizing an online platform to meet the needs and concerns of dentists and dental professionals across the state. The course has been a huge success! The ability to present the course entirely online, allowing for individual self-study and testing without having to travel has been very well received. Recently, Mr. Paul Knecht brought to my attention conversation among he and dentists with the South Dakota Dental Association in my presenting the Nitrous Oxide/ Oxygen Sedation Course via the same online platform. It is for this reason that I am requesting board approval for the ability to present the Nitrous Oxide/ Oxygen Sedation Certification Course in the same manner as the Radiology Certification Course, utilizing the online, on-demand platform for didactic instruction and hands-on testing.

Thank you for your consideration in this matter and for the opportunity to continue to provide education to dental professionals throughout the State of South Dakota.

Sincerely,

Leslie K. Greager, RDH, BSDH

Faculty:

As per the American Dental Association (ADA) *Guidelines* for Teaching Pain Control and Sedation to Dentists and Dental Students, it is understood that the recommendation be that the supervising Dentist in an educational setting be one who "should possess an active permit or license to administer moderate sedation in at least one state, have had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control." The Guidelines also include recommendations pertaining to the location where competency is evaluated. It states that the location must have "adequate facilities available for proper patient care, including drugs and equipment for the management of emergencies." The *Guidelines* also state that "it is not the intent of the *Guidelines* to fit every program into the same rigid educational mold. This is neither possible nor desirable. There must always be room for innovation and improvement. They do, however, provide a reasonable measure of program acceptability, applicable to all institutions and agencies engaged in predoctoral and continuing education."

Over the past ten years, I have taught the Nitrous Oxide/ Oxygen Minimal Sedation course in a face-to-face setting. The first day of the two-day course includes didactic lecture with an introduction to nitrous oxide/ oxygen sedation administration and equipment assembly. Day two includes extensive practice in the assembly of nitrous oxide/ oxygen sedation equipment and practice for the hands-on portion of the course; the hands-on and written exams conclude the course. The supervising Dentist utilized for this course has possessed an active permit or license to administer minimal sedation in at least one state and has had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. Dr. Shawn Lemmon has been the primary supervising Dentist for the hands-on training, which has taken place primarily at Advanced Dental Professionals in Rapid City, SD. I have also utilized Dr. Aaron Studer, Dr. Scott Van Dam, and Dr. Joshua Martin as the supervising Dentist when Dr. Lemmon has been unavailable; their respective dental offices have been utilized if Advanced Dental Professionals has been unailable. All dental offices where competency has been evaluated have nitrous oxide equipment that is in proper working order and have a medical emergency kit available to include a full-face mask in the event of an emergency.

I am requesting that the Board approve the utilization of a Dentist as the supervising Dentist for this online Nitrous Oxide/ Oxygen Minimal Sedation course as one who

possesses an active permit or license to administer minimal sedation in at least one state and has at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. I am also asking that the board approve the location for hands-on training be in a dental office where the nitrous oxide equipment is in proper working order and has a medical emergency kit available to include a full-face mask in the event of an emergency. Should the Board request the designation of a single Dentist to sit as the supervising Dentist for this course, Dr. Lemmon has agreed to act as such in the Rapid City, SD area. Should the Board request the designation of a specific facility, the hands-on training will take place at Advanced Dental Professionals in Rapid City, SD. For participants in the Sioux Falls, SD area, Dr. Drake has agreed to sit as the supervising Dentist. Dr. Drake's office location, Sioux Falls Smiles, will be the designated facility for the hands-on training. Both Dentists possess current minimal sedation permits in South Dakota.

In the event that the Board would prefer the designation of a single supervising Dentist for this course and one who possesses an active permit or license to administer moderate sedation in at least one state and has had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control for this course as per the recommendations listed in the American Dental Association *Guidelines,* Dr. Chad Carpenter at Carpenter Dental in Rapid City, SD and Dr. Leticia Jeffords at Sioux Falls Smiles in Sioux Falls, SD have agreed to sit as the supervising Dentist for this course; each have agreed to host the hands-on training at their respective offices. Dr. Carpenter currently holds a moderate sedation permit in the state of South Dakota; Dr. Jeffords currently holds a moderate sedation permit in the state of Texas but is willing to apply for a South Dakota permit should she be required to do so.

My goal is to provide an online platform for the Nitrous Oxide/ Oxygen Minimal Sedation Course following the Board's instruction to provide a thorough, appropriate, and safe learning environment for all participants.

Thank you for your consideration,

Leslie K. Greager, RDH, BSDH

Title: Nitrous Oxide/ Oxygen Sedation
Lecture Hours: 8
Clinical Hours: 8
Instructor: Leslie K. Greager, RDH, BSDH
Supervising Dentist: Dr. Rob Lyons, DDS

Course Goal: To provide attendees with didactic and clinical education pertaining to the administration and monitoring of nitrous oxide/ oxygen (N2O/ O2) sedation.

Course Objectives:
-After an eight-hour lecture, attendees will understand and have the ability to explain:
- -the term nitrous N2O/ O2 sedation
- -the different levels of sedation
- -the advantages and limitations of using N2O/ O2 sedation in the dental office
- -the enhancement of the effects of N2O/ O2 sedation
- -the uses of N2O/ O2 outside of dentistry
- -the history of N2O/ O2
- -the manufacturing, storage, transportation, and handling of N2O/ O2
- -the cost of N2O/ O2 tanks and refills
- -the differences between N2O and O2 tanks re: color, size, markings
- -the physical and chemical characteristics of N2O and O2
- -the functions of the respiratory system
- -diffusion hypoxia as it relates to N2O/ O2 in dentistry
- -the effects of N2O/ O2 on bodily systems
- -contraindications for use of N2O/ O2
- -the physical assessment of the patient and evaluation of the medical history prior to N2O/ O2
- -the steps necessary for the safe and effective administration of N2O/ O2 sedation
- -the main components/ equipment of the N2O/ O2 delivery system
- -the level at which most patients respond favorably to N2O/ O2 administration
- -the levels of over-sedation based on the patient's signs and symptoms
- -the current NIOSH and ADA occupational exposure limits of N2O/ O2 in the working environment
- -the legal and ethical issues related to N2O/ O2 administration
- -the rules and regulations of N2O/ O2 administration based on SD State Board of Dentistry statutes
- -the abuse of N2O/ O2

-After eight-hours of clinical instruction, attendees will have the ability to:
- -assess the patient's pre and post administration status of N2O/ O2 sedation via vital signs and the use of a pulse oximeter
- -administer, titrate, and monitor N2O/ O2 safely and competently
- -calculate and record the percentage of N2O/ O2 delivered to the patient
- -document N2O/ O2 percentages appropriately in the patient's chart
- -demonstrate an understanding of the maintenance, infection control, and trouble shooting of N2O/ O2 equipment

I. Nitrous Oxide/ Oxygen Sedation

A. Sedation: the act of calming, especially with a sedative; the state of being calm

1. Levels of sedation:
    a. General
    b. Deep
    c. Moderate
    d. Minimal

B. Nitrous Oxide Anxiolysis: the administration 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.

C. General Anesthesia: drug-induced loss of consciousness during which the patient is not arousable even by painful stimulation. The ability to independently maintain ventilatory function is impaired.

D. Deep Sedation: drug-induced depression of consciousness during which the patient cannot be easily aroused but responds purposefully after repeated or painful stimulation. The ability to independently maintain airway function is impaired.

E. Moderate Sedation: drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No intervention is required to maintain a patent airway. Moderate sedation is achieved when levels of N2O/ O2 are over 50%.

F. Minimal Sedation: drug-induced state during which the patient responds normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular function are unaffected. Achieved with N2O/ O2 levels less than 50%.

G. N2O/ O2 in Dentistry

1. Combination of N2O and O2
2. Effective means of alleviating anxiety and mild discomfort during dental procedures
3. Effective in reducing anxiety in patients who may not otherwise seek dental treatment
4. Anxiolytic agent

II. Benefits of Using N2O/ O2

A. Manages both fear and pain

B. Provides amnesic properties

C. Passage of time seems quick

D. Equipment allows easy titration of gases

E. Rapid onset

F. Rapid recovery

G. Limitations:

1. Initial cost of equipment
2. Equipment requires routine monitoring
3. Monitoring of evacuation system
4. Apprehension of patient and/ or clinician to sedation
5. Lack of education for auxiliaries to administer and monitor delivery
6. Variety of effects
7. Obstruction of nose hood
8. Insurance and abuse issues

III. Increasing Effects of N2O/ O2

A. Music

B. Imagery

C. Hypnosis

D. Electronic dental anesthesia

E. Oral premedication

F. Local anesthesia

IV. Other Uses of N2O/ O2

A. Hospitals

B. Emergency medicine

C. Food industry

D. Auto industry

E. Racing industry

F. Computer industry

V. History of N2O/ O2

A. Joseph Priestly 1770's

B. Humphrey Davy 1800

C. Samuel Colt 1800's (firearm)

D. Medical community 1800's

E. Horace Wells 1844

F. Dr. Colton 1860's

G. Dr. Edmund Andrews 1868

H. 20th Century

I. Lidocaine 1940's

J. N2O/ O2 taught in dental schools 1950's

K. Pain and anxiety control guidelines 1962

VI. Manufacturing of N2O/ O2

A. Process:

1. Raw ingredient is ammonia nitrate
2. Ammonia nitrate is heated to 250 degrees C; decomposes to water and steam
3. Once cooled to room temperature, steam is condensed, and water is removed
4. Crude N2O gas is scrubbed to remove contaminants then compressed, dried, cooled, and liquefied

B. Storage:

1. Liquefied gas stored at 300 psig at 4 degrees F in insulated tanks
2. Sent to gas re-packagers and distributors
3. Hospitals and medical facilities use the majority (80-90%) of N2O/ O2 produced in the US
4. Dentistry uses approximately 10%
5. Remaining used in previously discussed industries

C. Regulatory Agencies:

1. FDA regulates the manufacturing process
2. DOT oversees the packaging and transportation
3. NFPA code for requirements for appropriate cylinder storage

VII. Investment

A. Approximate cost:

1. New tanks $170.00
2. Refill for N2O $47.00
3. Refill for O2 $24.00

4. Cost varies by tank size and distance from the distributor

VIII. N2O/ O2 Tanks

A. Color Codes for countries

1. USA: N2O is blue/ O2 is green
2. Canada: N2O is blue/ O2 is white

B. Sizes

C. Markings: diagram

IX. Internal Properties In N2O/ O2 Tanks

A. N2O Tanks

1. Contains 95% liquid and 5% vapor
2. Stored at room temperature; gauge reads 750 psi when full
3. Gas is located above the liquid within the cylinder
4. Gauge reads full until 7/8 of the tank is used due to the liquid being vaporized as the gas is used
5. Nitrous tanks usually last twice as long as oxygen tanks

B. O2 Tanks

1. Contains 100% vapor (gas)
2. Gauge reads approximately 2000 psi when full
3. Gauge accurately reflects the quantity of oxygen in the tank
4. A half empty tank will read 1000 psi

X. Properties of N2O and O2 Gas

A. N2O Gas

1. Sweet smelling, colorless gas; cannot see it
2. Molecular weight is 44
3. Specific gravity is 1.53
4. Heavier than air and oxygen; helpful during administration due to gravitational pull
5. Found naturally in the atmosphere at 6 ppm
6. Gas oxidizes at room temperature; significant due to phenomenon called heat of combustion (increase in the temperature of the gas and metal to a level that ignites any hydrocarbon contaminants, causing a chemical reaction resulting in a fire or explosion)
7. Never store grease, lubricants, or oil near tanks

B. O2 Gas

1. Odorless, colorless, tasteless gas
2. Makes up 21% of the earth's atmosphere
3. Molecular weight is 32

4. Specific gravity is 1.105 (pure air is 1.0)
5. Like N2O, it supports heat of combustion

X. Respiratory System

A. Designation

1. Designed to exchange gases (oxygen and carbon dioxide) across pulmonary capillary membranes
2. Does this involuntarily by the medulla oblongata and voluntarily by the cerebral cortex

B. Upper Airway

1. Nose: warms, humidifies, and filters; must be clear for the administration of N2O/ O2
2. Pharynx: Cylindrical, muscular tube 12-14 cm long; divided into three parts

a. Nasopharynx; uppermost part of the nose located behind the nasal cavity; contains the adenoid, tonsils, and openings to the eustachian tubes; soft palate separates nasopharynx from oropharynx
b. Oropharynx: opens to the mouth; between the soft palate and epiglottis; serves as the entrance to the larynx and esophagus
c. Laryngopharynx: the throat; area of the pharynx from the epiglottis to the cricoid cartilage; contains the larynx

C. Lower Airway

1. Larynx: houses the vocal cords; false vocal cords prevent entry of foreign objects into the lungs; contact with this area causes cough reflex; N2O/ O2 at normal sedation levels does NOT affect cough reflex
2. Trachea: muscular tube continuous with the larynx; begins at C6; surrounded by horseshoe-shaped rings; approximately 11 cm long; divides into two bronchi
3. Carina: highly sensitive, neurologically rich area at the bifurcation of the trachea into the right and left bronchi; back up defense mechanism to the cough reflex
4. Bronchi: right and left

a. Right Bronchi: 2.5 cm long; deviates from the trachea at about 25 degrees; divides into 3 branches including 3 upper lobes, 2 middle lobes, and 5 lower lobes
b. Left Bronchi: 5 cm long; deviates from the trachea at about 45 degrees; divides into 2 branches which link the 5 upper lobes and 4 lower lobes

5. Bronchioles: have no cartilage, first 16 generations of airways are only conducting; respiration begins at the 17^{th} generation (gas exchange occurs in the alveoli)

D. Anatomy of Respiration

1. Oxygen (O2) moves from the lungs across the alveolar membranes into the capillaries, venules, and then to the pulmonary veins
2. Carbon Dioxide (CO2) moves from the pulmonary arteries, arterioles to the capillaries then across the alveolar membranes into the lungs
3. It is in the alveoli that gas exchange takes place
4. N2O exchange uses the same pathways as normal respiration

E. Respiratory Process

1. Medullary center of the brainstem controls the automatic respiratory process of breathing
2. Inspiration is the expansion of the chest creating a vacuum, pulling air into the lungs; controlled by the diaphragm, intercostal muscles, scalenes, and sternocleidomastoids
3. Continues until pressure inside the lungs equals atmospheric pressure
4. Expiration is the passive force of air out of the lungs; controlled by the chest wall and recoil of the lungs
5. Tidal flow is the automatic ebb and flow or movement of air
6. Tidal volume is the amount of gas inspired into the lungs dependent on physical characteristics of the individual

F. Minute Ventilation

1. Average adult tidal volume = 500 ml
2. Average adult respiration rate = 12-15/ minute
3. Minute ventilation (volume) = tidal volume X respiration rate
4. 500 ml X 12-15 rpm = approximately 6-7 liters/ minute
5. The flow rate of N2O/ O2 should be equal to the minute ventilation (volume) of the patient
6. Too little gas mixture of N2O and O2 may cause a suffocated feeling and the act of breathing may be laborious
7. Too much gas mixture of N2O and O2 wastes gas and pollutes the environment, exposes personnel to gas, and may dry the patient's eyes as it escapes from the nose mask

G. Gas Exchange

1. Simple diffusion across partial pressure gradients are at the alveolus- capillary level
2. Atmospheric Air:

a. 20.94% oxygen
b. 79.02% nitrogen
c. .04% carbon dioxide

XI. Diffusion Hypoxia

A. Explanation

1. As N2O is terminated, capillary tension quickly rises to that above alveolar pressure
2. N2O is quickly forced into the alveoli and exhaled through the lungs
3. N2O exits faster than the N2 that replaces it
4. Dilutes the supply of oxygen
5. Oxygen blood saturation is reduced
6. Leave 100% O2 on the patient for 2-5 minutes
7. Not likely at the concentrations used in dentistry; “prudent practice”

XII. N2O/ O2 Effects on Body Systems

A. Cardiovascular System

1. No effect on contractility, output, stroke volume, rate, or arrhythmias
2. Blood flow not affected

3. No known effect to kidney
4. No contraindications vs contraindications

I. Neuromuscular System

1. Does not provide direct skeletal muscle relaxation; indirect due to relaxation of patient
2. No known effect on patients with neuromuscular conditions
3. No contraindications vs contraindications

J. Vestibular System

1. Increased pressure in the middle ear may cause significant damage
2. Postpone administration of N2O/ O2 until middle ear infection/ disturbance has passed
3. No contraindications vs contraindications

XIII. Specific Conditions

A. Cancer

1. Does not affect metastatic cells
2. Used in the final stage of life for pain and anxiety control
3. Contraindicated for patients taking bleomycin sulfate (antineoplastic agent); may increase the incidence of pulmonary fibrosis

B. Allergies

1. No known reported allergies in 160 years
2. Latex allergy patients; contact dermatitis if equipment is not latex free

C. Malignant Hyperthermia

1. Unexpectedly occurs due to patient's response to certain drugs
2. Patient can be tested if known family history
3. N2O/ O2 is not a known trigger

D. Nutritional Disorders

1. No known affect with any nutritional conditions
2. Ongoing research in this area

E. Mind Altering Conditions

1. Careful consideration due to result in euphoria
2. Be sure patients understand the procedure and effects
3. Possible contraindications

F. Ophthalmic Considerations

1. Recent retinal surgery; gas bubble in the eye; N2O/ O2 may cause expansion; postpone

3. Positive effect on ischemic diseases due to increased oxygen
4. Blood pressure and heart rate may be lowered due to reduced anxiety; not direct effect
5. No contraindications vs contraindications

B. Respiratory System

1. Compromised air exchange may make administration difficult
2. Increased pressure in sinus cavity due to expansion of N2O
3. May create positive effect for asthma patients
4. No contraindications vs contraindications

C. Central Nervous System

1. Effects pain perception
2. Decreases sensory perception including pain, sight, and touch
3. Amnesic properties; may dilute memory depending on concentration levels
4. Distortion of spacial relation; feeling of floating or being heavy or light
5. No contraindications vs contraindications

D. Hematopoietic System

1. Megaloblastic bone marrow changes associated with high doses for long periods of time
2. May reduce absorption of vitamin B12; high doses over a long period of time (medical anesthesia)
3. No contraindications vs contraindications

E. Endocrine System

1. No contraindications vs contraindications

F. Hepatic System

1. Not metabolized in the liver
2. Does not affect the liver if liver damage is evident
3. No contraindications vs contraindications

G. Gastrointestinal System

1. N2O causes expansion of air spaces in the body; avoid using on patients with intestinal obstruction
2. No known negative effects on patients with ulcers
3. Nausea; may be caused by slight bloating of the stomach
4. No contraindications vs contraindications

H. Genitourinary and Reproductive Systems

1. Must obtain medical clearance prior to administration to a pregnant patient
2. Avoid administration during the first trimester; no known negative effect, although may be the blame for negative outcome

administration until healing complete/ medical clearance

G. Summary of Side Effects

1. Pressure/ volume effect
a. N2O causes increased pressure and volume in body cavities
b. May cause middle ear pressure, auditory acuity, GI distension, air emboli in the blood, tinnitus, flatulence, and nausea
2. Psychological and sexual reactions
a. Sexual hallucinations
b. Hallucinations
c. Dreams
d. Claustrophobia
e. Apprehension

XIIII. Patient Assessment

A. Medical history review, interview, and questionnaire regarding level of anxiety

B. Risk Assessment using ASA scale

C. Pre-operative vital signs

1. Blood Pressure
2. Pulse
3. Pulse Oximeter

D. Patient Preparation

1. NPO not necessary
2. Informed consent, intent of procedure, and how it will be accomplished

E. Patient Monitoring

1. Continuous
2. Communication, observation, and vital signs

XV. Equipment for portable and central supply systems

A. Control Panel

B. Manifold

1. Connects several cylinders of gas together; as one is depleted, another is used
2. Allows more than one operatory to be using gas at the same time; central supply
3. Newer manifold may contain safety and security devices

C. Copper Tubing

1. Found on central supply delivery system
2. Copper does not support combustion
3. Tubing size differs to prevent improper connection

D. Pin Index Safety System

1. Found only on portable units
2. Holes are arranged in a specific pattern; prevents placing a tank on an incorrect machine

E. Regulators

1. Found on both central and portable systems
2. Reduces gas pressure from the tanks before delivery to the tubing
3. Regulates the flow of gastrointestinal

F. Flow Meters

1. Visual indicator of amount of gas being delivered
2. Highly calibrated glass tubes
3. Numbers on the tubes represent liters being delivered
4. Middle of the ball is used to indicate amount of gas

G. Reservoir Bag

1. Provides additional gas for the patient to breathe if inadequate amounts of gas flowing through the hoses
2. Provides a mechanism for monitoring of breathing; aids in determining if more or less gas is needed
3. Assists in an emergency by supplying pressure assisted oxygen

H. Conduction Tubing

I. Nasal Hoods

1. Variety of types and sizes
2. Sterilizable or disposable
3. Scavenging apparatus

J. Scavenging System

1. Mandatory for the safety of office personnel
2. Two hole system; one delivers gas to the nasal hood; another evacuates excess gas exhaled by the patient
3. Tube attached to the high vacuum system (HVC) for portable units
4. Plumbing exhausts the gas out of the building for central supply systems
5. Central supply scavenger unit

a. Ball should be floating at the 45 lpm mark
b. Usually indicated by a green area on the gauge

XVI. N2O/ O2 Administration Technique

A. Steps

1. Assemble and assess armamentarium
a. Choose appropriate nasal hood
b. Bring portable nitrous unit and hood to operatory
c. Assemble scavenging system
d. Open tanks and check gauges
2. Medical history evaluation; obtain vital signs and informed consent
3. Turn on flow meter
4. Activate Oxygen; fill reservoir bag to 2/3 full utilizing O2 flush button
5. Position the patient in a supine position; secure the nasal hood and adjust the tubing
6. Establish tidal volume
a. Observe reservoir bag; increase or decrease tidal volume accordingly
b. Allow patient to ask questions at this level
7. Titrate to 10% nitrous oxide/ 90% oxygen for one minute
a. Verbalize potential effects at this level with patient
b. Remind the patient to breathe deeply; avoid conversation
8. Titrate to 20% nitrous oxide/ 80% oxygen for one minute
a. Verbalize potential effects at this level with patient (warmth, relaxation, paresthesia)
b. Remind the patient to breathe deeply; avoid conversation; utilize mouth breething if experiencing dizziness or nausea
9. If necessary, continue to titrate at 5% every one minute
a. Ask patient to verbalize what they are experiencing
b. Listen and observe patient
10. If 50% nitrous is reached with no symptoms, check for mouth breathing, shallow breathing, loose nasal hood, or a bend/ kink in the tubing
11. Ask the patient to take three deep breaths and adjust the flow rates accordingly
12. After procedure, decrease nitrous levels to 0 and increase oxygen levels to 100% for 2-5 minutes
13. Allow patient to recover in an upright, seated position
14. Determine complete recovery by obtaining post operative vital signs before releasing the patient
15. Use appropriate disinfection techniques
16. Complete chart documentation

XVII. Levels of N2O/ O2 Sedation

A. Optimal Levels; 25-40% N2O

1. Sense of relaxation
2. Happy, comfortable, aware of surroundings
3. Responds rationally and coherently
4. Acknowledges a reduced sense of anxiety and fear
5. Dreamy look or big smile
6. Tingling of extremities
7. Slight ringing in the ears or heightened sense of sound
8. Heaviness in the arms or legs
9. Vitals remain normal (may decrease due to relaxation, not N2O)

B. Inappropriate Signs/ Symptoms

1. Uncontrolled laughter
2. Sweating
3. Nausea
4. Marked lethargy; closes mouth frequently
5. Unresponsiveness; unaware of surroundings
6. Dysphoria (anxiety, depression, restlessness)
7. Inability to follow commands
8. Dilated pupils; hard stare
9. Agitated or combative
10. Hallucinations

XVIII. Detection and Monitoring

A. National Institute for Occupational Safety and Health (NIOSH)

1. Set the exposure limit for dental personnel at 50 ppm (8 hours time waited average) in 1977
2. ADA disputes; not based on scientific fact

B. Time Weighted Average (TWA) Dosimetry

1. Provides an estimate of the amount of exposure to a gas over a specified period of time
2. A badge is worn for the recommended period of time; returned to the company for analysis; an active material within the badge absorbs N2O; the amount is read by an infrared spectrophotometer to determine the parts per million of exposure
3. Inexpensive; provides information for offices which do not utilize N2O extensively
4. Information is derived "after the fact"; not beneficial

C. Infrared Spectrophotometry

1. Utilizes electromagnetic energy to detect levels of N2O in the atmosphere; can detect levels lower than 1 ppm
2. Can detect minute levels of gas immediately in the ambient air
3. Rental fee is reasonable
4. Provides instant information in any setting
5. Recommended in order to establish a baseline of exposure levels; recommended for periodic evaluation

D. Occupational Risks

1. Chronic occupational exposure may cause reproductive difficulty, megaloblastic anemia, or neurologic disorders (controversial)
2. Overexposure is minimal or non existent if appropriate protocols are followed
3. Chronic abuse differs from chronic exposure

XVIIII. Ethical and Legal Issues

A. Assessment of medical history

B. Patient monitoring

1. Legally, two people should be in the operatory at all times
2. Some states mandate only one

C. Regularly scheduled maintenance of equipment

D. Accurate record keeping

XX. Abuse Issues

A. N2O can be readily available; popular college activity

B. Healthcare personnel are noted recreational users

C. Lower on the list as compared to other drugs; not a public health abuse concern

D. Abuse potential outside of the medical and dental clinic

XXI. South Dakota State Board of Dentistry

A. Statute 20:43:09:06

1. Certified in administering basic life support by the American Heart Association for the Health Provider, the American Red Cross for the Porfessional Rescuer, or an equivalent program approved by the board.
2. Has successfully completed a board approved educational course that substantially meets the objectives required by the State Board of Dentistry.
3. Has completed the course within thirteen prior to application or has completed the course more than thirteen months prior to application but has legally administered N2O/ O2 for a period of time during the three years preceding application and provides a written document from the supervising dentist attesting to the applicants clinical proficiency.

GUIDELINES
for Teaching Pain Control and Sedation to Dentists and Dental Students

Adopted by the ADA House of Delegates, October 2025

I. INTRODUCTION

The administration of local anesthesia, sedation and general anesthesia is an integral part of the practice of dentistry. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists.

Anxiety and pain control can be defined as the application of various physical, chemical and psychological modalities to the prevention and treatment of preoperative, operative and postoperative patient anxiety and pain to allow dental treatment to occur in a safe and effective manner. It involves all disciplines of dentistry and, as such, is one of the most important aspects of dental education. The intent of these *Guidelines* is to provide direction for the teaching of pain control and sedation to dentists and can be applied at all levels of dental education from predoctoral through continuing education. They are designed to teach initial competency in pain control and minimal and moderate sedation techniques.

These *Guidelines* recognize that many dentists have acquired a high degree of competency in the use of anxiety and pain control techniques through a combination of instruction and experience. It is assumed that this has enabled these teachers and practitioners to meet the educational criteria described in this document.

It is not the intent of the *Guidelines* to fit every program into the same rigid educational mold. This is neither possible nor desirable. There must always be room for innovation and improvement. They do, however, provide a reasonable measure of program acceptability, applicable to all institutions and agencies engaged in predoctoral and continuing education.

The curriculum in anxiety and pain control is a continuum of educational experiences that will extend over several years of the predoctoral program. It should provide the dental student with the knowledge and skills necessary to provide minimal sedation to alleviate anxiety and control pain without inducing detrimental physiological or psychological side effects. Dental schools whose goal is to have predoctoral students achieve competency in techniques such as local anesthesia and nitrous oxide inhalation and minimal sedation must meet all of the goals, prerequisites, didactic content, clinical experiences, faculty and facilities, as described in these *Guidelines*.

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Techniques for the control of anxiety and pain in dentistry should include both psychological and pharmacological modalities. Psychological strategies should include simple relaxation techniques for the anxious patient and more comprehensive behavioral techniques to control pain. Pharmacological strategies should include not only local anesthetics but also sedatives, analgesics and other useful agents. Dentists should learn indications and techniques for administering these drugs enterally, parenterally and by inhalation as supplements to local anesthesia.

The predoctoral curriculum should provide instruction, exposure and/or experience in anxiety and pain control, including minimal and moderate sedation. The predoctoral program must also provide the knowledge and skill to enable students to recognize and manage any emergencies that might arise as a consequence of treatment. Predoctoral dental students must complete a course in Basic Life Support. Though Basic Life Support courses are available online, any course taken online should be followed up with a hands-on component and be approved by the American Heart Association or the American Red Cross.

Local anesthesia is the foundation of pain control in dentistry. Although the use of local anesthetics in dentistry has a long record of safety, dentists must be aware of the maximum safe dosage limit for each patient, since large doses of local anesthetics may increase the level of central nervous system depression with sedation. The use of minimal and moderate sedation requires an understanding of local anesthesia and the physiologic and pharmacologic implications of the local anesthetic agents when combined with the sedative agents.

Level of sedation is entirely independent of the route of administration. Moderate and deep sedation or general anesthesia may be achieved via any route of administration and thus an appropriately consistent level of training must be established.

For children, the American Dental Association supports the use of the *American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures* and the American Dental Association's Council on Dental Education and Licensure's *Guidelines for Teaching Pediatric Pain Control and Sedation to Dentists and Dental Students.* The American Dental Association further recognizes that other disciplines of dentistry may provide sedation/anesthesia care to children in accordance with their respective guidelines, Commission on Dental Accreditation Standards for anesthesia education and training, and state laws, rules and/or regulations.

The knowledge, skill and clinical experience required for the safe administration of deep sedation and/or general anesthesia are beyond the scope of predoctoral and continuing education programs. Advanced education programs that teach deep sedation and/or general anesthesia to competency have specific teaching requirements described in the Commission on Dental Accreditation requirements for those advanced programs and represent the educational and clinical requirements for teaching deep sedation and/or general anesthesia in dentistry.

The objective of educating dentists to utilize pain control, sedation and general anesthesia is to enhance their ability to provide oral health care. The American Dental Association urges dentists to participate regularly in continuing education update courses in these modalities in order to remain current.

All areas in which local anesthesia and sedation are being used must be properly equipped with written emergency protocols, suction, physiologic monitoring equipment, a positive pressure oxygen delivery system suitable for the patient being treated and emergency drugs. Training sessions, including simulation, should be developed and rehearsed frequently. Protocols for the management of emergencies must be developed and training programs held at frequent intervals.

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.[1]

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

II. DEFINITIONS

METHODS OF ANXIETY AND PAIN CONTROL

MINIMAL SEDATION (PREVIOUSLY KNOWN AS ANXIOLYSIS) – a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's *normal* response to verbal command.

They will also retain the ability to independently and continuously maintain an airway. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.[1]

The following definitions apply to administration of minimal sedation:

maximum recommended dose (MRD) – maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.

dosing for minimal sedation via the enteral route – minimal sedation may be achieved by the administration of a drug, either singly or in divided doses, by the enteral route to achieve the desired clinical effect, not to exceed the maximum recommended dose (MRD).

The administration of an enteral drug exceeding the maximum recommended dose for unmonitored home use during a single appointment is considered to be moderate sedation and the moderate sedation guidelines apply.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

If more than one enteral drug is administered to achieve the desired sedation effect, with or without the concomitant use of nitrous oxide, the guidelines for moderate sedation must apply.

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. The use of the MRD to guide dosing for minimal sedation is intended to create this margin of safety.

MODERATE SEDATION – a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.[1]

Note: In accord with this particular definition, 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 dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to administration of moderate and deeper levels of sedation:

titration – administration of incremental doses of an intravenous or inhalation 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.

deep sedation – a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.[1]

general anesthesia – a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.[1]

ROUTES OF ADMINISTRATION

enteral – any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

parenteral – a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

transdermal – a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal – a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation – a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

TERMS

analgesia – the diminution or elimination of pain.

local anesthesia – the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must always be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression especially in combination with sedative agents.

qualified dentist – a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations.

must/shall – indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should – indicates the recommended manner to obtain the standard; highly desirable.

may – indicates freedom or liberty to follow a reasonable alternative.

continual – repeated regularly and frequently in a steady succession.

continuous – prolonged without any interruption at any time.

time-oriented anesthesia record – documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

LEVELS OF KNOWLEDGE

familiarity – a simplified knowledge for the purpose of orientation and recognition of general principles.

in-depth – a thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding (highest level of knowledge).

LEVELS OF SKILL

exposed – the level of skill attained by observation of or participation in a particular activity.

competent – while performing independently, displaying special skill or knowledge derived from training and experience.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS (ASA) PATIENT PHYSICAL STATUS CLASSIFICATION[2]

ASA PS Classification	Definition	Adult Examples, including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, **ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents
ASA IV	A patient with severe systemic disease that is a constant threat to life	Recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or **ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	

**The addition of "E" denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)

AMERICAN SOCIETY OF ANESTHESIOLOGISTS' FASTING GUIDELINES[3]

Ingested Material	Minimum Fasting Period†
Clear liquids‡	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk§	6 hours
Light meal**	6 hours
Fried foods, fatty meal, or meat	Additional fasting time (e.g. 8 or more hours) may be needed

Modifications to the above should be considered for patients with physiologic conditions or taking medications that delay gastric emptying (i.e., GLP-1 agonists).

*These recommendations apply to healthy patients who are undergoing elective procedures. They are not intended for women in labor. Following the guidelines does not guarantee complete gastric emptying.

†The fasting periods noted above apply to all ages.

‡Examples of clear liquids include water, fruit juices without pulp, carbonated beverages, clear tea, and black coffee.

§Since nonhuman milk is similar to solids in gastric emptying time, the amount ingested must be considered when determining an appropriate fasting period.

**A light meal typically consists of toast and clear liquids. Meals that include fried or fatty foods or meat may prolong gastric emptying time. Additional fasting time (e.g., 8 or more hours) may be needed in these cases. Both the amount and type of foods ingested must be considered when determining an appropriate fasting period.

EDUCATION COURSES

Education may be offered at different levels (competency, update, survey courses and advanced education programs). A description of these different levels follows:

1. **Competency Courses** are designed to meet the needs of dentists who wish to become competent in the safe and effective administration of local anesthesia, minimal and moderate sedation. They consist of lectures, demonstrations and sufficient clinical participation to assure the faculty that the dentist understands the procedures taught and can safely and effectively apply them so that mastery of the subject is achieved. Faculty must assess and document the dentist's competency upon successful completion of such training. To maintain competency, periodic update courses must be completed.

2. **Update Courses** are designed for persons with previous training. They are intended to provide a review of the subject and an introduction to recent advances in the field. They should be designed didactically and clinically to meet the specific needs of the participants. Participants must have completed previous competency training (equivalent, at a minimum, to the competency course described in this document) and have current experience to be eligible for enrollment in an update course.

3. **Survey Courses** are designed to provide general information about subjects related to pain control and sedation. Such courses should be didactic and not clinical in nature, since they are not intended to develop clinical competency.

4. **Advanced Education Courses** are a component of an advanced dental education program, accredited by the Commission on Dental Accreditation in accord with the *Accreditation Standards* for advanced dental education programs. These courses are designed to prepare the graduate dentist or postdoctoral student in the most comprehensive manner to be competent in the safe and effective administration of minimal, moderate and deep sedation and general anesthesia.

III. TEACHING PAIN CONTROL

These *Guidelines* present a basic overview of the recommendations for teaching pain control.

A. General Objectives: Upon completion of a predoctoral curriculum in pain control the dentist must:

1. have an in-depth knowledge of those aspects of anatomy, physiology, pharmacology and psychology involved in the use of various anxiety and pain control methods;
2. be competent in evaluating the psychological and physical status of the patient, as well as the magnitude of the operative procedure, in order to select the proper regimen;
3. be competent in monitoring vital functions;
4. be competent in prevention, recognition and management of related complications;
5. have in-depth knowledge of the appropriateness of and the indications for medical consultation or referral;
6. be competent in the maintenance of proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs administered and patient response.

B. Pain Control Curriculum Content:

1. Philosophy of anxiety and pain control and patient management, including the nature and purpose of pain
2. Review of physiologic and psychologic aspects of anxiety and pain
3. Review of airway anatomy and physiology
4. Physiologic monitoring
   a. Observation
      1). Central nervous system
      2). Respiratory system
         a. Oxygenation
         b. Ventilation
      3). Cardiovascular system
   b. Monitoring equipment
5. Pharmacologic aspects of anxiety and pain control
   a. Routes of drug administration
   b. Sedatives and anxiolytics
   c. Local anesthetics
   d. Analgesics and antagonists
   e. Adverse side effects
   f. Drug interactions
   g. Drug abuse

6. Control of preoperative and operative anxiety and pain
    a. Patient evaluation
        1). Psychological status
        2). ASA physical status
        3). Type and extent of operative procedure
    b. Nonpharmacologic methods
        1). Psychological and behavioral methods
            a). Anxiety management
            b). Relaxation techniques
            c). Systematic desensitization
        2). Interpersonal strategies of patient management
        3). Hypnosis
        4). Acupuncture/Acupressure
        5). Other
    c. Local anesthesia
        1). Review of related anatomy, and physiology
        2). Pharmacology
            a). Dosing
            b). Toxicity
            c). Selection of agents
        3). Techniques of administration
            a). Topical
            b). Infiltration (supraperiosteal)
            c). Nerve block – maxilla-to include:
                (aa). Posterior superior alveolar
                (bb). Infraorbital
                (cc). Nasopalatine
                (dd). Greater palatine
                (ee). Maxillary (2nd division)
                (ff). Other blocks
            d. Nerve block – mandible – to include:
                (aa). Inferior alveolar-lingual
                (bb). Mental-incisive
                (cc). Buccal
                (dd). Gow-Gates
                (ee). Closed mouth
            e. Alternative injections-to include:
                (aa). Periodontal ligament
                (bb). Intraosseous
    d. Prevention, recognition and management of complications and emergencies

C. Sequence of Pain Control Didactic and Clinical Instruction: Beyond the basic didactic instruction in local anesthesia, additional time should be provided for demonstrations and clinical practice of the injection techniques. The teaching of other methods of anxiety and pain control, such as the use of analgesics and enteral, inhalation and parenteral sedation, should be coordinated with a course in pharmacology. By this time the student also will have developed a better understanding of patient evaluation and the problems related to prior patient care. As part of this instruction, the student should be taught the techniques of venipuncture and physiologic monitoring. Time should be included for demonstration of minimal and moderate sedation techniques.

Following didactic instruction in minimal and moderate sedation, the student must receive sufficient clinical experience to demonstrate competency in those techniques in which the student is to be certified. It is understood that not all institutions may be able to provide instruction to the level of clinical competence in pharmacologic sedation modalities to all students. The amount of clinical experience required to achieve competency will vary according to student ability, teaching methods and the anxiety and pain control modality taught.

Clinical experience in minimal and moderate sedation techniques should be related to various disciplines of dentistry and not solely limited to surgical cases. Typically, such experience will be provided in managing healthy adult patients.

Throughout both didactic and clinical instruction in anxiety and pain control, psychological management of the patient should also be stressed. Instruction should emphasize that the need for sedative techniques is directly related to the patient's level of anxiety, cooperation, medical condition and the planned procedures.

D. Faculty: Instruction must be provided by qualified faculty for whom anxiety and pain control are areas of major proficiency, interest and concern.

E. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

IV. TEACHING ADMINISTRATION OF MINIMAL SEDATION

The faculty responsible for curriculum in minimal sedation techniques must be familiar with the ADA Policy Statement: *Guidelines for the Use of Sedation and General Anesthesia by Dentists*, and the Commission on Dental Accreditation's Accreditation *Standards* for dental education programs.

These *Guidelines* present a basic overview of the recommendations for teaching minimal sedation. These include courses in nitrous oxide/oxygen sedation, enteral sedation, and combined inhalation/enteral techniques.

General Objectives: Upon completion of a competency course in minimal sedation, the dentist must be able to:

1. Describe the adult anatomy and physiology of the respiratory, cardiovascular and central nervous systems, as they relate to the above techniques.
2. Describe the pharmacological effects of drugs.
3. Describe the methods of obtaining a medical history and conduct an appropriate physical examination.
4. Apply these methods clinically in order to obtain an accurate evaluation.
5. Use this information clinically for ASA classification risk assessment and pre-procedure fasting instructions.
6. Choose the most appropriate technique for the individual patient.
7. Use appropriate physiologic monitoring equipment.
8. Describe the physiologic responses that are consistent with minimal sedation.
9. Understand the sedation/general anesthesia continuum.
10. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia than intended.

INHALATION SEDATION (NITROUS OXIDE/OXYGEN)

A. Inhalation Sedation Course Objectives: Upon completion of a competency course in inhalation sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of inhalation sedation.
4. List and discuss the indications and contraindications of inhalation sedation.
5. List the complications associated with inhalation sedation.
6. Discuss the prevention, recognition and management of these complications.
7. Administer inhalation sedation to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other untoward effects of inhalation agents.

B. Inhalation Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in inhalation sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of inhalation sedation.
8. Review of dental procedures possible under inhalation sedation.
9. Patient monitoring using observation and monitoring equipment (i.e., pulse oximetry), with particular attention to vital signs and reflexes related to pharmacology of nitrous oxide.
10. Importance of maintaining proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs and doses administered and patient response.
11. Prevention, recognition and management of complications and life-threatening situations.
12. Administration of local anesthesia in conjunction with inhalation sedation techniques.
13. Description, maintenance and use of inhalation sedation equipment.
14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Inhalation Sedation Course Duration: While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should be a minimum of *14 hours* plus management of clinical dental cases, during which clinical competency in inhalation sedation technique is achieved. The inhalation sedation course most often is completed as a part of the predoctoral dental education program. However, the course may be completed in a postdoctoral continuing education competency course.

D. Participant Evaluation and Documentation of Inhalation Sedation Instruction: Competency courses in inhalation sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director must certify the competency of participants upon satisfactory completion of training. Records of the didactic instruction and clinical experience, including the number of patients treated by each participant must be maintained and available.

E. Faculty: The course should be directed by a dentist qualified by experience and training. This individual should possess an active permit or license to administer moderate sedation in at least one state, have had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. In addition, the participation of highly qualified individuals in related fields should be encouraged.

A participant-faculty ratio of not more than ten-to-one when inhalation sedation is being used allows for adequate supervision during the clinical phase of instruction; a one-to-one ratio is recommended during the early state of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

ENTERAL AND/OR COMBINATION INHALATION-ENTERAL MINIMAL SEDATION

A. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Objectives: Upon completion of a competency course in enteral and/or combination inhalation-enteral minimal sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
4. List and discuss the indications and contraindications for the use of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
5. List the complications associated with enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
6. Discuss the prevention, recognition and management of these complications.
7. Administer enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation) to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other effects of enteral and inhalation agents.
9. Discuss the pharmacology of the enteral and inhalation drugs selected for administration.
10. Discuss the precautions, contraindications and adverse reactions associated with the enteral and inhalation drugs selected.
11. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for management of life-threatening situations.
12. Demonstrate the ability to manage life-threatening emergency situations, including current certification in Basic Life Support.
13. Discuss the pharmacological effects of combined drug therapy, their implications and their management. Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.



B. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological profiling.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in enteral and/or combination inhalation-enteral minimal sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
8. Review of dental procedures possible under enteral and/or combination inhalation-enteral minimal sedation).
9. Patient monitoring using observation, monitoring equipment, with particular attention to vital signs and reflexes related to consciousness.
10. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
11. Prevention, recognition and management of complications and life-threatening situations.
12. Administration of local anesthesia in conjunction with enteral and/or combination inhalation-enteral minimal sedation techniques.
13. Description, maintenance and use of inhalation sedation equipment.
14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Duration:
Participants must be able to document current certification in Basic Life Support and have completed a nitrous oxide competency course to be eligible for enrollment in this course. While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should include a minimum of *16 hours*, plus clinically-oriented experiences during which competency in enteral and/or combined inhalation-enteral minimal sedation techniques is demonstrated. Clinically-oriented experiences may include simulation, group observations on patients undergoing enteral and/or combination inhalation-enteral minimal sedation. Clinical experience or simulation training in airway management is critical to the prevention of life-threatening emergencies and must be included in the course. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted. The educational course may be completed in a predoctoral dental education curriculum or a postdoctoral continuing education competency course.

D. Participant Evaluation and Documentation of Instruction: Competency courses in combination inhalation-enteral minimal sedation techniques must afford participants with sufficient clinical understanding to enable them to achieve competency. The course director must certify the competency of participants upon satisfactory completion of the course. Records of the course instruction must be maintained and available.

E. Faculty: The course should be directed by a dentist qualified by experience and training. This individual should possess a current permit or license to administer moderate sedation in at least one state, have had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields should be encouraged. The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

V. TEACHING ADMINISTRATION OF MODERATE SEDATION

These *Guidelines* present a basic overview of the requirements for a competency course in moderate sedation. These include courses in enteral and parenteral moderate sedation. The teaching guidelines contained in this section on moderate sedation reflect the delivery methodologies and practice environment in dentistry.

Completion of a pre-requisite nitrous oxide-oxygen competency course is required for participants combining moderate sedation with nitrous oxide-oxygen.

A. Course Objectives: Upon completion of a course in moderate sedation, the dentist must be able to:

1. List and discuss the advantages and disadvantages of moderate sedation.
2. Discuss the prevention, recognition and management of complications associated with moderate sedation.
3. Administer moderate sedation to patients in a clinical setting in a safe and effective manner.
4. Discuss the abuse potential, occupational hazards and other untoward effects of the agents utilized to achieve moderate sedation.
5. Describe and demonstrate the technique of intravenous access, intramuscular injection and other parenteral techniques.
6. Discuss the pharmacology of the drug(s) selected for administration.
7. Discuss the precautions, indications, contraindications and adverse reactions associated with the drug(s) selected.
8. Administer the selected drug(s) to dental patients in a clinical setting in a safe and effective manner.



9. List the complications associated with techniques of moderate sedation.
10. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for the prevention and management of emergency situations.
11. Discuss principles of advanced cardiac life support or an appropriate dental sedation/anesthesia emergency course equivalent.
12. Demonstrate the ability to manage emergency situations.
13. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia than intended.

B. Moderate Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Use of patient history and examination for ASA classification, risk assessment and pre-procedure fasting instructions.
4. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
5. Description of the sedation anesthesia continuum, with special emphasis on the distinction between the conscious and the unconscious state.
6. Review of adult respiratory and circulatory physiology and related anatomy.
7. Pharmacology of local anesthetics and agents used in moderate sedation, including drug interactions and contraindications.
8. Indications and contraindications for use of moderate sedation.
9. Review of dental procedures possible under moderate sedation.
10. Patient monitoring using observation and monitoring equipment, with particular attention to vital signs, ventilation/breathing and reflexes related to consciousness.
11. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
12. Prevention, recognition and management of complications and emergencies.
13. Description, maintenance and use of moderate sedation monitors and equipment.
14. Discussion of abuse potential.
15. Intravenous access: anatomy, equipment and technique.
16. Prevention, recognition and management of complications of venipuncture and other parenteral techniques.
17. Description and rationale for the technique to be employed.
18. Prevention, recognition and management of systemic complications of moderate sedation, with particular attention to airway maintenance and support of the respiratory and cardiovascular systems.



C. Moderate Sedation Course Duration and Documentation:
The Course must include:

- A minimum of 60 hours of instruction.
- Supervised individual administration of moderate sedation for at least twenty (20) dental patients receiving moderate sedation.
- Certification of competence in moderate sedation technique(s).
- Certification of competence in rescuing patients from a deeper level of sedation than intended including managing the airway, intravascular or intraosseous access, and reversal medications.
- Provision by course director or faculty of additional clinical experience if participant competency has not been achieved in time allotted.
- Records of instruction and clinical experiences (i.e., number of patients managed by each participant in each modality/route) that are maintained and available for participant review.

D. Documentation of Instruction: The course director must certify the competency of participants upon satisfactory completion of training in each moderate sedation technique, including instruction, clinical experience, managing the airway, intravascular/intraosseous access, and reversal medications.

E. Faculty: The course must be directed by a dentist qualified by experience and training. This individual shall possess a current permit or license to administer moderate or deep sedation and general anesthesia in at least one state, have had at least three years of experience, including formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields should be encouraged.

A participant-faculty ratio of not more than four-to-one when moderate sedation is being taught allows for adequate supervision during the clinical phase of instruction. A one-to-one ratio is recommended during the early stage of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses in moderate sedation must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies. These facilities may include dental and medical schools/offices, hospitals and surgical centers.

ENDNOTES

1 Excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/ Analgesia*, 2024, of the American Society of Anesthesiologists. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173-4973 or online at **www.asahq.org**.

2 Excerpted from *Standards and Practice Parameters: Statement on ASA Physical Status Classification System*, 2020, of the American Society of Anesthesiologists. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173-4973 or online at **www.asahq.org**.

3 Excerpted from American Society of Anesthesiologists: Practice Guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures. *Anesthesiology*, 2017. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173-4973 or online at **www.asahq.org**.

South Dakota State Board of Dentistry

P.O. Box 1079, 1351 N. Harrison Ave. Pierre, SD 57501-1079
Ph: 605-224-1282 Fax: 1-888-425-3032

E-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.com

Radiography Course Approval Request Form

The following information is required for Board review of a radiography course per ARSD 20:43:07:06 and must be submitted at least 30 days prior to a scheduled board meeting to be considered.

Name of Person Requesting Approval: Emily VanDevender

Address: 1201 W. Peachtree Street NW Suite 2347

Atlanta, GA 30309

Phone: 662-803-1622 Email: emilycompliancespecialist@gmaxseo.com

Notification regarding approval of the course will be sent to this email address.

Title of Course: Midwest Dental Assistant Program

Sponsor Organization: Midwest Dental Assistant School, LLC

Course Length: 128 Hrs.

Instructor(s): Dr. Todd Jared Loftus

Location(s): 8008 Stage Stop Road

Summerset, SD 57718

Date(s) of Course: Expected Start Date: October 1, 2026

The following must be attached to this application or it will not be considered:

1. A resume or curriculum vitae for each course instructor; and
2. A detailed course outline that documents:
   i) 16 hours of instruction; and
   ii) Training in all areas outlined in ARSD 20:43:07:06.

Contact Person:
Emily Cunningham
emilycompliancespecialist@gmaxseo.com

For Office Use Only: Approved: y/n _____

TODD J LOFTUS, DDS

DOCTOR OF DENTAL SURGERY

CONTACT

605-390-1217
Loftus.TJ@gmail.com
www.LoftusDental.com

PROFESSIONAL AFFILIATIONS

American Dental Association
South Dakota Dental Association
International Congress of Oral Implantologists
International Association of Orthodontics

EDUCATION

University of Iowa
1992 - 1996
Doctor of Dental Surgery

Liberty University
1988 - 1992
Bachelor's degree Biology

EXECUTIVE SUMMARY

Accomplished and entrepreneurial Doctor of Dental Surgery with 30 years of clinical and operational leadership across two premier practices in western South Dakota. A board-certified clinician since 1996, recognized for integrating cutting-edge dental technologies with patient-centric care models. Proven track record in practice growth, multidisciplinary treatment planning, and building high-performing clinical teams. Active member of elite international and national dental organizations, dedicated to driving excellence in implantology, orthodontics, and comprehensive oral health.

TECHNICAL PROFICIENCIES

Digital Dentistry: Iterative digital scanning, high-resolution 3D imaging (CBCT), and advanced laser technology.
Advanced Restorations: Single-visit efficiency utilizing same-day crown workflows.
Patient Comfort: Specialized administration of advanced, painless numbing techniques.

PROFESSIONAL EXPERIENCE

Doctor of Dental Surgery & Practice Owner |
1996 – Present *Loftus Dental - Sturgis, SD*
2026 – Present Summerset Dental - Summerset, SD
Strategic Expansion: Successfully scaled regional operations, managing two modern dental facilities to serve the Sturgis and Summerset communities.
Clinical Excellence: Execute complex treatment plans utilizing state-of-the-art laser, imaging, and same-day restorative technology to optimize patient outcomes.
Team Leadership: Direct, mentor, and align multi-practice teams of hygienists, assistants, and administrative staff to enforce rigorous standards of care.

SOUTH DAKOTA DENTAL RADIOLOGY COURSE

Course Sponsor Information

Course Title: Dental Radiology Certification Course

Sponsor Organization: Midwest Dental Assistant School

Sponsor Type:
☐ ADA CERP Recognized Provider
☐ CODA Accredited Institution
☑ Educational Institution with Dental Assisting Program
☐ Other: _____

Course Director: Dr. Todd Loftus

Course Location: Midwest Dental Assistant School, 8008 Stage Stop Road, Summerset, SD 57718
Contact Person: Emily VanDevender

Telephone: 662-803-1622

Email: emilycompliancespecialist@gmaxseo.com

Course Dates: to be determined

Maximum Enrollment: 6

Instructor-to-Student Ratio (Lab): Maximum 1:6

Mannequin available: 6 Dexter Mannequins with Typodont

X-ray Equipment Available: Nomad portable X-ray machine

Types of operatories/layouts: Floor plan is attached. Layout includes 6 treatment rooms, 2 hygiene rooms, 1 consultation/office, sterilization and resupply room, lab and model storage area, imaging room, business office, doctor's office, patient lounge and reception area, team lounge, team mudroom, multiple patient restrooms, and additional storage and support spaces.

Number of Radiographic Units: 6

Student-to-Machine Ratio: Maximum 2:1

COURSE DESCRIPTION

This **21-hour Dental Radiography Certification Course** is designed to provide dental assistants with the didactic knowledge and laboratory competencies required by the **South Dakota State Board of Dentistry**, including **ARSD 20:43:07** and applicable **ARSD 44:03** Radiation Safety

regulations. The course provides instruction in the operation of dental radiographic equipment, radiation safety, digital image acquisition, image evaluation, and the successful completion of a diagnostic full-mouth radiographic series using digital radiography systems.

Prerequisites

Participants must:

- Be currently employed as a dental assistant; or
- Be enrolled in an approved dental assisting program.

Course Completion Requirements

Students must successfully complete all with an 80% minimum:

- Radiation Safety Examination
- Comprehensive Final Written Examination
- Final Laboratory Practical Examination

LEARNING OBJECTIVES

Upon successful completion of the course, students will be able to:

1. Identify and explain principles of radiation physics.
2. Describe biologic effects of ionizing radiation.
3. Apply ALARA radiation protection principles.
4. Identify components and operation of dental x-ray equipment.
5. Operate dental x-ray equipment in proper sequence.
6. Identify characteristics of a diagnostic digital image.
7. Evaluate image quality and correct technical errors.
8. Differentiate effects Kilovoltage, Milliamperage, exposure time, and distance on image quality.
9. Demonstrate proper infection control during radiographic procedures.
10. Position patients correctly for intraoral radiography.
11. Acquire diagnostic digital radiographs.

12. Complete a full-mouth radiographic series on a mannequin.
13. Demonstrate compliance with state and federal radiation safety requirements.

COURSE DESCRIPTION

This course provides instruction in:

- Radiation physics and biology
- Radiation protection principles
- Dental x-ray equipment operation
- Digital radiographic imaging
- Infection control procedures
- Exposure techniques
- Image evaluation and error correction
- Patient positioning
- Full-mouth radiographic series acquisition
- Compliance with state and federal radiation protection standards

Training includes both classroom instruction and extensive laboratory practice utilizing dental radiography, dexter mannequins and digital imaging systems

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COURSE FORMAT

Component	Hours
Didactic Instruction	7
Laboratory Instruction	14
Total Hours	21

EXAMINATION REQUIREMENTS

Radiation Safety Examination

- Administered before radiographic exercises
- 50 multiple-choice questions

- Minimum passing score: 80%

Didactic Final Examination

- 100 multiple-choice questions
- Minimum passing score: 80%

Laboratory Final Examination

Conducted on a mannequin and includes completion of a diagnostic full-mouth series.

Minimum passing score: 80%.

Compliance with radiation safety procedures: 100%

These examination requirements are designed to meet the educational standards of **ARSD 20:43:07** and applicable **ARSD 44:03** Radiation Safety requirements.

GRADING CRITERIA

Evaluation Method	Weight
Radiation Safety Exam	Pass/Fail
Didactic Final Exam	40%
Laboratory Competencies	20%
Final Laboratory Examination	40%
Minimum Overall Passing	Score: 80%

FACILITY COMPLIANCE STATEMENT

The course facility certifies that:

- Nomad portable digital radiography equipment is available.
- No more than two students are assigned to one x-ray machine.
- Laboratory instruction maintains a maximum ratio of six students to one instructor.
- Training is conducted in compliance with applicable OSHA, infection control, and radiation protection requirements.
- Students practice on Dexter mannequins.

- Instructor does have a current radiology instructor's certification and is current with their radiology continuing education.
- Course sponsor does provide all necessary supplies and comply with the Board's rules regarding sanitation, sterilization and infection control

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3-Day Detailed Hourly Itinerary

Day 1: Didactic Lectures & Safety Benchmark (7 Hours Didactic)

- **08:00 AM – 09:30 AM | Module 1: Dental X-Ray Physics & Equipment Operation (1 hour)**
    - Essentials of atomic structure, ionization, and X-ray production.
    - Framework of the X-ray tube head, control panel, and beam components.
    - Adjusting exposure variables: Kilovoltage, Milliamperage, time, and PID distance.
- **09:30 AM – 11:00 AM | Module 2: Radiation Biology & Protection Guidelines (1.5 hours)**
    - Latent periods, cumulative effects, and tissue sensitivity to ionizing radiation.
    - Patient protection procedures: Lead aprons, thyroid collars, and fast digital sensors.
    - Operator protection rules: Distance, positioning angles, and structural barriers.
- **11:00 AM – 11:15 AM | Morning Break (Free time)**
- **11:15 AM – 12:45 PM | Module 3: Digital Imaging & Intraoral Landmarks (1.5 hours)**
    - Anatomy of the maxilla and mandible, including radiopaque and radiolucent landmarks.
    - Solid-state digital sensors and Photostimulable Phosphor plates.
    - Digital image management, software layouts, and data privacy.
- **12:45 PM – 01:45 PM | Lunch Break (Free time)**
- **01:45 PM – 03:15 PM | Module 4: Radiographic Techniques & Error Management (1.5 hours)**
    - Geometry of the **Paralleling Technique** versus the Bisecting Angle Technique.
    - Troubleshooting technique errors: Cone-cutting, horizontal overlapping, vertical foreshortening, and elongation.
- **03:15 PM – 03:30 PM | Afternoon Break (Free time)**

- **03:30 PM – 05:00 PM | Module 5: Written Safety Examination & Review and correction (1.0 hour)**
    - Administration of the **Radiation Safety Exam**
    - Review of exam answers, question review and correction, and individual feedback.

Day 2: Infection Control & Practical Simulation (7 Hours Lab)

- **08:00 AM – 10:00 AM | Lab Unit 1: Infection Control & Operator Setup (2.0 hours)**
    - Applying applicable South Dakota infection control requirements, OSHA standards, and current CDC infection prevention guidelines.
    - Barrier placement on tube heads, control panels, extension arms, and chairs.
    - Placing digital sensor barriers and assembling beam-aligning instruments
- **10:00 AM – 12:00 PM | Lab Unit 2: Bitewing Survey Practice (2.0 hours)**
    - Demonstration of horizontal and vertical bitewing placement on a dental dexter mannequin.
    - Student practice: Aligning the PID, selecting exposure settings, and exposing bitewing surveys.
- **12:00 PM – 01:00 PM | Lunch Break (Free time)**
- **01:00 PM – 03:00 PM | Lab Unit 3: Anterior Periapical Practice (2.0 hours)**
    - Instructor presentation and explanation of maxillary and mandibular anterior periapical film placement.
    - Hands-on student practice applying the paralleling technique on mannequins.
- **03:00 PM – 03:15 PM | Afternoon Break (Free time)**
- **03:15 PM – 04:15 PM | Lab Unit 4: Posterior Periapical Practice (1.0 hour)**
    - Maxillary and mandibular molar/premolar positioning techniques.
    - Student exercise adjusting vertical and horizontal sensor positioning angles.

Day 3: Clinical Competency & Final Examinations (7 Hours Lab)

- **08:00 AM – 10:30 AM | Lab Unit 5: Comprehensive Full Mouth Series (2.5 hours)**

- Combining Anterior Periapical, Posterior Periapical, and bitewing sequences into a fluid workflow.
- Complete 18-to-20 image Full Mouth Series acquisition on a radiography mannequin under strict instructor supervision.

- **10:30 AM – 12:00 PM | Lab Unit 6: Digital Software Mounting & Error Analysis (1.5 hours)**
  - Transferring captured images into digital mounting templates using anatomical markers.
  - Guided self-critique: Documenting errors and outlining corrective steps.
- **12:00 PM – 01:00 PM | Lunch Break (Free time)**
- **01:00 PM – 03:00 PM | Lab Evaluation: Final Practical Competency Exam (2.0 hours)**
  - Autonomous student execution of a timed Full Mouth Series on a mannequin.
  - Grading based on radiation safety compliance (pass/fail) and final image diagnostic quality.
- **03:00 PM – 03:15 PM | Afternoon Break (Free time)**
- **03:15 PM – 05:00 PM | Final Program Administration & Testing (1.0 hour)**
  - Administration of the SD Dental Radiology Written Exam.
  - Distribution of course completion certificates for board registration.

Floor Plan for Midwest Dental Assistant School, LLC, 8008 Stage Stop Road, Summerset, SD 57718 is included as attachment.

of the reasons therefor and findings of fact on each issue and conclusions of law necessary for the proposed decision. The final decision shall be made by a majority of the commission members, with each member's vote set forth in the written decision. The final decision shall be filed with the attorney general and shall be provided to the public entity and or public officer involved, the state's attorney, and any person that has made a written request for such determinations. If the commission finds a violation of this chapter, the commission shall issue a public reprimand to the offending official or governmental entity. However, no violation found by the commission may be subsequently prosecuted by the state's attorney or the attorney general. All findings and public censures of the commission shall be public records pursuant to § 1-27-1. Sections 1-25-6 to 1-25-9, inclusive, are not subject to the provisions of chapter 1-26.

1-25-8. OMC MEMBERS. The South Dakota Open Meeting Commission is comprised of five state's attorneys or deputy state's attorneys appointed by the attorney general. Each commissioner serves at the pleasure of the attorney general. The members of the commission shall choose a chair of the commission annually by majority vote.

1-25-12. DEFINITIONS. Terms used in the open meetings laws mean:

(1) "Official meeting," any meeting of a quorum of a public body at which official business or public policy of that public body is discussed or decided by the public body, whether in person or by means of teleconference or electronic means, including electronic mail, instant messaging, social media, text message, or virtual meeting platform, provided the term does not include communications solely to schedule a meeting or confirm attendance availability for a future meeting;

(2) "Political subdivision," any association, authority, board, municipality, commission, committee, council, county, school district, task force, town, township, or other local governmental entity, which is created by statute, ordinance, or resolution, and is vested with the authority to exercise any sovereign power derived from state law;

(3) "Public body," any political subdivision or the state;

(4) "State," each agency, board, commission, or department of the State of South Dakota, not including the Legislature; and

(5) "Teleconference," an exchange of information by any audio, video, or electronic medium, including the internet.

1-25-13. ANNUAL REVIEW OF OPEN MEETING LAWS. Any agency, as defined in § 1-26-1, or political subdivision of this state, that is required to provide public notice of its meetings pursuant to § 1-25-1.1 or 1-25-1.3 must annually review the following, during an official meeting of the agency or subdivision:

(1) The explanation of the open meeting laws of this state published by the attorney general, pursuant to § 1-11-1; and

(2) Any other material pertaining to the open meeting laws of this state provided by the attorney general.

The agency or subdivision must include in the minutes of the official meeting an acknowledgement that the review was completed.

1-27-1.16. MEETING PACKETS AND MATERIALS. If a meeting is required to be open to the public pursuant to § 1-25-1 and if any printed material relating to an agenda item of the meeting is prepared or distributed by or at the direction of the governing body or any of its employees and the printed material is distributed before the meeting to all members of the governing body, the material shall either be posted on the governing body's website or made available at the official business office of the governing body at least twenty-four hours prior to the meeting or at the time the material is distributed to the governing body, whichever is later. If the material is not posted to the governing body's website, at least one copy of the printed material shall be available in the meeting room for inspection by any person while the governing body is considering the printed material. However, the provisions of this section do not apply to any printed material or record that is specifically exempt from disclosure under the provisions of this chapter or to any printed material or record regarding the agenda item of an executive or closed meeting held in accordance with § 1-25-2. A violation of this section is a Class 2 misdemeanor. However, the provisions of this section do not apply to printed material, records, or exhibits involving contested case proceedings held in accordance with the provisions of chapter 1-26.

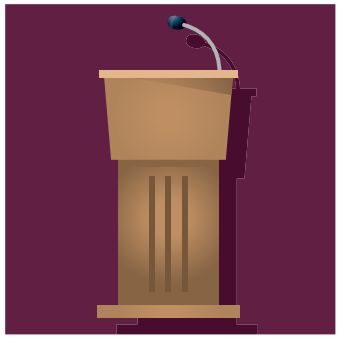
1-27-1.17. DRAFT MINUTES. The unapproved, draft minutes of any public meeting held pursuant to § 1-25-1 that are required to be kept by law shall be available for inspection by any person within ten business days after the meeting. However, this section does not apply if an audio or video recording of the meeting is available to the public on the governing body's website within five business days after the meeting. A violation of this section is a Class 2 misdemeanor. However, the provisions of this section do not apply to draft minutes of contested case proceedings held in accordance with the provisions of chapter 1-26.

1-27-1.18. WORKING GROUP REPORTS. Any final recommendations, findings, or reports that result from a meeting of a committee, subcommittee, task force, or other working group which does not meet the definition of a political subdivision or public body pursuant to § 1-25-1, but was appointed by the governing body, shall be reported in open meeting to the governing body which appointed the committee, subcommittee, task force, or other working group. The governing body shall delay taking any official action on the recommendations, findings, or reports until the next meeting of the governing body.









Conducting the Public's Business in Public

An explanation of South Dakota's Open Meetings Laws

(Effective July 1, 2026)

Prepared by:
S.D. Attorney General's Office
in partnership with the
S.D. NewsMedia Association

Published by:
South Dakota NewsMedia Association
1125 32nd Ave. Brookings, SD 57006

Q: WHAT ARE SOUTH DAKOTA'S OPEN MEETINGS LAWS?

A: South Dakota's open meetings laws embody the principle that the public is entitled to the greatest possible information about public affairs and are intended to encourage public participation in government. SDCL Ch. 1-25 requires that official meetings of public bodies must be public and advance notice is to be given of such meetings. The statutes define an "official meeting" as one where a quorum of the public body is present and at which official business or public policy of the body is discussed or decided. **Openness in government is encouraged.**

Q: WHO DOES THE OPEN MEETINGS LAWS APPLY TO?

A: The open meetings laws apply to all public bodies of the state and its political subdivisions. SDCL 1-25-1, 1-25-12(3). This includes cities, counties, school boards and other public bodies created by ordinance or resolution, such as appointed boards, task forces, and committees, so long as they have authority to exercise sovereign power. SDCL 1-25-12(2). Although no court decisions have been issued on the subject, this probably does not include bodies that serve only in an advisory capacity. The State Constitution allows the Legislature and the Unified Judicial System to create rules regarding their own separate functions.

Q: WHAT MUST BE INCLUDED ON THE PROPOSED AGENDA?

A: A proposed agenda, as required by § 1-25-1.1 or 1-25-1.3, must list all items to be considered by a public body during any official meeting. The proposed agenda items must be described in sufficient detail to reasonably inform the public of any official business or public policy intended to be considered at the meeting.

Q: ARE TELECONFERENCES CONSIDERED PUBLIC MEETINGS?

A: Yes. The open meetings laws allow meetings, including executive or closed meetings, to be conducted by teleconference – defined as an exchange of information by audio, video, or electronic means (including the internet) – if a place is provided for the public to participate. SDCL 1-25-1.5, 1-25-12(5). In addition, for teleconferences where less than a quorum of the public body is present at the location open to the public, arrangements must also be made for the public to listen by telephone or internet (except for portions of meetings properly closed for executive sessions). SDCL 1-25-1.6. The media and public must be notified of teleconference meetings under the same notice requirements as any other meeting.

Q: HOW ARE THE PUBLIC AND MEDIA NOTIFIED WHEN PUBLIC BUSINESS IS BEING DISCUSSED?

A: SDCL 1-25-1.1 requires that all political subdivisions (except the state and its boards, commissions, or departments as provided in § 1-25-1.3) prominently post a notice and copy of the proposed agenda at the political subdivision's principal office. At a minimum, the proposed agenda must include the date, time, and location of the meeting and must be visible, readable, and accessible to the public for 24 continuous hours immediately preceding the meeting. Also, if the political subdivision has its own website, the notice must be posted on the website upon dissemination of the notice. For special or rescheduled meetings, political subdivisions must comply with the regular meeting notice requirements as much as circumstances permit. The notice must be delivered in person, by mail, by email, or by telephone to all local news media who have asked to be notified. It is good practice for local media to renew requests for notification of special or rescheduled meetings at least annually.

SDCL 1-25-1.3 varies slightly from SDCL 1-25-1.1 and requires the State and its agencies, boards, commissions, or departments to post a proposed agenda both on http://boardsandcommissions.

business or public policy intended to be considered at the meeting. A violation of this section is a Class 2 misdemeanor.

1-25-2. EXECUTIVE SESSION. An executive session or closed meetings may be held only for the purposes of:

(1) Discussing the character, competence, fitness, performance, or qualifications of any current or prospective public officer or employee, not including an independent contractor;

(2) Discussing a student's:

(a) Discipline, expulsion, or suspension;

(b) Assignment or educational program; or

(c) Eligibility to participate in interscholastic activities provided by the South Dakota High School Activities Association;

(3) Consulting with legal counsel, or reviewing communications from legal counsel, about proposed or pending litigation or contractual matters;

(4) Preparing for contract negotiations or negotiating with employees or employee representatives;

(5) Discussing marketing or pricing strategies by a board or commission of a business that is owned by the state or any of its political subdivisions, if public discussion may be harmful to the competitive position of the business; or

(6) Discussing the following information pertaining to the protection of public or private property and any person on or within the property:

(a) Any vulnerability assessment or response plan intended to prevent or mitigate criminal acts;

(b) Emergency management or response;

(c) Public safety information that would create a substantial likelihood of endangering public safety or property, if disclosed;

(d) Communications network schema, computer systems, cyber security plans, passwords, or user identification names;

(e) Guard schedules;

(f) Lock combinations; and

(g) Any blueprint, building plan, or infrastructure record regarding any building or facility, which would expose or create vulnerability through disclosure of the configuration, location, or security of critical systems of the building or facility;

(7) Discussing any emergency or disaster response plans or protocols, safety or security audits or reviews, or lists of emergency or disaster response personnel or material; and

(8) Discussing the location of or listing any:

(a) Ammunition or weapons;

(b) Biological, chemical, or nuclear agents; or

(c) Other military or law enforcement equipment or personnel.

An executive session or closed meeting may be held only upon a majority vote of the members of the public body present and voting at an otherwise open official meeting.

In the absence of a unanimous vote, any vote to enter executive session must be taken by roll call. A motion to enter executive session must state the applicable subdivision in this section, or any other applicable law, pursuant to which the executive session is to be held. The motion and vote to enter executive session must be reported in the minutes of the proceedings. Discussion during executive session is restricted to the purpose specified in the motion to enter executive session.

Any official action concerning the matters considered pursuant to this section must be taken at an open official meeting.

Nothing in § 1-25-1 or this section prevents an executive session or closed meeting if the federal or state Constitution or any federal or state statute permits or requires the session or meeting. A violation of this section is a Class 2 misdemeanor.

1-25-6. DUTY OF STATE'S ATTORNEY. If a complaint alleging a violation of chapter 1-25 is made pursuant to § 23A-2-1, the state's attorney shall take one of the following actions:

(1) Prosecute the case pursuant to Title 23A;

(2) Determine that there is no merit to prosecuting the case. Upon doing so, the state's attorney shall send a copy of the complaint and any investigation file to the attorney general. The attorney general shall use the information for statistical purposes and may publish abstracts of such information, including the name of the government body involved for purposes of public education; or

(3) Send the complaint and any investigation file to the South Dakota Open Meetings Commission for further action.

1-25-6.1. DUTY OF STATE'S ATTORNEY (COUNTY COMMISSION ISSUES). If a complaint alleges a violation of this chapter by a board of county commissioners, the state's attorney shall take one of the following actions:

(1) Prosecute the case pursuant to Title 23A;

(2) Determine that there is no merit to prosecuting the case. The attorney general shall use the information for statistical purposes and may publish abstracts of the information as provided by § 1-25-6;

(3) Send the complaint and any investigation file to the South Dakota Open Meetings Commission for further action; or

(4) Refer the complaint to another state's attorney or to the attorney general for action pursuant to § 1-25-6.

1-25-7. REFERRAL TO OMC. Upon receiving a referral from a state's attorney or the attorney general, the South Dakota Open Meetings Commission shall examine the complaint and investigatory file submitted by the state's attorney or the attorney general and shall also consider signed written submissions by the persons or entities that are directly involved. Based on the investigatory file submitted by the state's attorney or the attorney general and any written responses, the commission shall issue a written determination on whether the conduct violates this chapter, including a statement

PERTINENT S.D. OPEN MEETINGS STATUTES
(other specific provisions may apply depending on the public body involved)

1-25-1. OPEN MEETINGS.

An official meeting of a public body is open to the public unless a specific law is cited by the public body to close the official meeting to the public.

It is not an official meeting of one public body if its members provide information or attend the official meeting of another public body for which the notice requirements of § 1-25-1.1 or 1-25-1.3 have been met. It is not an official meeting of a public body if its members attend a press conference called by a representative of the public body.

For any event hosted by a nongovernmental entity to which a quorum of the public body is invited and public policy may be discussed, but the public body does not control the agenda, the public body may post a public notice of a quorum, in lieu of an agenda. The notice of a quorum must meet the posting requirements of § 1-25-1.1 or 1-25-1.3 and must contain, at a minimum, the date, time, and location of the event.

The public body shall reserve at every official meeting a period for public comment, limited at the public body's discretion as to the time allowed for each topic and the total time allowed for public comment, but not so limited as to provide for no public comment.

Public comment is not required at an official meeting held solely for the purpose of meeting in executive session, an inauguration, presentation of an annual report to the public body, or swearing in of a newly elected official, regardless of whether the activity takes place at the time and place usually reserved for an official meeting.

If a quorum of township supervisors, road district trustees, or trustees for a municipality of the third class meets solely for purposes of implementing previously publicly adopted policy; carrying out ministerial functions of that township, district, or municipality; or undertaking a factual investigation of conditions related to public safety; the meeting is not subject to the provisions of this chapter.

A violation of this section is a Class 2 misdemeanor.

1-25-1.1. PUBLIC NOTICE OF POLITICAL SUBDIVISIONS. Each political subdivision shall provide public notice, with proposed agenda, that is visible, readable, and accessible for at least an entire, continuous twenty-four hours immediately preceding any official meeting, by posting a copy of the notice, visible to the public, at the principal office of the political subdivision holding the meeting. The proposed agenda shall include the date, time, and location of the meeting. The notice shall also be posted on the political subdivision's website upon dissemination of the notice, if a website exists. For any special or rescheduled meeting, the information in the notice shall be delivered in person, by mail, by email, or by telephone, to members of the local news media who have requested notice. For any special or rescheduled meeting, each political subdivision shall also comply with the public notice provisions of this section for a regular meeting to the extent that circumstances permit. A violation of this section is a Class 2 misdemeanor.

1-25-1.3. PUBLIC NOTICE OF STATE. The state shall provide public notice of a meeting, at least seventy-two hours before the meeting is schedule to start, not including Saturday, Sunday, or any legal holiday, by posting a copy of the proposed agenda:

(1) At the principal office of the board, commission, or department holding the meeting;

(2) That includes the date, time, and location of the meeting;

(3) That is visible, readable, and accessible to the public; and

(4) On a state website, designated by the commissioner of the Bureau of Finance and Management.

For any special or rescheduled meeting, the information in the notice must be delivered in person, or by mail, email, or telephone, to members of the local news media who have requested notice. The state shall also comply with all other requirements of this section, for a special or rescheduled meeting, as circumstances permit. A violation of this section is a Class 2 misdemeanor.

1-25-1.5. TELECONFERENCE MEETING. Any official meeting may be conducted by teleconference. A teleconference may be used to conduct a hearing or take final disposition regarding an administrative rule pursuant to § 1-26-4. A member is deemed present if the member answers present to the roll call conducted by teleconference for the purpose of determining a quorum. Each vote at an official meeting held by teleconference may be taken by voice vote. If any member votes in the negative, the vote shall proceed to a roll call vote.

1-25-1.6. TELECONFERENCE PARTICIPATION. At any official meeting conducted by teleconference, there shall be provided one or more places at which the public may listen to and participate in the teleconference meeting. For any official meeting held by teleconference, that has less than a quorum of the members of the public body participating in the meeting who are present at the location open to the public, arrangements shall be provided for the public to listen to the meeting via telephone or internet. The requirement to provide one or more places for the public to listen to the teleconference does not apply to official meetings closed to the public pursuant to specific law.

1-25-1.7. AGENDA DETAILS ARE REQUIRED. A proposed agenda, as required by § 1-25-1.1 or 1-25-1.3, must list all items to be considered by a public body during any official meeting. The proposed agenda items must be described in sufficient detail to reasonably inform the public of any official

sd.gov and at their principal place of business at least 72 continuous hours before a meeting is scheduled to start (this does not include any weekend or legal holiday).

Q: WHO ARE LOCAL NEWS MEDIA?

A: There is no definition of "local news media" in SDCL ch. 1-25. "News media" is defined in SDCL 13-1-57 generally as those personnel of a newspaper, periodical, news service, radio station, or television station regardless of the medium through which their content is delivered. The Attorney General is of the opinion that "local news media" is all news media – broadcast and print – that regularly carry news to the community.

Q: IS A PUBLIC COMMENT PERIOD REQUIRED AT PUBLIC MEETINGS?

A: Yes. Public bodies are required to provide at every official meeting a period of time on their agenda for public comment. SDCL 1-25-1. Each public body has the discretion to limit public comment as to the time allowed for each topic commented on, and as to the total time allowed for public comment. Public comment is not required at meetings held solely for an executive session, inauguration, presentation of an annual report, or swearing in of elected officials.

Q: CAN PUBLIC MEETINGS BE RECORDED?

A: Yes, SDCL 1-25-11 requires public bodies to allow recording (audio or video) of their meetings if the recording is reasonable, obvious, and not disruptive. This requirement does not apply to those portions of a meeting confidential or closed to the public.

Q: WHEN CAN A MEETING BE CLOSED TO THE PUBLIC AND MEDIA?

A: SDCL 1-25-2 allows a public body to close a meeting for the following purposes: 1) to discuss personnel issues pertaining to officers or employees; 2) consideration of the performance or discipline of a student, or the student's participation in interscholastic activities; 3) consulting with legal counsel, or reviewing communications from legal counsel about proposed or pending litigation or contractual matters; 4) employee contract negotiations; 5) to discuss marketing or pricing strategies of a publicly-owned competitive business; or 6) to discuss information related to the protection of public or private property such as emergency management response plans or other public safety information. The statute also recognizes that executive session may be appropriate to comport with other laws that require confidentiality or permit executive or closed meetings. Federal law pertaining to students and medical records will also cause school districts and other entities to conduct executive sessions or conduct meetings to refrain from releasing confidential information. Meetings may also be closed by cities and counties for certain economic development matters. SDCL 9-34-19.

Note that SDCL 1-25-2 and SDCL 9-34-19 do not require meetings be closed in any of these circumstances.

Any official action based on discussions in executive session must, however, be made at an open meeting.

Q: WHAT IS THE PROPER PROCEDURE FOR EXECUTIVE SESSIONS?

A: A motion to enter executive session must be made and seconded, followed by a vote. If the motion does not receive a majority vote, a roll call vote is required. Both the motion and the resulting vote must be recorded in the minutes of the proceedings.

Q: WHAT MUST BE STATED IN A MOTION FOR EXECUTIVE SESSION?

A: Motions for executive sessions must refer to the specific state or federal law allowing for the executive session i.e. "pursuant to SDCL 1-25-2(3)." Also, best practice to avoid public confusion would be that public bodies explain the reason for going into executive session. For example, the motion might state "motion to go into executive session pursuant to SDCL 1-25-2(1) for the purposes of discussing a personnel matter," or "motion to go into executive session pursuant to SDCL 1-25-2(3) for

the purposes of consulting with legal counsel."

Discussion in the executive session must be strictly limited to the announced subject. No official votes may be taken on any matter during an executive session. The public body must return to open session before any official action can be taken.

Q: WHAT HAPPENS IF THE MEDIA OR PUBLIC IS IMPROPERLY EXCLUDED FROM A MEETING OR OTHER VIOLATIONS OF THE OPEN MEETING LAWS OCCUR?

A: Excluding the media or public from a meeting that has not been properly closed subjects the public body or the members involved to: (a) prosecution as a Class 2 misdemeanor punishable by a maximum sentence of 30 days in jail, a $500 fine or both; or (b) a reprimand by the Open Meeting Commission ("OMC"). The same penalties apply if the agenda for the meeting is not properly posted, or other open meeting violations occur.

Also, action taken during any meeting that is not open or has not been properly noticed could, if challenged, be declared null and void.

Q: HOW ARE ISSUES REFERRED TO THE OPEN MEETINGS COMMISSION ("OMC")?

A: Persons alleging violations of the open meetings laws must make their complaints with law enforcement officials in the county where the offense occurred. After a signed and notarized complaint is made under oath, and any necessary investigation is conducted, the State's Attorney may: (a) prosecute the case as a misdemeanor; (b) find that the matter has no merits and file a report with the Attorney General for statistical purposes; or (c) forward the complaint to the OMC for a determination. The OMC is comprised of five State's Attorneys or Deputy State's Attorneys appointed by the Attorney General. The OMC examines whether a violation has occurred and makes written public findings explaining its reasons. If you have questions on the procedures or status of a pending case, you may contact the Attorney General's Office at 605-773-3215 to talk to an assistant for the OMC. Procedures for the OMC are posted on the website for the Office of Attorney General. http://atg.sd.gov/.

Q: WHAT DOES THE TERM "SOVEREIGN POWER" MEAN?

A: The open meetings laws do not define this term, but it generally means the power to levy taxes, impose penalties, make special assessments, create ordinances, abate nuisances, regulate the conduct of others, or perform other traditional government functions. The term may include the exercise of many other governmental functions. If an entity is unclear whether it is exercising "sovereign power" it should consult with legal counsel.

Q: MAY AGENDA ITEMS BE CONSIDERED IF THEY ARE ADDED LESS THAN 24 HOURS BEFORE A MEETING?

A: Proposed agendas for public meetings must be posted at least 24 hours in advance of the meeting. The purpose of providing advance notice of the topics to be discussed at a meeting is to provide information to interested members of the public concerning the governing body's anticipated business. Typically, the public body adopts the final agenda upon convening the meeting. At the time the final agenda is adopted, the governing body may add or delete agenda items and may also change the order of business. See In re Yankton County Commission, Open Meetings Commission Decision # 20-03, December 31, 2020. New items cannot be added after the agenda has been adopted by the governing body.

Public bodies are strongly encouraged to provide at least 24 hours' notice of all agenda items so as to be fair to the public and to avoid dispute.

For special or rescheduled meetings, public bodies are to comply to the extent circumstances permit. In other words, posting less than 24 hours in advance may be permissible in emergencies.

Q: ARE EMAIL DISCUSSIONS "MEETINGS" FOR PURPOSES OF THE OPEN MEETINGS LAWS?

A: The definition of an "official meeting" in SDCL 1-25-12(1) specifically includes meetings conducted by "electronic means, including electronic mail, instant messaging, social media, text message, or virtual meeting platform[.]" A quorum of a public body that discusses official business of that body via electronic means is conducting an official meeting for purposes of the open meetings laws. Electronic communications made solely for scheduling purposes do not fall within the definition of an official meeting.

Q: WHAT RECORDS MUST BE AVAILABLE TO THE PUBLIC IN CONJUNCTION WITH PUBLIC MEETINGS?

A: SDCL 1-25-1.4 requires state boards, commissions, or departments to make public meeting materials available on http://boardsandcommissions.sd.gov. SDCL 1-27-1.16 requires that any other public body must post meeting materials on the public body's website or make those materials available to the public at least twenty-four hours prior to the hearing or when made available to the members of the public body, whichever is later. Finally, SDCL 1-27-1.17 requires that draft minutes of public meetings must be made available to the public at the principal place of business for the public body within 10 business days after the meeting (or any audio and visual recording must be made available on the website for the public body within five business days).

These laws are in addition to any specific requirements for public bodies (i.e., publication requirements in state laws pertaining to cities, counties, or school districts). Enforcement of public records laws contained in SDCL Ch. 1-27 are handled by separate procedures found in SDCL 1-27-35, et. seq. rather than the open meeting procedures described above. Violations of SDCL 1-27-1.16 and 1-27-1.17 are also Class 2 misdemeanors.

Q: WHAT REQUIREMENTS APPLY TO TASK FORCES, COMMITTEES AND WORKING GROUPS?

A: Task forces and committees that exercise "sovereign power," and are created by statute, ordinance, or proclamation are required to comply with the open meetings laws. SDCL 1-25-12(1). Task forces, committees, and working groups that are not created by statute, ordinance, or proclamation, or are advisory only, may not be subject to the open meetings laws, but are encouraged to comply to the extent possible when public matters are discussed. Ultimately, if such advisory task forces, committees and working groups present any reports or recommendations to public bodies, the public bodies must wait until the next meeting (or later) before taking final action on the recommendations. SDCL 1-27-1.18.

Q: ARE PUBLIC BODIES REQUIRED TO REVIEW THE OPEN MEETINGS LAWS?

A: Public bodies must annually review an explanation of the open meetings laws provided by the Attorney General, along with any other material pertaining to the open meetings laws made available by the Attorney General. SDCL 1-25-13. Each public body must report in its minutes that the annual review of the open meetings laws was completed.

SOUTH DAKOTA
STATE BOARD OF DENTISTRY

MAILING ADDRESS: PO Box 42, Black Hawk, SD 57718
PHYSICAL ADDRESS: 1760 Rand Road Ste B, Rapid City, SD 57702
PHONE: 605-791-3650
EMAIL: contactus@sdboardofdentistry.com

CONTINUING EDUCATION APPROVAL REQUEST FORM

Applicant/Contact: _____ Phone: _____

Organization: _____ Email: _____
**Questions and notification of approval will be sent to the above email address.*

Course Title: _____

Course Date(s): _____Presenter(s): _____

The board generally recognizes continuing education providers certified through the Amercian Dental Association Continuing Education Recognition Program (ADA CERP) or the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE).

Please check the certification of the presenter: ☐ ADA CERP ☐ AGD PACE ☐ Other

Other (Explain): _____

Has the course been previously approved? ☐ YES ☐ NO If yes, most recent date: _____

Format: ☐ In-Person ☐ Live Webinar (Zoom/Teams) ☐ Home Study

Please indicate the number of hours and CE category requested for this course. For courses that have multiple topics, please attached a schedule that includes the number of hours and CE category for each topic.

_____ Academic (*Dentist Only) _____Clinical _____Practice Management

_____ Nutrition _____Home Study _____Anesthesia/Sedation

_____ Radiography _____Clinical-Volunteer

ACADEMIC HOURS ONLY

ARSD 20:40:03:07 requires academic content to relate directly to clinical dental services and meet at least one criteria below. Select each applicable criterion and attach verification.

- ☐ Course physically taken at a CODA-accredited dental school
- ☐ Presenter affiliated with a CODA-accredited dental school
- ☐ Provider approved through ADA CERP
- ☐ Provider approved through AGD PACE

You must include verification of ADA CERP or AGD PACE designation to be approved for Academic hours.

Applicable laws: SDCL 36-6A-14, 36-6A-52, 36-6A-55, 36-6A-57, and 36-6A-59 govern Board authority, renewal, CE verification, and enforcement. CE requirements: ARSD 20:43:03:07 (dentists and academic credit), 20:43:03:07.01 (dental hygienists), 20:43:08:09.01 (registered dental assistants), and 20:43:07:10 (dental radiographers). Additional anesthesia and sedation requirements appear in ARSD chapter 20:43:09.

DENTAL EXAMINATION - New Graduates	CRDTS		CDCA/WREB/CITA (ADEX Exam)		SRTA
20:43:03:02. Clinical competency examination -- License to practice as a dentist. *Components must demonstrates evidence of psychometric soundness, including documentation of variability, validity, reliability, fidelity and fairness.*	**2026: Patient Based**	**2026: Simulation Based or Manikin Based**	**2026: Patient Based**	**2026: Simulation Based or Manikin Based**	**No longer offered in 2026**
(1) A patient-based or equivalent simulation-based or manikin-based periodontal component;	Yes	Yes	Yes	Yes	N/A
(2) A patient-based or equivalent simulation-based or manikin-based restorative component;	Yes	Yes	Yes	Yes	N/A
(3) A simulation-based or manikin-based prosthodontic component;	Yes	Yes	Yes	Yes	N/A
(4) A simulation-based or manikin-based endodontic component; and	Yes	Yes	Yes	Yes	N/A
(5) A remediation policy to address candidate deficiencies.	Yes	Yes	Yes	Yes	N/A
DENTAL HYGIENE EXAMINATION - New Graduates	**CRDTS**		**CDCA/WREB/CITA (ADEX Exam)**		**SRTA**
20:43:03:09. Clinical competency examination -- License to practice as a dental hygienist. *Components must demonstrates evidence of psychometric soundness, including documentation of variability, validity, reliability, fidelity and fairness.*	**2026: Patient Based**	**2026: Simulation Based or Manikin Based**	**2026: Patient Based**	**2026: Simulation Based or Manikin Based**	**No longer offered in 2026**
(1) Pocket depth detection;	Yes	Yes	Yes	Yes	N/A
(2) Calculus detection and removal;	Yes	Yes	Yes	Yes	N/A
(3) An intra oral and extra oral assessment; and	Yes	Yes	Yes	Yes	N/A
(4) A remediation policy to address candidate deficiencies.	Yes	Yes	Yes	Yes	N/A
DENTAL EXAMINATION - Credential	**CRDTS**		**CDCA/WREB/CITA (ADEX Exam)**		**SRTA**
20:43:03:04 (4) . Application for license to practice as a dentist -- Credential verification.	**Patient Based**	**Simulation Based or Manikin Based**	**Patient Based**	**Simulation Based or Manikin Based**	**No longer offered in 2026**
Verification of passage of a patient-based, simulation-based or manikin-based clinical competency examination that has been approved by the board	Yes	Yes	Yes	Yes	N/A
DENTAL HYGIENE EXAMINATION - Credential	**CRDTS**		**CDCA/WREB/CITA (ADEX Exam)**		**SRTA**
20:43:03:10. Application for license to practice as a dental hygienist -- Credential verification.	**Patient Based**	**Simulation Based or Manikin Based**	**Patient Based**	**Simulation Based or Manikin Based**	**No longer offered in 2026**
Verification of passage of a patient-based, simulation-based, or manikin-based clinical competency examination that has been approved by the board	Yes	Yes	Yes	Yes	N/A

South Dakota State Board of Dentistry
P.O. Box 42, Black Hawk, SD 575718
Ph: 605-791-3650 Fax: 1-605-791-0261
E-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.org

Application for Continuing Education Course Honorarium

Background

It is the policy of the Board to allocate resources, when available, to fund continuing education courses that further the mission of the Board.

Procedure

Application Deadline:	December 31, 2026. *Applications received after this deadline will not be considered.*
Submit Applications to:	South Dakota State Board of Dentistry PO Box 42 Black Hawk, SD 57702 Or electronically to contactus@sdboardofdentistry.com
Fund Amount:	The Board will fund up to $10,000 in total during this cycle.

Criteria for Consideration

- ✓ Any funded course must be open to all dental professionals free of charge.
- ✓ The sponsor organization must meet the applicable state contractor requirements.
- ✓ The course must further the mission of the Board.
- ✓ Preference will be given to courses that impact a large number of licensees or registrants and courses provided in partnership with other professional associations.
- ✓ If the Board receives multiple applications, the maximum funding amount may be split.

If an application is approved:

- ✓ The sponsor organization must be prepared to complete the state contract process.
- ✓ The sponsor organization must note in its promotional materials the following: *"The honorarium for this speaker is being funded by the South Dakota State Board of Dentistry. This course is open to all dental professionals free of charge. The content and opinions expressed during this course do not necessarily reflect the views of nor are they endorsed by the South Dakota State Board of Dentistry."*
- ✓ Following the course date, the sponsor organization must submit a brief report, including how many South Dakota licensees and/or registrants attended.

South Dakota State Board of Dentistry

Application for Continuing Education Course Honorarium

Course Information

Title of Course: *Detailed course outline must be attached:*

_____

Speaker(s): *Curriculum Vitae or Resume must be attached:*

_____

Date(s) of Course: _____

Course Location: _____

Speaker Honorarium Total: $ _____

South Dakota State Board of Dentistry Honorarium Amount requested: $_____

Applicant Information

Sponsor Organization Name: _____

Sponsor Organization Contact: _____

Address: _____

Phone: _____ Email: _____

Partner Organization Name (if applicable):

_____

Application Questions

Please type or print clearly; use additional paper if necessary.

1. Does the sponsor organization meet the requirements to serve as a state contractor?

   ☐ Yes

   ☐ No

2. Please list the course objectives:

3. What is the target population?

4. What is the anticipated number of *South Dakota* licensees and/or registrants that will attend this course?
   a. Dentists:_____
   b. Dental Hygienists: _____
   c. Registered Dental Assistants: _____
   d. Radiographers: _____
   e. Other Dental Office Staff: _____

5. List other possible sources of financial support for this course: