Oregon
Tina Kotek, Governor

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MEETING NOTICE

LICENSING, STANDARDS AND COMPETENCY COMMITTEE MEETING

Oregon Board of Dentistry
1500 SW 1st Ave.,
Portland, Oregon 97201

ZOOM MEETING INFORMATION
https://us02web.zoom.us/j/81012440427?pwd=Um5JTDJYcis4MTVNa1FVSitnUk9hZz09
Dial-In Phone #: 1-253-215-8782 • Meeting ID: 810 1244 0427 • Passcode: 292562

July 12, 2023
5:00 p.m. – 7:00 p.m.

Committee Members: New Members assigned after April Board Meeting
Chair, Chip Dunn
Sheena Kansal, D.D.S.
Terrence Clark, D.M.D.
Sharity Ludwig, R.D.H., E.P.P.
Olesya Salathe, D.M.D. - ODA Rep.
Susan Kramer, R.D.H. - ODHA Rep.
Ginny Jorgensen, CDA, EFDA, EFODA, AAS - ODAA Rep.
Yadira Martinez, R.D.H. – DT Rep.

AGENDA

Call to Order: Chip Dunn, Chair

1. Review and approve Minutes of November 16, 2022 Committee Meeting.
   - November 16, 2022 Minutes – **Attachment #1**

2. Review and discuss refining the referenced rules for clarification. At the November 16, 2022 Committee meeting potential amendments to the Dental Implant Rule and CE updates were discussed and OBD staff was directed to bring back an updated version of the rule for the Committee to review (Staff recommendations).
   - OAR 818-012-0005(4) & (5) - **Attachment #2**

3. Review, discuss and make possible recommendations to the Board regarding proposed new rule: OAR 818-021-XXXX - Dental, Dental Therapy and Dental Hygiene Licensure for Active-Duty Members of the Uniformed Services and their Spouses Stationed in Oregon
   - OAR 818-021-XXXX - **Attachment #3**

4. Review and discuss Pacific University Dental Hygiene Students March 2021 proposal of adding a Local Anesthesia Endorsement for Dental Assistants, which was moved to this Committee at the April 2021 Board Meeting. At the August 2022 Board Meeting correspondence and draft rules from Ms. Lomax,

Ms. Lewelling & Ms. Jorgenson which was similar was also moved to this Committee for review and discussion.

- Pacific University Letter & Proposal – **Attachment #4**
- Draft Rules & Letter from Ms. Lomax, Ms. Lewelling & Ms.Jorgenson – **Attachment #5**
- OAR 818-035-0040 (for reference) – **Attachment #6**

5. Review, discuss and make possible recommendations to the Board regarding the potential for a licensing compact.
   - CSG - D & DH License Compact Model Rule Language - **Attachment #7**
   - Article – US Bureau of Labor Occupational Licensure & Migration – **Attachment #8**
   - Opposition of HB 2736 - Enactment of the OT Compact - **Attachment #9**
   - OTLB License Compact Bill – impact - **Attachment #10**

6. Review, discuss and make possible recommendations to the Board regarding OAR 818-042-0050 – Taking of X-Rays — Exposing of Radiographic Images and OAR 818-042-0060 - Certification — Radiologic Proficiency
   - OAR 818-042-0050 – Taking of X-Rays — Exposing of Radiographic Images (for reference) - **Attachment #11**
   - OAR 818-042-0060 – Certification — Radiologic Proficiency - **Attachment #12**
   - OAR 333-106-0055 - General Requirements: X-ray Operator Training - **Attachment #13**
   - DANB Radiology Pathway I – Application - **Attachment #14**

7. Review, discuss and make possible recommendations to OAR 818-042-0080 Certification – Expanded Function Dental Assistant (EFDA), OAR 818-042-0110 – Certification – Expanded Function Orthodontic Assistant (EFODA) and OAR 818-042-0113 – Certification – Expanded Function Preventive Dental Assistants (EFPDA). All three were referred back to this Committee from the October 7, 2020 Licensing, Standards and Competency Committee because the Committee felt that in the midst of the pandemic, they did not want to create any new or additional barriers to care at that time.
   - OAR 818-042-0080 - Certification – EFDA - **Attachment #15**
   - OAR 818-042-0110 - Certification – EFODA - **Attachment #16**
   - OAR 818-042-0113 - Certification – EFPDA - **Attachment #17**

8. Review, discuss and make possible recommendations to the Board regarding OAR 818-042-0115 Expanded Functions – Certified Anesthesia Dental Assistant and OAR 818-042-0117 – Initiation of IV Line. Referred from Staff for discussion. This was discussed at October 23, 2020 Meeting that Anesthesia Dental Assistants could perform phlebotomy for dental procedures such as PRP/PRF.
   - OAR 818-042-0115 - Expanded Functions — Certified Anesthesia Dental Assistant - **Attachment #18**
   - OAR 818-042-0117 - Initiation of IV Line - **Attachment #19**
   - Phlebotomy course letter from June Board Meeting - **Attachment #20**
   - Phlebotomy MEMO – Staff Recommendations - **Attachment #21**

9. Review, discuss and make possible recommendations to the Board regarding OAR 818-042-0113 - Certification – EFPDA and OAR 818-042-0114 - Additional Functions of EFPDAs (Staff recommendations).
   - Staff Recommendations for rule change- **Attachment #22**

10. Review, discuss and make possible recommendations to the Board regarding OAR 818-042-0020 and OAR 818-042-0100 language for dental assistants taking impressions (Staff recommendations).
    - Staff Recommendations for rule change- **Attachment #23**

11. At the Dec 17, 2021 Board Meeting, Board moved discussion of Instructor requirements to teach Radiologic Proficiency to dental assistants and dental therapists to this Committee for review and discussion.
    - Instructor Application Form - **Attachment #24**

12. Review, discuss and make possible recommendations to the Board regarding HB 3223

- HB 3223 - **Attachment #25**

13. Recommend to the Board that the Board recognize that the Dental Assistant National Board (DANB) is an organization the Board recognizes and is approved to administer dental assisting tests or exams for dental assistant certifications in Oregon. Staff recommends that this be added in rule to the Dental Practice Act. - **Attachment #26**

Any Other Business

Adjourn

Draft

LICENSING, STANDARDS AND COMPETENCY COMMITTEE
Held as a Zoom Meeting

Minutes
November 16, 2022

MEMBERS PRESENT:	Jose Javier, D.D.S., Chair Sheena Kansal, D.D.S. Sharity Ludwig, R.D.H., E.P.P. Jennifer Brixey Olesya Salathe, D.M.D. - ODA Representative Susan Kramer, R.D.H. - ODHA Representative Ginny Jorgensen, CDA, EFDA, EFODA, AAS - ODAA Representative Yadira Martinez, R.D.H., E.P.P., DT Representative
STAFF PRESENT:	Stephen Prisby, Executive Director Angela Smorra, D.M.D., Dental Director/Chief Investigator Haley Robinson, Office Manager Ingrid Nye, Investigator Samantha Plumlee, Licensing Manager Teresa Haynes, Project Manager Kathleen McNeal, Office Specialist
ALSO PRESENT:	Lori Lindley, Sr. Assistant Attorney General
VISITORS PRESENT:	Michelle Aldrich, D.M.D., Lisa Rowley, R.D.H. – ODHA, Jill Lomax, Jen Hawley Price, Katherine Landsberg – DANB, Tony Garcia – DANB, Mary Harrison, Aaron White - DANB, Barbara Sigurdson, Jen Lewis-Goff – ODA, Katy Adishian – ODA, Peggy Lewelling

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

Call to Order: The meeting was called to order by Dr. Javier at 5:00 p.m.

MINUTES

Ms. Martinez moved and Ms. Kramer seconded that the minutes of the October 7, 2020 Licensing, Standards and Competency meeting be approved as presented. The motion passed unanimously.

Ms. Martinez moved and Ms. Jorgensen seconded the Committee recommend that the Board move OAR 818-001-0002 as presented to the Rules Oversight Committee. The motion passed unanimously.

818-001-0002 –Definitions.
As used in OAR chapter 818:

(1) "Board" means the Oregon Board of Dentistry, the members of the Board, its employees, its agents, and its consultants.
(2) "Dental Practice Act" means ORS Chapter 679 and 680.010 to 680.170 and the rules adopted pursuant thereto.
(3) "Dentist" means a person licensed pursuant to ORS Chapter 679 to practice dentistry.
(4) "Dental Hygienist" means a person licensed pursuant to ORS 680.010 to 680.210 to practice dental hygiene.
(5) "Direct Supervision" means supervision requiring that a dentist diagnose the condition to be treated, that a dentist authorize the procedure to be performed, and that a dentist remain in the dental treatment room while the procedures are performed.
(6) "General Supervision" means supervision requiring that a dentist authorize the procedures, but not requiring that a dentist be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the usual place of practice of the dentist.
(7) "Indirect Supervision" means supervision requiring that a dentist authorize the procedures and that a dentist be on the premises while the procedures are performed.
(8) "Informed Consent" means the consent obtained following a thorough and easily understood explanation to the patient, or patient's guardian, of the proposed procedures, any available alternative procedures and any risks associated with the procedures. Following the explanation, the licensee shall ask the patient, or the patient's guardian, if there are any questions. The licensee shall provide thorough and easily understood answers to all questions asked.
(9) "Licensee" means a dentist or hygienist.
(10) “Volunteer Licensee” is a dentist or dental hygienist licensed according to rule to provide dental health care without receiving or expecting to receive compensation.
(11) "Limited Access Patient" means a patient who, due to age, infirmity, or handicap is unable to receive regular dental hygiene treatment in a dental office.
(12) "Specialty." The specialty definitions are added to more clearly define the scope of the practice as it pertains to the specialty areas of dentistry.
(a) “Dental Anesthesiology” is the specialty of dentistry that deals with the management of pain through the use of advanced local and general anesthesia techniques.
(b) "Dental Public Health" is the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice which serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.
(c) "Endodontics" is the specialty of dentistry which is concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.
(d) "Oral and Maxillofacial Pathology" is the specialty of dentistry and discipline of pathology that deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of oral pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations.
(e) “Oral and Maxillofacial Radiology” is the specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.

(f) "Oral and Maxillofacial Surgery" is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.
(g) "Oral Medicine" is the specialty of dentistry responsible for the oral health care of medically complex patients and for the diagnosis and management of medically-related diseases, disorders and conditions affecting the oral and maxillofacial region.
(h) "Orofacial Pain" Orofacial Pain is the specialty of dentistry that encompasses the diagnosis, management and treatment of pain disorders of the jaw, mouth, face, head and neck. The specialty of Orofacial Pain is dedicated to the evidenced-based understanding of the underlying pathophysiology, etiology, prevention, and treatment of these disorders and improving access to interdisciplinary patient care.
(i) "Orthodontics and Dentofacial Orthopedics" is the specialty of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application and control of functional and corrective appliances; and the guidance of the dentition and its supporting structures to attain and maintain optimum occlusal relations in physiologic and esthetic harmony among facial and cranial structures.
(j) "Pediatric Dentistry" is an age defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.
(k) "Periodontics" is the specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues.
(l) "Prosthodontics" is the specialty of dentistry pertaining to the restoration and maintenance of oral functions, comfort, appearance and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes.
(13) “Full-time” as used in ORS 679.025 and 680.020 is defined by the Board as any student who is enrolled in an institution accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency in a course of study for dentistry or dental hygiene.
(14) For purposes of ORS 679.020(4)(h) the term “dentist of record” means a dentist that either authorized treatment for, supervised treatment of or provided treatment for the patient in clinical settings of the institution described in 679.020(3).
(15) “Dental Study Group” as used in ORS 679.050, OAR 818-021-0060 and OAR 818-021-0070 is defined as a group of licensees who come together for clinical and non-clinical educational study for the purpose of maintaining or increasing their competence. This is not meant to be a replacement for residency requirements.
(16) “Physical Harm” as used in OAR 818-001-0083(2) is defined as any physical injury that caused, partial or total physical disability, incapacity or disfigurement. In no event shall physical harm include mental pain, anguish, or suffering, or fear of injury.
(17) “Teledentistry” is defined as the use of information technology and telecommunications to facilitate the providing of dental primary care, consultation, education, and public awareness in the same manner as telehealth and telemedicine.
(18) “BLS for Healthcare Providers or its Equivalent” the BLS~~/CPR~~ certification standard is the

American Heart Association's BLS Healthcare Providers Course or its equivalent, as determined by the Board. This initial BLS~~/CPR~~ course must be a hands-on course; online BLS~~/CPR~~ courses will not be approved by the Board for initial BLS~~/CPR~~ certification: After the initial BLS~~/CPR~~ certification, the Board will accept a Board-approved BLS for Healthcare Providers or its equivalent Online Renewal course for license renewal. A BLS~~/CPR~~ certification card with an expiration date must be received from the BLS~~/CPR~~ provider as documentation of BLS~~/CPR~~ certification. The Board considers the BLS~~/CPR~~ expiration date to be the last day of the month that the BLS~~/CPR~~ instructor indicates that the certification expires.

Ms. Martinez moved and Ms. Ludwig seconded the Committee recommend that the Board move OAR 818-012-0005 as presented to the Rules Oversight Committee. The motion passed unanimously.

818-012-0005
Scope of Practice
(1) No dentist may perform any of the procedures listed below:
(a) Rhinoplasty;
(b) Blepharoplasty;
(c) Rhytidectomy;
(d) Submental liposuction;
(e) Laser resurfacing;
(f) Browlift, either open or endoscopic technique;
(g) Platysmal muscle plication;
(h) Otoplasty;
(i) Dermabrasion;
(j) Hair transplantation, not as an isolated procedure for male pattern baldness; and
(k) Harvesting bone extra orally for dental procedures, including oral and maxillofacial procedures.
(2) Unless the dentist:
(a) Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by The American Dental Association, Commission on Dental Accreditation (CODA), or
(b) Holds privileges either:
(A) Issued by a credentialing committee of a hospital accredited by the Joint Commission On Accreditation of Healthcare Organizations (JCAHO) to perform these procedures in a Hospital setting; or
(B) Issued by a credentialing committee for an ambulatory surgical center licensed by the State of Oregon and accredited by either the JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC).
(3) A dentist may utilize Botulinum Toxin Type A ~~and dermal fillers~~ to treat ~~a~~ condition**s** that ~~is~~ **are** within the **oral and maxillofacial region** ~~scope of the practice of dentistry~~ after completing a minimum of **10** ~~20~~ hours in a hands on clinical course(s), ~~which includes both~~ **in** Botulinum Toxin Type A ~~and dermal fillers~~, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP).
Alternatively, a dentist may meet the requirements of subsection (3) by successfully completing training in Botulinum Toxin Type A as part of a CODA accredited program.
(4) A dentist may utilize dermal fillers to treat conditions that are within the oral and maxillofacial region after completing a minimum of 10 hours in a hands on clinical

course(s), in dermal fillers, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP). Alternatively, a dentist may meet the requirements of subsection (4) by successfully completing training in dermal fillers as part of a CODA accredited program.

(5) A dentist may place endosseous implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP).

(6) A dentist placing endosseous implants must complete at least seven (7) hours of continuing education related to the placement and or restoration of dental implants every licensure renewal period. (Effective ~~July 1, 2022~~ **January 1, 2024**).

Ms. Martinez moved and Ms. Jorgensen seconded the Committee recommend that the Board move OAR 818-012-0005 as presented to the Rules Oversight Committee. The motion passed unanimously.

818-012-0005
Scope of Practice

(1) No dentist may perform any of the procedures listed below:
(a) Rhinoplasty;
(b) Blepharoplasty;
(c) Rhytidectomy;
(d) Submental liposuction;
(e) Laser resurfacing;
(f) Browlift, either open or endoscopic technique;
(g) Platysmal muscle plication;
(h) Otoplasty;
(i) Dermabrasion;
(j) Hair transplantation, not as an isolated procedure for male pattern baldness; and
(k) Harvesting bone extra orally for dental procedures, including oral and maxillofacial procedures.
(2) Unless the dentist:
(a) Has successfully completed a residency in Oral and Maxillofacial Surgery accredited by the American Dental Association, Commission on Dental Accreditation (CODA), or
(b) Holds privileges either:
(A) Issued by a credentialing committee of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to perform these procedures in a hospital setting; or
(B) Issued by a credentialing committee for an ambulatory surgical center licensed by the State of Oregon and accredited by either the JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC).
(3) A dentist may utilize Botulinum Toxin Type A and dermal fillers to treat a condition that is within the scope of the practice of dentistry after completing a minimum of 20 hours in a hands on clinical course(s), which includes both Botulinum Toxin Type A and dermal fillers, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing

Education (AGD PACE) or by the American Dental Association Continuing Education Recognition Program (ADA CERP).
(4) A dentist may place endosseous implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE), by the American Dental Association Continuing Education Recognition Program (ADA CERP) or by a Commission on Dental Accreditation (CODA) approved graduate dental education program.
(5) A dentist placing endosseous implants must complete at least seven (7) hours of continuing education related to the placement and or restoration of dental implants every licensure renewal period (Effective ~~July 1, 2022~~ **January 1, 2024**).

Ms. Martinez moved and Ms. Brixey seconded the Committee send OAR 818-012-0005 and OAR 818-021-0060 back to Board staff for further refinement. The motion passed unanimously.

Ms. Martinez moved and Ms. Jorgensen seconded the Committee recommend that the Board move OAR 818-012-0007 as presented to the Rules Oversight Committee. The motion passed unanimously.

818-012-0007
Procedures, Record Keeping and Reporting of Vaccines
(1) Prior to administering a vaccine to a patient of record, the dentist must follow the "Model Standing Orders" approved by the Oregon Health Authority (OHA) for administration of vaccines and the treatment of severe adverse events following administration of a vaccine.
(2) The dentist must maintain written policies and procedures for handling and disposal of used or contaminated equipment and supplies.
(3) The dentist or designated staff must give the appropriate Vaccine Information Statement (VIS) to the patient or legal representative with each dose of vaccine covered by these forms. The dentist or designated must ensure that the patient or legal representative is available and has read, or has had read to them, the information provided and has had their questions answered prior to the dentist administering the vaccine. The VIS given to the patient must be the most current statement.
(4) The dentist or designated staff must document in the patient record:
(a) The date and site of the administration of the vaccine;
(b) The brand name, or NDC number, or other acceptable standardized vaccine code set, dose, manufacturer, lot number, and expiration date of the vaccine;
(c) The name or identifiable initials of the administering dentist;
(d) The address of the office where the vaccine(s) was administered unless automatically embedded in the electronic report provided to the OHA ALERT Immunization System;
(e) The date of publication of the VIS; and
(f) The date the VIS was provided and the date when the VIS was published.
(5) If providing state or federal vaccines, the vaccine eligibility code as specified by the OHA must be reported to the ALERT system.
(6) A dentist who administers any vaccine must report, the elements of Section (3), and Section (4) of this rule if applicable, to the OHA ALERT Immunization System within 14 days of administration.
(7) The dentist must report adverse events as required by the Vaccine Adverse Events Reporting System (VAERS), to the Oregon Board of Dentistry within 10 business days and to

the primary care provider as identified by the patient.
(8) A dentist who administers any vaccine will follow storage and handling guidance from the vaccine manufacturer and the Centers for Disease Control and Prevention (CDC).
(9) Dentists who do not follow this rule can be subject to discipline for failure to adhere to these requirements.

Ms. Martinez moved and Ms. Jorgensen seconded the Committee recommend that the Board move OAR 818-012-0030 as amended to the Rules Oversight Committee. The motion passed unanimously.

818-012-0030
Unprofessional Conduct
The Board finds that in addition to the conduct set forth in ORS 679.140(2), unprofessional conduct includes, but is not limited to, the following in which a licensee does or knowingly permits any person to:
(1) Attempt to obtain a fee by fraud, or misrepresentation.
(2) Obtain a fee by fraud, or misrepresentation.
(a) A licensee obtains a fee by fraud if the licensee knowingly makes, or permits any person to make, a material, false statement intending that a recipient, who is unaware of the truth, rely upon the statement.
(b) A licensee obtains a fee by misrepresentation if the licensee obtains a fee through making or permitting any person to make a material, false statement.
(c) Giving cash discounts and not disclosing them to third party payers is not fraud or misrepresentation.
(3) Offer rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee, or employer.
(4) Accept rebates, split fees, or commissions for services rendered to a patient from any person other than a partner, employee, or employer.
(5) Initiate, or engage in, with a patient, any behavior with sexual connotations. The behavior can include but is not limited to, inappropriate physical touching; kissing of a sexual nature; gestures or expressions, any of which are sexualized or sexually demeaning to a patient; inappropriate procedures, including, but not limited to, disrobing and draping practices that reflect a lack of respect for the patient's privacy; or initiating inappropriate communication, verbal or written, including, but not limited to, references to a patient's body or clothing that are sexualized or sexually demeaning to a patient; and inappropriate comments or queries about the professional's or patient's sexual orientation, sexual performance, sexual fantasies, sexual problems, or sexual preferences.
(6) Engage in an unlawful trade practice as defined in ORS 646.605 to 646.608.
(7) Fail to present a treatment plan with estimated costs to a patient upon request of the patient or to a patient's guardian upon request of the patient's guardian.
(8) Misrepresent any facts to a patient concerning treatment or fees.
(9)(a) Fail to provide a patient or patient's guardian within 14 days of written request:
(A) Legible copies of records; and
(B) Duplicates of study models, radiographs of the same quality as the originals, and photographs if they have been paid for.
(b) The licensee may require the patient or guardian to pay in advance a fee reasonably calculated to cover the costs of making the copies or duplicates. The licensee may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for pages 11 through 50 and no more than $0.25 for each additional page (including records copied from microfilm), plus any postage costs to mail copies requested and actual

costs of preparing an explanation or summary of information, if requested. The actual cost of duplicating radiographs may also be charged to the patient. Patient records or summaries may not be withheld from the patient because of any prior unpaid bills, except as provided in (9)(a)(B) of this rule.
(10) Fail to identify to a patient, patient's guardian, or the Board the name of an employee, employer, contractor, or agent who renders services.
(11) Use prescription forms pre-printed with any Drug Enforcement Administration number, name of controlled substances, or facsimile of a signature.
(12) Use a rubber stamp or like device to reproduce a signature on a prescription form or sign a blank prescription form.
(13) Order drugs listed on Schedule II of the Drug Abuse Prevention and Control Act, 21 U.S.C. Sec. 812, for office use on a prescription form.
(14) Violate any Federal or State law regarding controlled substances.
(15) Becomes addicted to, or dependent upon, or abuses alcohol, illegal or controlled drugs, or mind altering substances, or practice with an untreated substance use disorder diagnosis that renders the licensee unable to safely conduct the practice of dentistry or dental hygiene.
(16) Practice dentistry or dental hygiene in a dental office or clinic not owned by an Oregon licensed dentist(s), except for an entity described under ORS 679.020(3) and dental hygienists practicing pursuant to ORS 680.205(1)(2).
(17) Make an agreement with a patient or person, or any person or entity representing patients or persons, or provide any form of consideration that would prohibit, restrict, discourage or otherwise limit a person's ability to file a complaint with the Oregon Board of Dentistry; to truthfully and fully answer any questions posed by an agent or representative of the Board; or to participate as a witness in a Board proceeding.
(18) Fail to maintain at a minimum a current BLS for Healthcare Providers certificate or its equivalent.
(19) Conduct unbecoming a licensee or detrimental to the best interests of the public, including conduct contrary to the recognized standards of ethics of the licensee’s profession or conduct that endangers the health, safety or welfare of a patient or the public.
(20) Knowingly deceiving or attempting to deceive the Board, an employee of the Board, or an agent of the Board in any application or renewal, or in reference to any matter under investigation by the Board. This includes but is not limited to the omission, alteration or destruction of any record in order to obstruct or delay an investigation by the Board, or to omit, alter or falsify any information in patient or business records.
(21) Knowingly practicing with a physical or mental impairment that renders the Licensee unable to safely conduct the practice of dentistry or dental hygiene.
(22) Take any action which could reasonably be interpreted to constitute harassment or retaliation towards a person whom the licensee believes to be a complainant or witness.
(23) Fail to register with the Prescription Drug Monitoring Program (PDMP) in order to have access to the Program’s electronic system if the Licensee holds a Federal DEA registration.
(24) Fail to comply with ORS 413.550-413.558, regarding health care interpreters.

Dr. Kansal moved and Ms. Jorgensen seconded the Committee recommend that the Board move adopt phrasing for OAR 818-012-0030 as amended to the Rules Oversight Committee. The motion passed unanimously.

818-012-0030
Unprofessional Conduct
The Board finds that in addition to the conduct set forth in ORS 679.140(2), unprofessional conduct includes, but is not limited to, the following in which a licensee

does or knowingly permits any person to:
(1) Attempt to obtain a fee by fraud, or misrepresentation.
(2) Obtain a fee by fraud, or misrepresentation.
(a) A licensee obtains a fee by fraud if the licensee knowingly makes, or permits any person to make, a material, false statement intending that a recipient, who is unaware of the truth, rely upon the statement.
(b) A licensee obtains a fee by misrepresentation if the licensee obtains a fee through making or permitting any person to make a material, false statement.
(c) Giving cash discounts and not disclosing them to third party payers is not fraud or misrepresentation.
(3) Offer rebates, split fees, or commissions for services rendered to a patient to any person other than a partner, employee, or employer.
(4) Accept rebates, split fees, or commissions for services rendered to a patient from any person other than a partner, employee, or employer.
(5) Initiate, or engage in, with a patient, any behavior with sexual connotations. The behavior can include but is not limited to, inappropriate physical touching; kissing of a sexual nature; gestures or expressions, any of which are sexualized or sexually demeaning to a patient; inappropriate procedures, including, but not limited to, disrobing and draping practices that reflect a lack of respect for the patient's privacy; or initiating inappropriate communication, verbal or written, including, but not limited to, references to a patient's body or clothing that are sexualized or sexually demeaning to a patient; and inappropriate comments or queries about the professional's or patient's sexual orientation, sexual performance, sexual fantasies, sexual problems, or sexual preferences.
(6) Engage in an unlawful trade practice as defined in ORS 646.605 to 646.608.
(7) Fail to present a treatment plan with estimated costs to a patient upon request of the patient or to a patient's guardian upon request of the patient's guardian.
(8) Misrepresent any facts to a patient concerning treatment or fees.
(9) (a) Fail to **release patient records pursuant to OAR 818-012-0032.** ~~provide a patient or patient's guardian within 14 days of written request:~~
~~(A) Legible copies of records; and~~
~~(B) Duplicates of study models, radiographs of the same quality as the originals, and photographs if they have been paid for.~~
~~(b) The licensee may require the patient or guardian to pay in advance a fee reasonably calculated to cover the costs of making the copies or duplicates. The licensee may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for pages 11 through 50 and no more than $0.25 for each additional page (including records copied from microfilm), plus any postage costs to mail copies requested and actual costs of preparing an explanation or summary of information, if requested. The actual cost of duplicating radiographs may also be charged to the patient. Patient records or summaries may not be withheld from the patient because of any prior unpaid bills, except as provided in (9)(a)(B) of this rule.~~
(10) Fail to identify to a patient, patient's guardian, or the Board the name of an employee, employer, contractor, or agent who renders services.
(11) Use prescription forms pre-printed with any Drug Enforcement Administration number, name of controlled substances, or facsimile of a signature.
(12) Use a rubber stamp or like device to reproduce a signature on a prescription form or sign a blank prescription form.
(13) Order drugs listed on Schedule II of the Drug Abuse Prevention and Control Act, 21 U.S.C. Sec. 812, for office use on a prescription form.

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

Ms. Martinez moved and Ms. Kramer seconded the Committee recommend that the Board move adopt phrasing for OAR 818-012-0032 as amended to the Rules Oversight Committee. The motion passed unanimously.

818-012-0032
Diagnostic Records
(1) Licensees shall provide duplicates of physical diagnostic records ~~that have been paid for~~ to patient or patient's guardian within 14 calendar days of receipt of written request.
~~(A)~~ **(a)** Physical records include**:**
(A) Legible copies of paper charting and chart notes, and;
(B) Duplicates of silver emulsion radiographs **of the same quality as the originals**, **duplicates of** physical study models, ~~paper charting and chart notes,~~ **and photographs if they have been paid for**.
~~(B)~~ **(b)** Licensees may require the patient or patient's guardian to pay in advance the fee reasonably calculated to cover costs of making the copies or duplicates.
~~(1)~~ **(2)** Licensee may charge a fee not to exceed $30 for copying 10 or fewer pages of written material and no more than $0.50 per page for 11-50 and no more than $0.25 for each additional page, including cost of microfilm plus any postage costs to mail copies requested and actual

costs of preparing an explanation or summary of information, if requested. The actual costs of duplicating radiographs may also be charged to the patient.
~~(2)~~ **(3)** Licensees shall provide duplicates of digital patient records within 14 calendar days of receipt of written request by the patient or patient's guardian.
~~(A)~~ **(a)** Digital records include any patient diagnostic image, study model, test result or chart record in digital form.
~~(B)~~ **(b)** Licensees may require the patient or patient's guardian to pay for the typical retail cost of the digital storage device, such as a CD, thumb drive, or DVD as well as associated postage.
~~(C)~~ **(c)** Licensees shall not charge any patient or patient's guardian to transmit requested digital records over email if total records do not exceed 25 Mb.
~~(D) A clinical day is defined as a day during which the dental clinic treated scheduled patients.~~
~~(E)~~ **(d)** Licensees may charge up to $5 for duplication of digital records up to 25Mb and up to $30 for more than 25Mb.
~~(F)~~ **(e)** Any transmission of patient records shall be in compliance with the Health Insurance Portability and Accountability Act (HIPAA Act) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act).
~~(G)~~ **(f)** Duplicated digital records shall be of the same quality as the original digital file.
~~(3)~~ **(4)** If a records summary is requested by patient or patient's guardian, the actual cost of creating this summary and its transmittal may be billed to the patient or patient's guardian.
(5) Patient records or summaries may not be withheld from the patient because of any prior unpaid bills, except as provided in (1)(a)(B) of this rule.

Dr. Kansal moved and Ms. Ludwig seconded that the Committee defer changing any rules involving the HPSP until there is more information regarding the future of the program. The motion passed unanimously.

Ms. Martinez moved and Dr. Kansal seconded the Committee recommend that the Board repeal OAR 818-015-0007 in its entirety as presented to the Rules Oversight Committee. The motion passed unanimously.

~~**818-015-0007**~~
~~**Specialty Advertising**~~
~~(1) A dentist may only advertise as a specialist in an area of dentistry which is recognized by the Board and in which the dentist is licensed or certified by the Board.~~
~~(2) The Board recognizes the following specialties:~~
~~(a) Endodontics;~~
~~(b) Oral and Maxillofacial Surgery;~~
~~(c) Oral and Maxillofacial Radiology;~~
~~(d) Oral and Maxillofacial Pathology;~~
~~(e) Orthodontics and Dentofacial Orthopedics;~~
~~(f) Pediatric Dentistry;~~
~~(g) Periodontics;~~
~~(h) Prosthodontics;~~
~~(i) Dental Public Health;~~
~~(j) Dental Anesthesiology;~~
~~(k) Oral Medicine;~~
~~(l) Orofacial Pain.~~
~~(3) A dentist whose license is not limited to the practice of a specialty under OAR 818-021-0017 may advertise that the dentist performs or limits practice to specialty services even if the dentist is not a specialist in the advertised area of practice so long as the dentist clearly discloses that~~

~~the dentist is a general dentist or a specialist in a different specialty. For example, the following disclosures would be in compliance with this rule for dentists except those licensed pursuant to 818-021-0017: "Jane Doe, DDS, General Dentist, practice limited to pediatric dentistry." "John Doe, DMD, Endodontist, practice includes prosthodontics."~~

Ms. Martinez moved and Ms. Kramer seconded the Committee recommend that the Board move OAR 818-021-0012 as presented to the Rules Oversight Committee. The motion passed unanimously.

818-021-0012
Specialties Recognized
~~(1) A dentist may advertise that the dentist is a dentist anesthesiologist, endodontist, oral and maxillofacial pathologist, oral and maxillofacial surgeon, oral and maxillofacial radiologist, oral medicine dentist, orofacial pain dentist, orthodontist and dentofacial orthopedics, pediatric dentist, periodontist, prosthodontist or dental public health dentist, only if the dentist is licensed or certified by the Board in the specialty in accordance with Board rules.~~
~~(2) A dentist may advertise that the dentist specializes in or is a specialist in dental anesthesiology, endodontics, oral and maxillofacial pathology, oral and maxillofacial surgery, oral and maxillofacial radiology, oral medicine, orofacial pain, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics or dental public health only if the dentist is licensed or certified by the Board in the specialty in accordance with Board rules.~~
The Board recognizes the following specialties:
(a) Dental Anesthesiology;
(b) Dental Public Health;
(c) Endodontics;
(d) Oral and Maxillofacial Pathology;
(e) Oral and Maxillofacial Radiology;
(f) Oral and Maxillofacial Surgery;
(g) Oral Medicine;
(h) Orofacial Pain;
(i) Orthodontics and Dentofacial Orthopedics;
(j) Pediatric Dentistry;
(k) Periodontics;
(l) Prosthodontics.

Ms. Martinez moved and Ms, Kramer seconded the Committee recommend that the Board move OAR 818-021-0015 as presented to the Rules Oversight Committee. The motion passed unanimously.

818-021-0015
Certification as a Specialist
The Board may certify a dentist as a specialist if the dentist:
(1) Holds a current Oregon dental license;
(2) Is a diplomate of or a fellow in a specialty board accredited or recognized by the American Dental Association; or
(3) Has completed a post-graduate program approved by the Commission on Dental Accreditation of the American Dental Association; or
~~(4) Was qualified to advertise as a specialist under former OAR 818-010-0061.~~

Ms. Martinez moved and Ms. Kramer seconded the Committee recommend that the Board move OAR 818-015-0005 as amended to the Rules Oversight Committee. The motion passed unanimously.

818-015-0005
General Provisions
(1) "To advertise" means to publicly communicate information about a licensee's professional services or qualifications for the purpose of soliciting business.
(2) Advertising shall not be false, deceptive, misleading or not readily subject to verification and shall not make claims of professional superiority which cannot be substantiated by the licensee, who shall have the burden of proof.
(3) Advertising shall not make a representation that is misleading as to the credentials, education, or the licensing status of a licensee. Licensee may not claim a degree, credential, or distinction granted by a professional organization or institution of higher learning that has not been earned.
(4~~3~~) A licensee who authorizes another to disseminate information about the licensee's professional services to the public is responsible for the content of that information unless the licensee can prove by clear and convincing evidence that the content of the advertisement is contrary to the licensee's specific directions.
(5) A dentist shall adhere to the Doctors' Title Act, ORS 676.110 (Use of title "doctor")

Dr. Kansal moved and Ms. Martinez seconded the Committee recommend that the Board move OAR 818-021-0017 presented to the Rules Oversight Committee. The motion passed unanimously.

818-021-0017
Application to Practice as a Specialist
(1) A dentist who wishes to practice as a specialist in Oregon, who does not have a current Oregon license, in addition to meeting the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of:
(a) Having graduated from a school of dentistry accredited by the Commission on Dental Accreditation of the American Dental Association and active licensure as a general dentist in another state. Licensure as a general dentist must have been obtained as a result of the passage of any clinical Board examination administered by any state or regional testing agency;
(b) Certification of having passed the dental examination administered by the Joint Commission on National Dental Examinations or Canadian National Dental Examining Board Examination; and
(c) Proof of satisfactory completion of a post-graduate specialty program accredited by the Commission on Dental Accreditation of the American Dental Association.
(d) Passing the Board's jurisprudence examination.
(e) Completion of a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).
(2) A dentist who graduated from a dental school located outside the United States or Canada who wishes to practice as a specialist in Oregon, who does not have a current Oregon license, in addition to meeting the requirements set forth in ORS 679.060 and 679.065, shall submit to the Board satisfactory evidence of:
(a) Completion of a post-graduate specialty program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental

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

Ms. Martinez moved and Ms. Jorgensen seconded the Committee recommend that the Board repeal OAR 818-021-0030 and 818-021-0040 as presented to the Rules Oversight Committee. The motion passed unanimously.

~~**818-021-0030**~~
~~**Dismissal from Examination**~~
~~(1) The Board may dismiss any applicant from an examination whose conduct interferes with the examination and fail the applicant on the examination.~~
~~(2) Prohibited conduct includes but is not limited to:~~
~~(a) Giving or receiving aid, either directly or indirectly, during the examination process;~~
~~(b) Failing to follow directions relative to the conduct of the examination, including termination of~~

~~procedures;~~
~~(c) Endangering the life or health of a patient;~~
~~(d) Exhibiting behavior which impedes the normal progress of the examination; or~~
~~(e) Consuming alcohol or controlled substances during the examination.~~

~~**818-021-0040**~~
~~**Examination Review Procedures**~~
~~(1) An applicant may review the applicant's scores on each section of the examination.~~
~~(2) Examination material including test questions, scoring keys, and examiner's personal notes shall not be disclosed to any person.~~
~~(3) Any applicant who fails the examination may request the Chief Examiner to review the examination. The request must be in writing and must be postmarked within 45 days of the postmark on the notification of the examination results. The request must state the reason or reasons why the applicant feels the results of the examination should be changed.~~
~~(4) If the Chief Examiner finds an error in the examination results, the Chief Examiner may recommend to the Board that it modify the results.~~

Dr. Kansal moved and Ms. Martinez seconded the Committee recommend that the Board move OAR 818-021-0060 (8) as presented to the Rules Oversight Committee. The motion passed unanimously.

818-021-0060
Continuing Education — Dentists
(1) Each dentist must complete 40 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.
(2) Dentists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dentists is April 1 through March 31.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.
(3) Continuing education includes:
(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.
(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than 12 hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)
(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course includes an examination and the dentist passes the examination.
(d) Continuing education credit can be given for volunteer pro bono dental services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Examinations taken after initial licensure; a recognized specialty examination taken after initial licensure; or test development for clinical dental, dental hygiene or specialty examinations. No more than 6 hours of credit may be in these areas.
(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than four hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.

(5) At each renewal, all dentists licensed by the Oregon Board of Dentistry will complete a one hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority (Effective July 1, 2022).
(6) At least two (2) hours of continuing education must be related to infection control.
(7) At least two (2) hours of continuing education must be related to cultural competency (Effective January 1, 2021).
(8) A dentist placing endosseous implants must complete at least seven (7) hours of continuing education related to the placement of dental implants every licensure renewal period (Effective ~~July 1, 2022~~**January 1, 2024**).

Dr. Kansal moved and Ms. Martinez seconded the Committee recommend that the Board move OAR 818-021-0060, 818-021-0070 and 818-021-0076 as amended to the Rules Oversight Committee. The motion passed unanimously.

818-021-0060
Continuing Education — Dentists
(1) Each dentist must complete 40 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.
(2) Dentists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dentists is April 1 through March 31.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.
(3) Continuing education includes:
(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.
(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than 12 hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)
(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course ~~includes an examination and the dentist passes the examination.~~ **provides a certificate of completion to the dentist. The certificate of completion should list the dentist's name, course title, course completion date, course provider name, and continuing education hours completed.**
(d) Continuing education credit can be given for volunteer pro bono dental services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Examinations taken after initial licensure; a recognized specialty examination taken after initial licensure; or test development for clinical dental, dental hygiene or specialty examinations. No more than 6 hours of credit may be in these areas.
(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than four hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.
(5) All dentists licensed by the Oregon Board of Dentistry will complete a one-hour pain management course specific to Oregon provided by the Pain Management Commission of the Oregon Health Authority. All applicants or licensees shall complete this requirement by January 1, 2010 or within 24 months of the first renewal of the dentist's license.
(6) At least two (2) hours of continuing education must be related to infection control.

(7) At least two (2) hours of continuing education must be related to cultural competency (Effective January 1, 2021).

818-021-0070
Continuing Education — Dental Hygienists
(1) Each dental hygienist must complete 24 hours of continuing education every two years. An Expanded Practice Permit Dental Hygienist shall complete a total of 36 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.
(2) Dental hygienists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dental hygienists is October 1 through September 30.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.
(3) Continuing education includes:
(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.
(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than six hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)
(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course ~~includes an examination and the dentist passes the examination.~~ **provides a certificate of completion to the dental hygienist. The certificate of completion should list the dental hygienist's name, course title, course completion date, course provider name, and continuing education hours completed.**
(d) Continuing education credit can be given for volunteer pro bono dental hygiene services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Hygiene Examination, taken after initial licensure; or test development for clinical dental hygiene examinations. No more than 6 hours of credit may be in these areas.
(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than two hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.
(5) Dental hygienists who hold a Nitrous Oxide Permit must meet the requirements contained in OAR 818-026-0040(11) for renewal of the Nitrous Oxide Permit.
(6) At least two (2) hours of continuing education must be related to infection control.
(7) At least two (2) hours of continuing education must be related to cultural competency (Effective January 1, 2021).

818-021-0076
Continuing Education - Dental Therapists
(1) Each dental therapist must complete 36 hours of continuing education every two years. Continuing education (C.E.) must be directly related to clinical patient care or the practice of dental public health.
(2) Dental therapists must maintain records of successful completion of continuing education for at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for dental therapists is October 1 through September 30.) The licensee, upon request by the Board, shall provide proof of successful completion of continuing education courses.
(3) Continuing education includes:

(a) Attendance at lectures, dental study groups, college post-graduate courses, or scientific sessions at conventions.
(b) Research, graduate study, teaching or preparation and presentation of scientific sessions. No more than six hours may be in teaching or scientific sessions. (Scientific sessions are defined as scientific presentations, table clinics, poster sessions and lectures.)
(c) Correspondence courses, videotapes, distance learning courses or similar self-study course, provided that the course ~~includes an examination and the dentist passes the examination.~~ **provides a certificate of completion to the dental therapist. The certificate of completion should list the dental therapist's name, course title, course completion date, course provider name, and continuing education hours completed.**
(d) Continuing education credit can be given for volunteer pro bono dental therapy services provided in the state of Oregon; community oral health instruction at a public health facility located in the state of Oregon; authorship of a publication, book, chapter of a book, article or paper published in a professional journal; participation on a state dental board, peer review, or quality of care review procedures; successful completion of the National Board Dental Therapy Examination, taken after initial licensure; or test development for clinical dental therapy examinations. No more than 6 hours of credit may be in these areas.
(4) At least three hours of continuing education must be related to medical emergencies in a dental office. No more than two hours of Practice Management and Patient Relations may be counted toward the C.E. requirement in any renewal period.
(5) At least two (2) hours of continuing education must be related to infection control.
(6) At least two (2) hours of continuing education must be related to cultural competency.
(7) At least one (1) hour of continuing education must be related to pain management.

Dr. Kansal moved and Ms. Jorgensen seconded the Committee recommend that the Board adopt a rule offering licensees a Temporary Volunteer Status per ORS 679.025 (j)(B) and ORS 679.020 (k) as presented to the Rules Oversight Committee. The motion passed unanimously.

OAR 818-021-XXXX Temporary Practice Approval
(1) A dentist, dental therapist or dental hygienist may practice, without compensation and in connection with a coordinating organization or other entity, the health care profession that the health care practitioner is authorized to practice for a maximum of 30 days each calendar year without licensure requirement. Compensation is defined as something given or received as payment including but not limited to bartering, tips, monies, donations, or services.
(2) A dentist, dental therapist or dental hygienist is not required to apply for licensure or other authorization from the Board in order to practice under this rule.
(3) To practice under this rule, a dentist, dental therapist or dental hygienist shall submit, at least 10 days prior to commencing practice in this state, to the Board:
(a) Out-of State volunteer application;
(b) Proof that the practitioner is in good standing and is not the subject of an active disciplinary action;
(c) An acknowledgement that the practitioner may provide services only within the scope of practice of the health care profession that the practitioner is authorized to practice and will provide services pursuant to the scope of practice of Oregon or the health care practitioner's licensing agency, whichever is more restrictive;
(d) An attestation from the dentist, dental therapist, or dental hygienist that the practitioner will not receive compensation for practice in this state;
(e) The name and contact information of the dental director of the coordinating

organization or other entity through which the practitioner will practice; and
(f) The dates on which the practitioner will practice in this state.
Failure to submit (a)-(e) above will result in non-approval.
(4) Misrepresentation as to information provided in the application for the temporary practice approval may be grounds to open a disciplinary investigation that may result in discipline under OAR 818-012-0060.
(5) Practitioner acknowledges they are subject to the laws and rules governing the health care profession in Oregon and that the practitioner is authorized to practice and are subject to disciplinary action by the Board.
(6) A practitioner who is authorized to practice in more than one other jurisdiction shall provide to the Board proof from the National Practitioner Data Bank and their other state licensing Board that the practitioner is in good standing and not subject to any active disciplinary actions in any jurisdiction in which the practitioner is authorized to practice.

The committee discussed the ODA and ODAA meeting to discuss the proposal further before moving rule to the full Board for consideration. The committee ultimately decided to send the rule as presented. Discussions between the ODA and ODAA would occur alongside the rulemaking process, in order to prevent any delay.

Dr. Kansal moved and Ms. Jorgensen seconded the Committee recommend that the Board adopt the proposed rule allowing dental assistants to administer local anesthesia as presented to the Rules Oversight Committee. The motion passed with Dr. Kansal, Ms, Jorgensen, Ms. Brixie, Ms. Martinez, Ms. Kramer voting aye. Dr. Salathe and Dr. Javier voted no. The motion passed.

818-042-00XX
Local Anesthesia Functions of Dental Assistants
(1) The Board shall issue a Local Anesthesia Functions Certificate (LAFC) to a dental assistant who holds an Oregon EFDA Certificate, and has successfully completed a Board approved curriculum from a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board.
(2) A dental assistant may administer local anesthetic agents and local anesthetic reversal agents under the indirect supervision of a licensed dentist. Local anesthetic reversal agents shall not be used on children less than 6 years of age or weighing less than 33 pounds.

Ms. Martinez moved and Dr. Kansal seconded the Committee recommend that the Board move OAR 818-042-0040 as presented to the Rules Oversight Committee. The motion passed unanimously.

818-042-0040
Prohibited Acts
No licensee may authorize any dental assistant to perform the following acts:
(1) Diagnose or plan treatment.
(2) Cut hard or soft tissue.
(3) Any Expanded Function duty (OAR 818-042-0070 and OAR 818-042-0090) or Expanded Orthodontic Function duty (OAR 818-042-0100) or Restorative Functions (OAR 818-042-0095 or Expanded Preventive Duty (OAR 818-042-0113 and OAR 818-042-0114) or Expanded

Function Anesthesia (OAR 818-042-0115) without holding the appropriate certification.
(4) Correct or attempt to correct the malposition or malocclusion of teeth except as provided by OAR 818-042-0100.
(5) Adjust or attempt to adjust any orthodontic wire, fixed or removable appliance or other structure while it is in the patient's mouth.
(6) Administer any drug except **as allowed under the indirect supervision of a Licensee, such as** fluoride, topical anesthetic, desensitizing agents, **topical tooth whitening agents,** over the counter medications per package instructions or drugs administered pursuant to OAR 818-026-0050(5)~~(a)~~, OAR 818-026-0060(12), OAR 818-026-0065(12), OAR 818-026-0070(12) and as provided in OAR 818-042-0070, OAR 818-042-0090 and OAR 818-042-0115.
(7) Prescribe any drug.
(8) Place periodontal packs.
(9) Start nitrous oxide.
(10) Remove stains or deposits**,** except **when using topical teeth whitening agents, or** as provided in OAR 818-042-0070.
(11) Use ultrasonic equipment intra-orally except as provided in OAR 818-042-0100.
(12) Use a high-speed handpiece or any device that is operated by a high-speed handpiece intra-orally except as provided in OAR 818-042-0095, and only for the purpose of adjusting occlusion, contouring, and polishing restorations on the tooth or teeth that are being restored.
(13) Use lasers, except laser-curing lights.
(14) Use air abrasion or air polishing.
(15) Remove teeth or parts of tooth structure.
(16) Cement or bond any fixed prosthesis or orthodontic appliance including bands, brackets, retainers, tooth moving devices, or orthopedic appliances except as provided in OAR 818-042-0100.
(17) Condense and carve permanent restorative material except as provided in OAR 818-042-0095.
(18) Place any type of retraction material subgingivally except as provided in OAR 818-042-0090.
(19) Apply denture relines except as provided in OAR 818-042-0090(2).
(20) Expose radiographs without holding a current Certificate of Radiologic Proficiency issued by the Board (OAR 818-042-0050 and OAR 818-042-0060) except while taking a course of instruction approved by the Oregon Health Authority, Oregon Public Health Division, Office of Environmental Public Health, Radiation Protection Services, or the Oregon Board of Dentistry.
(21) Use the behavior management techniques known as Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.
(22) Perform periodontal assessment.
(23) Place or remove healing caps or healing abutments, except under direct supervision.
(24) Place implant impression copings, except under direct supervision.
(25) Any act in violation of Board statute or rules.

Ms. Jorgensen moved and Ms. Kramer seconded the Committee recommend that the Board keep 818-042-0060 as presented to the Rules Oversight Committee and keep the Radiologic Proficiency Certification requirements the same. The motion passed unanimously.

818-042-0060
Certification — Radiologic Proficiency
(1) The Board may certify a dental assistant in radiologic proficiency by credential in accordance with OAR 818-042-0120, or if the assistant:
(2) Submits an application on a form approved by the Board, pays the application fee and:

(a) Completes a course of instruction approved by the Oregon Board of Dentistry, in accordance with OAR 333-106-0055 or submits evidence that the Oregon Health Authority, Center for Health Protection, Radiation Protection Services recognizes that the equivalent training has been successfully completed;
(b) Certification by an Oregon licensee that the assistant is proficient to take radiographs.

Chair Javier thanked everyone for their attendance and contributions.

The meeting adjourned at 7:00 p.m.

1. **STRONG RECOMMENDATION – RULE CHANGE**: Change from OAR 818-012-0005(4-5) to "endosseous **or other dental** implants to replace natural teeth", or alternatively, strike the word "endosseous". There are many other types of implants, that are not considered endosseous, that the Board likely does not want people placing without the 56 hours of training, including: endosteal implants, transosteal implants, subperiosteal implants, zygomatic implants, or other future technical advancements. Board Staff considers "endosseous **or other dental implants**" to be the better option in terms of clarifying that the training is required for all types of dental implants. Suggestion for revised language:

   OAR 818-012-0005 – Scope of Practice

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

   (5) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement and**/**or restoration of dental implants every licensure renewal period. (Effective ~~July 1, 2022~~ **January 1, 2024**.)

   OAR 818-021-0060 – Continuing Education-Dentists

   (8) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement **and/or restoration** of dental implants every licensure renewal period (Effective ~~July 1, 2022~~ **January 1, 2024**.)

2. **STRONG RECOMMENDATION – RULE CHANGE**: The last part of the existing rule is confusing. As written, the CE provider must be approved in one of the following ways:
   a. AGD PACE may approve the CE provider.
   b. ADA CERP may approve the CE provider.
   c. CODA-approved graduate dental education program may approve the CE provider.

   The issue is with "c" above. First of all, it should read "CODA-accredited" rather than "CODA-approved", as CODA is an accreditation authority. Did the Board intend to include CODA-accredited graduate dental education programs, or did it intend to require those CODA-accredited graduate dental education programs to approve CE providers? Would these graduate dental education programs have to approve themselves or potentially obtain PACE/CERP approval to provide this education? As written, training completed as part of a CODA-accredited graduate dental education program would **not** be acceptable unless that program was PACE/CERP approved and/or they approved themselves, which seems like a needless hurdle. AMS confirmed that she has never heard of CODA-accredited graduate dental programs approving other CE providers; they would provide the training themselves. Therefore, we have concluded that this is likely a phrasing error and we suggest the remedy below:

OAR 818-012-0005 – Scope of Practice

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

3. **STRONG RECOMMENDATION – RULE CHANGE**: The rule as written doesn't specifically say that the 56 hours of training have to be related to dental implants. Even though most people would say it's obvious what the Board meant, we foresee a licensee potentially arguing that the rule as written doesn't specifically prohibit them from counting the 20 hours of "treatment planning" courses they took towards the requirement, even though the training they completed was treatment planning for, say, a partial denture. "a minimum of 56 hours of hands on clinical **dental implant** course(s)" is the briefest possible way to make this clarification. A slightly wordier version would be "a minimum of 56 hours of hands on clinical course(s) **related to dental implants**".

OAR 818-012-0005 – Scope of Practice

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

(5) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement and**/**or restoration of dental implants every licensure renewal period. (Effective ~~July 1, 2022~~ **January 1, 2024**.)

OAR 818-021-0060 – Continuing Education-Dentists

(8) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement **and/or restoration** of dental implants every licensure renewal period (Effective ~~July 1, 2022~~ **January 1, 2024**.)

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

OAR 818-012-0005 – Scope of Practice

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

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

(5) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement and/or restoration of dental implants every licensure renewal period. (Effective ~~July 1, 2022~~ **January 1, 2024**.)

OAR 818-021-0060 – Continuing Education-Dentists

(8) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement **and/or restoration** of dental implants every licensure renewal period (Effective ~~July 1, 2022~~ **January 1, 2024**.)

5. **CONSIDERATION – NO CHANGE RECOMMENDED**: Since Lori has been clear that we cannot require that licensees "permanently maintain" verification of completion of the 56 required hours of training, the rules could be changed to include specific mention that the records must be provided to the OBD upon request. Technically, if we requested the records and the licensee did not provide them, we could potentially argue that they have failed to cooperate with the Board, a violation of the existing DPA. Therefore, **we do not believe this change is necessary at this time**.

OAR 818-012-0005 – Scope of Practice

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

(5) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement and/or restoration of dental implants every licensure renewal period. (Effective ~~July 1, 2022~~ **January 1, 2024**.)

OAR 818-021-0060 – Continuing Education-Dentists

(8) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement **and/or restoration** of dental implants every licensure renewal period (Effective ~~July 1, 2022~~ **January 1, 2024**.)

6. **QUESTION ABOUT BOARD INTENT – NO CHANGE RECOMMENDED**: If the Board intended to "grandfather in" all licensees who were licensed before the effective date of the rule, the rule text as written does not achieve that goal. As written, the rule will apply to all licensees, rather than just licensees who receive their Oregon license prior to July 2022. Individuals who had already completed the 56 hours of training meeting the new requirements would be allowed to continue placing

implants, but individuals who hadn't completed the 56 hours of training meeting the new requirements would need to desist placing implants, even if they have been placing them successfully for many years. Ensure that the effect of the rule matches the Board's intent. If they do want to "grandfather in" all licensees licensed before July 2022, they would need to add to the rule to indicate this.

OAR 818-012-0005 – Scope of Practice

(4) A dentist **first licensed in Oregon after July 1, 2022** may place endosseous **or other dental** implants to replace natural teeth after completing a minimum of 56 hours of hands on clinical **dental implant** course(s), which includes treatment planning, appropriate case selection, potential complications and the surgical placement of the implants under direct supervision, and the provider is **a Commission on Dental Accreditation (CODA)-accredited graduate dental education program, or a provider that has been** approved by the Academy of General Dentistry Program Approval for Continuing Education (AGD PACE), **or** by the American Dental Association Continuing Education Recognition Program (ADA CERP) ~~or by a Commission on Dental Accreditation (CODA) approved graduate dental education program~~. **Evidence of completion of the required training must be provided to the Board upon request.**

(5) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement and**/**or restoration of dental implants every licensure renewal period. (Effective ~~July 1, 2022~~ **January 1, 2024**.)

OAR 818-021-0060 – Continuing Education-Dentists

(8) A dentist placing endosseous **or other dental** implants must complete at least seven (7) hours of continuing education related to the placement **and/or restoration** of dental implants every licensure renewal period (Effective ~~July 1, 2022~~ **January 1, 2024**.)

Proposed New Rule:

OAR 818-021-XXXX
Dental, Dental Therapy and Dental Hygiene Licensure for Active-Duty Members of the Uniformed Services and their Spouses Stationed in Oregon

The OBD has been made aware of new federal legislation that went into effect on January 1, 2023, mandating portability of professional licenses for uniformed servicemembers and their spouses.

SEC. 19. PORTABILITY OF PROFESSIONAL LICENSES OF MEMBERS OF THE UNIFORMED SERVICES AND THEIR SPOUSES.

(a) IN GENERAL.— Title VII of the Servicemembers Civil Relief Act (50 U.S.C. 4021 et seq.) is amended by inserting after section 705 (50 U.S.C. 4025) the following new section:

''SEC. 705A. PORTABILITY OF PROFESSIONAL LICENSES OF SERVICEMEMBERS AND THEIR SPOUSES.

''(a) IN GENERAL.— In any case in which a servicemember or the spouse of a servicemember has a covered license and such servicemember or spouse relocates his or her residency because of military orders for military service to a location that is not in the jurisdiction of the licensing authority that issued the covered license, such covered license shall be considered valid at a similar scope of practice and in the discipline applied for in the jurisdiction of such new residency for the duration of such military orders if such servicemember or spouse—
''(1) provides a copy of such military orders to the licensing authority in the jurisdiction in which the new residency is located;
''(2) remains in good standing with—
''(A) the licensing authority that issued the covered license; and
''(B) every other licensing authority that has issued to the servicemember or the spouse of a servicemember a license valid at a similar scope of practice and in the discipline applied in the jurisdiction of such licensing authority;
''(3) submits to the authority of the licensing authority in the new jurisdiction for the purposes of standards of practice, discipline, and fulfillment of any continuing education requirements.
''(b) INTERSTATE LICENSURE COMPACTS.— If a servicemember or spouse of a servicemember is licensed and able to operate in multiple jurisdictions through an interstate licensure compact, with respect to services provided in the jurisdiction of the interstate licensure compact by a licensee covered by such compact, the servicemember or spouse of a servicemember shall be subject to the requirements of the compact or the applicable provisions of law of the applicable State and not this section.
''(c) COVERED LICENSE DEFINED.— In this section, the term 'covered license' means a professional license or certificate—
''(1) that is in good standing with the licensing authority that issued such professional license or certificate;
''(2) that the servicemember or spouse of a servicemember has actively used during the two years immediately preceding the relocation described in subsection (a); and
''(3) that is not a license to practice law.''.

Uniformed Servicemembers of the United States include army, marine corps, navy, air force, space force, coast guard, public health service commissioned corps, and national oceanic and atmospheric administration commissioned officer corps.

The OBD must create a new rule and a new licensure pathway to accommodate this change, as none of our existing pathways are compliant with the new federal laws. Noteworthy differences between our existing pathways and this new pathway will include:

1) Applicants licensed under this pathway will not be subject to license renewal every two years. The license will remain active for the duration of the military orders.

2) In lieu of a renewal application, licensees who were licensed under this pathway will be asked to provide a Biennial Uniformed Servicemember Status Confirmation Form. Details of this form can be found in the proposed rule below.

3) Applicants who took a clinical exam greater than five years ago will not have to provide verification of 3,500 hours of licensed clinical practice in the last five years.

818-021-XXXX
Dental, Dental Therapy and Dental Hygiene Licensure for Active-Duty Members of the Uniformed Services and their Spouses Stationed in Oregon

(1) A license to practice dentistry, dental hygiene or dental therapy shall be issued to Active-Duty Members of the Uniformed Services or their spouse when the following requirements are met:

(a) Completed application and payment of fee is received by the Board; and

(b) Satisfactory evidence of having graduated from a dental, dental hygiene or dental therapy program accredited by the Commission on Dental Accreditation of the American Dental Association; or

(c) Satisfactory evidence of having graduated from a dental school located outside the United States or Canada, completion of a predoctoral dental education program of not less than two years at a dental school accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; or

(d) Satisfactory evidence of having graduated from a dental hygiene program located outside the United States or Canada, completion of not less than one year in a program accredited by the Commission on Dental Accreditation of the American Dental Association, and proficiency in the English language; or

(e) Satisfactory evidence of having successfully completed or graduated from a Board-approved dental therapy education program that includes the procedures outlined in OAR 818-038-0020, and includes at least 500 hours of didactic and hands-on clinical dental therapy practice.

(f) Submission of a copy of the military orders assigning the active-duty member to an assignment in Oregon; and

(g) The applicant holds a current license in another state to practice dentistry, dental hygiene or dental therapy at the level of application; and

(h) The license is unencumbered and verified as active and current through processes defined by the Board; and

(i) Satisfactory evidence of successfully passing a clinical examination administered by any state, national testing agency or other Board-recognized testing agency; and

(j) Verification of completion of the Board's Continuing Education (CE) requirements in accordance with OAR 818-021-0060, OAR 818-021-0070 & OAR 818-021-0076.

(2) The temporary license shall remain active for the duration of the above-mentioned military orders.

(3) Once licensed, each biennium, the licensee shall submit to the Board a Biennial Uniformed Servicemember Status Confirmation Form. The confirmation form shall include the following:

(a) Licensee's full name;

(b) Licensee's mailing address;

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

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

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

(f) Licensee's assumed business name;

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

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

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

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

(k) Confirmation of current active-duty status of servicemember.

(l) The form will be provided, depending on licensure type, pursuant to ORS 679.120(6), 680.075(6) and 679.615(4)(b).

(4) If military orders are reassigned, notification to the Board is required within 30 days of receipt.

(5) Any Board permits held by Licensees are required to be renewed per rule requirements on permit types.

(6) Individuals who are licensed under this rule are required to adhere to the Dental Practice Act and are subject to the same requirements and standards of practice as any other licensee of the Board.

From: Phetnouvong, Fiona <phet4123@pacificu.edu>
Sent: Wednesday, March 31, 2021 10:54 PM
To: PRISBY Stephen *OBD <Stephen.PRISBY@oregondentistry.org>
Cc: Simonne Soudan <soud5365@pacificu.edu>; Amanda Musgrave <musg5639@pacificu.edu>
Subject: Proposal for Administration of Local Anesthesia

Fiona Phetnouvong
Kat Soudan
Amanda Musgrave
Pacific University
222 SE 8th Ave.
Hillsboro, OR 97123

March 31, 2021

Director Stephen Prisby
Executive Director for the Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, OR 97201

Hello Director Prisby,

As senior year students in the dental hygiene program at Pacific university, we have participated in an amazing year long collaboration with our advisory board members focused solely on creating a proposal for our capstone project.

We are delighted to share this capstone project with you, which proposes to allow dental assistants to expand their scope of practice to include the administration of local anesthesia. We respectfully submit this proposal for consideration by the Oregon Board of Dentistry.

We wish to express our utmost gratitude for this opportunity, and are incredibly thankful for your time and effort in considering our submission at this time. We look forward to our upcoming meeting with the Oregon Board of Dentistry.

Sincerely,
Fiona Phetnouvong, Kat Soudan, Amanda Musgrave

Dental Assistant Administration of Local Anesthesia - Oregon Students: Kat Soudan, Fiona Phetnouvong, Amanda Musgrave
Proposal
The creation of a Local Anesthesia Expanded Functions certificate that would allow administration of local anesthesia procedures, (placement of topical anesthetic, determination of the type of anesthetic needed, calculation of MRD, evaluation of indications and contraindications for local anesthesia, documentation of patient's medical history, loading and unloading of syringe, needle placement, delivery of local anesthetic, identification of a medical emergency, responding to medical emergencies), to appropriately educated dental assistants, under the indirect supervision of a dentist and/or dental hygienist that maintains their current anesthesia endorsement.
Justification
The creation of a Local Anesthesia Expanded Functions certificate in Oregon would provide an additional professional pathway for interested dental assistants. It would allow dental assistants to demonstrate their current knowledge, and expand on that through continuing education of head and neck anatomy, pharmacology, medical emergencies, and additional continuing education courses. Utilization of an Expanded Functions Dental Assistant that is able to administer local anesthesia would allow interested dentists to increase productivity in practice, provide effective quality care, increase practice income, serve more "at-risk" or low income patients, and improve significantly in time management. According to Kracher C, "As the dental delivery system evolves in the next 25 years, the demand for dental assistants to have more advanced clinical skills will increase, creating a need for their education to change. This

demand may grow as evidence accumulates that use of expanded function dental assistants can increase the profitability of a practice." This indicates the potential to serve greater numbers of patients in Oregon through the use of local anesthesia by an Expanded Functions Dental Assistant.

National Perspective

Several states allow educated dentists, dental hygienists and dental assistants to expand their scope of practice in many skills such as restorative, nitrous, IV sedation, gingival curettage, etc. During the development of this proposal we looked at the provisions in Oregon, Kentucky Minnesota, North Dakota, Oklahoma, South Dakota, and Washington State which currently authorize Dental Hygienists and Dental Assistants to initiate an IV line. In reference to the Dental Assisting National Board Inc; dental assistants can obtain certification to prepare for IV medication, sedation, or general anesthesia under the indirect supervision of a dentist or registered dental hygienist.

According to Mike DeWine, a U.S. Senator from the State of Ohio In December 1997, however, the Health Care Finance Administration (HCFA) issued a proposed rule that would eliminate the physician supervision requirement for Certified Registered Nurse Anesthetists (CRNA's). HCFA acknowledged that there has been no new studies comparing outcomes between patients who have received doctor-supervised anesthesia versus those who received anesthesia without the supervision of a doctor. Instead, the rationale offered for the proposed rule was essentially that the HCFA is interested in decreasing regulatory requirements and increasing state flexibility. HCFA argued that anesthesia regulations are an appropriate area to do so, given that the anesthesia-related death rate is extremely low. Patients can receive the same level of care at a lower cost, and have more available clinics to choose from if the practices have employees that have an expanded scope of practice.

Similarly, in dentistry, all members of the dental field are continually working to expand their scope of practice in order to provide these types of services. This speaks to confidence in the education and skill of expanded functions dental assistants afforded them by both the dental community and the patients they serve.

Recommendations

The Local Anesthesia Expanded Functions Advisory Board proposes the following criteria for dental assistants for application for the permit to deliver local anesthesia. Upon the completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course approved by the Board, a dental assistant may administer local anesthesia under the indirect supervision of a licensed dentist and/or dental hygienist that maintains their current anesthesia certificate in accordance with the Board's rules regarding anesthesia under the expanded functions certificate.

- Prerequisite Requirement:
  - Dental Assisting National Board (DANB), Certified Dental Assistant (CDA)

    and
  - Oregon Expanded Functions Certificate (OR-EFDA)
- Successful completion of an Oregon Board of Dentistry approved local anesthesia curriculum from a program accredited by the Commision on Dental Accreditation.
  - Curriculum should be not less than 65 hours of didactic and clinical instruction and successfully with a grade point average of 75% and above.
  - Proposed curriculum should include content in all of the following:
    - Theory of pain control

        - Selection of pain control modalities
        - Medical history and documentation
        - Dental history and documentation
        - Contraindications of local anesthesia
        - Head & Neck Anatomy
        - Neurophysiology
        - Pharmacology of local anesthetics
        - Pharmacology of vasoconstrictors
        - Psychological aspects of pain control
        - Systemic complications
        - Techniques of maxillary anesthesia
        - Techniques of mandibular anesthesia
        - Infection control
        - Local anesthesia medical emergencies
- Dental Assisting National Board (DANB), Certified Dental Assistant (CDA) annual requirements for recertification:
    - Must complete 12 hours of annual CE to main the CDA must include:
        - Bloodborne Pathogen Training (1 hour)
        - Infection Control Training (2 hours)
        - CPR Certificate Training
        - Clinical Education as it pertains to dentistry/dental assisting
- Applicants for the Local Anesthesia Expanded Functions certificate must successfully pass the Western Regional Examination Board both written and clinical within 18 months of the completion of required coursework.
- Dental Assistants must hold, maintain, and show evidence of current certification in basic or advanced cardiac life support.
    - Renewal requirement every 2 years

Conclusion

Expanded Functions Dental Assistants who are interested in expanding their scope of practice to include delivering local anesthesia is a highly considerable notion. Abiding by the rules and regulations to obtain this certification, it is clear that as part of dental health care, dental assistants are an essential contributor in adequate patient care. This certificate will assist in improving quality patient care, providing care to more individuals, increasing time management, increasing profit and increasing production. In dentistry, dental hygienists and dentists are regulated through the state legislature. To obtain their licensure, they have to pass state licensing exams and be regulated by their own state boards. There is no reason why dental assistant regulation is unable to be performed by those same organizations, after they have received additional education to allow them the ability to perform additional tasks- including local anesthesia. If dental assistants are properly educated in providing local anesthesia (just as dentists and hygienists are) they should be fully capable of providing local anesthesia for their patients just as dentists and hygienists are. “As the dental delivery system evolves over the next 25 years, the demand for dental assistants to have more advanced clinical skills will increase, creating a need for dental education to change.” (Kracher C, et al. 2017). The requirements to practice after obtaining credentials and licensure should follow the same exact protocols for renewal to continue in clinical practice.

Resources

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Advisory Board
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***Affiliations are listed for identification purposes only and are not necessarily an indication of endorsement.

From: Jill Lomax <jill.lomax@chemeketa.edu>
Sent: Tuesday, August 2, 2022 12:03 PM
To: PRISBY Stephen * OBD <Stephen.PRISBY@obd.oregon.gov>
Cc: Peggy Lewelling <peggy.lewelling15@pcc.edu>; Ginny Jorgensen <ginjorge53@gmail.com>
Subject: Local Anesthesia Functions of Dental Assistants Proposal

Greetings Mr. Prisby,

I am **Jill Lomax**, Program Chair of the Dental Assisting Program at Chemeketa Community College. My colleagues, **Peggy Lewelling and Ginny Jorgenson,** are instructors with the dental assisting programs at Portland Community College.

We are submitting to the Oregon Board of Dentistry a proposal that would allow dentists in Oregon to delegate administration of **local anesthesia** to their dental assistants. We hope that you will place this proposal on the agenda for the next OBD meeting on August 19th, 2022.

The following documents are attached for the Board's consideration:

Proposed Rule & Current Rules – This document outlines a proposed administrative rule 818-042-00XX Local Anesthesia Functions of Dental Assistants. For comparison purposes, this document also includes the current administrative rules for dental hygienists to perform local anesthesia and for dental assistants to perform restorative functions.

Frequently Asked Questions (FAQs) – This document provides additional information about this proposed administrative rule.

Dental Assistant Questionnaire – This document shows the results of a survey conducted by the Oregon Board of Dentistry in 2019 that asked dentists about the expanded functions they allow their dental assistants to do. Local anesthesia was the top answer on the list of duties that dentists would like to see added as an expanded function for dental assistants.

Both myself and Ginny Jorgenson will be able to attend the August 19th Board meeting to answer any questions.

Thank you in advance to the Oregon Board of Dentistry for considering this proposal.

Sincerely,

Jill Lomax, EdM, CDA, EFDA-RF, FADAA

Peggy Lewelling, EFDA, CDA, RDH, BSDH, MEd

Ginny Jorgenson, CDA, EFDA, EFODA, AAS

Jill Lomax, EdM, CDA, EFDA-RF, FADAA | Dental Assisting Program Chair

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Local Anesthesia Functions of Dental Assistants
Proposed Oregon Administrative Rule (OAR)

Proposed Rule & Current Rules

Proposed Rule

818-042-00?? Local Anesthesia Functions of Dental Assistants

(1) The Board shall issue a Local Anesthesia Functions Certificate (LAFC) to a dental assistant who holds an Oregon EFDA Certificate, and has successfully completed a Board approved curriculum from a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board.

(2) A dental assistant may administer local anesthetic agents and local anesthetic reversal agents under the indirect supervision of a licensed dentist. Local anesthetic reversal agents shall not be used on children less than 6 years of age or weighing less than 33 pounds.

Current Rules

818-035-0040 Expanded Functions of Dental Hygienists

(1) Upon completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, a dental hygienist who completes a Board approved application shall be issued an endorsement to administer local anesthetic agents and local anesthetic reversal agents under the general supervision of a licensed dentist. Local anesthetic reversal agents shall not be used on children less than 6 years of age or weighing less than 33 pounds.

818-042-0095 Restorative Functions of Dental Assistants

(1) The Board shall issue a Restorative Functions Certificate (RFC) to a dental assistant who holds an Oregon EFDA Certificate, and has successfully completed:

(a) A Board approved curriculum from a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, and successfully passed the Western Regional Examining Board's Restorative Examination or other equivalent examinations approved by the Board within the last five years, or

(b) If successful passage of the Western Regional Examining Board's Restorative Examination or other equivalent examinations approved by the Board occurred over five years from the date of application, the applicant must submit verification from another state or jurisdiction where the applicant is legally authorized to perform restorative functions and certification from the supervising dentist of

successful completion of at least 25 restorative procedures within the immediate five years from the date of application.

(2) A dental assistant may perform the placement and finishing of direct restorations, except gold foil, under the indirect supervision of a licensed dentist, after the supervising dentist has prepared the tooth (teeth) for restoration(s):

(a) These functions can only be performed after the patient has given informed consent for the procedure and informed consent for the placement of the restoration by a Restorative Functions dental assistant.

(b) Before the patient is released, the final restoration(s) shall be checked by a dentist and documented in the chart.

Local Anesthesia Functions of Dental Assistants
Proposed Oregon Administrative Rule (OAR)

Frequently Asked Questions (FAQs)
Revised August 1, 2022

EDUCATION

- **Could a dental assistant be trained on-the-job to administer local anesthesia?**
  No, the dental assistant would need to successfully complete a Board approved curriculum from a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board. The Board approved program would be consistent with the course of instruction approved by the Board that is required for a dental hygienist to administer local anesthesia.

- **Would administration of local anesthesia be added to our dental assisting education programs?**
  No, at this time we anticipate that this training would be offered as a continuing education course to dental assistants who hold an EFDA Certificate and are working in a dental setting. This would be similar to the restorative functions training that is currently being provided for dental assistants who hold an EFDA Certificate.

- **Would the continuing education program be comparable to those that are offered for dental hygienists?**
  Yes, the continuing education program would need to be Board approved and would need to be comparable to the training that are offered for dental hygienists. The training program would include a review of dental anatomy, head & neck anatomy, pharmacology & management of medical emergencies.

CLINICAL PRACTICE

- **Do dentists want their dental assistants to be able to administer local anesthesia?**
  Yes, in 2019 the Oregon Board of Dentistry conducted a Dental Assistant Questionnaire that asked dentists about the expanded functions that they allow their dental assistants to do. The last question was “What duties would you like to see added to the expanded functions list?” Local anesthesia was the top answer on the list of duties that dentists would like to see added as an expanded function for dental assistants.

- **Why would a dentist want their dental assistants to be able to administer local anesthesia?**

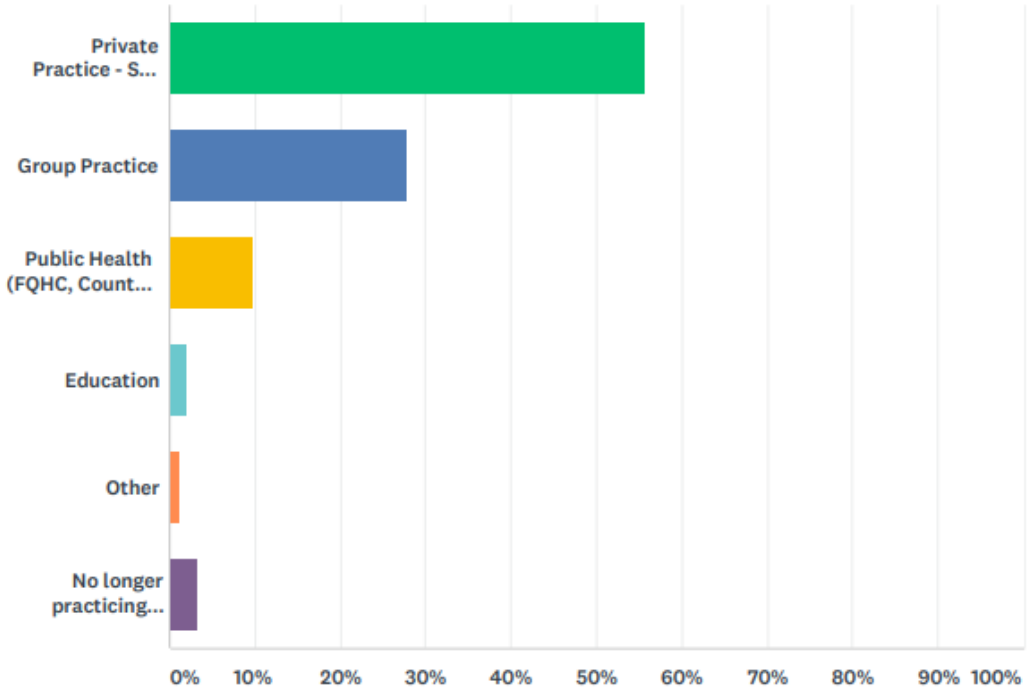
  Dental assistants help their dentists to provide restorative treatment for their patients. For a typical restorative appointment, the dental assistant seats the patient and places topical anesthetic on the soft tissue where the local anesthesia will be administered. After 1-2 minutes the dentist enters the treatment room and administers local anesthesia to the patient and then leaves the room for 5-10 minutes to allow the local anesthesia to take effect while the dental assistant places a rubber dam to isolate the teeth to be treated. Then the dentist returns to the room to begin the dental treatment. If the dental assistant could administer the local anesthesia, this would save time and make the process more efficient for both the dentist and the patient.

- **Would a dentist be required to allow a dental assistant to administer local anesthesia?**
  No, as with all dental assisting procedures the dentist would need to authorize a dental assistant to administer local anesthesia under indirect supervision.

- **Could a dental assistant administer local anesthesia without the dentist?**
  No, the dental assistant would only be able to administer local anesthesia under the indirect supervision of a dentist. The dentist would need to authorize the procedure and be on the premises when it is performed.

Q1 What type of setting do you primarily practice dentistry?

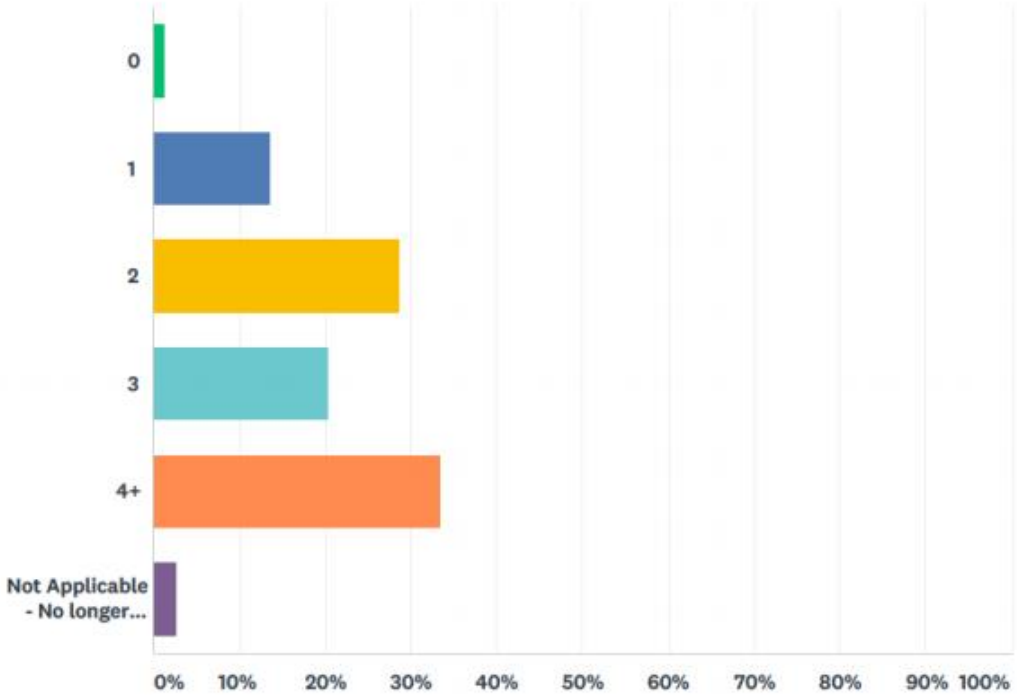
Answered: 472 Skipped: 0



ANSWER CHOICES	RESPONSES	
Private Practice - Sole Practitioner	55.72%	263
Group Practice	27.75%	131
Public Health (FQHC, County, Corrections, Community etc.)	9.75%	46
Education	2.12%	10
Other	1.27%	6
No longer practicing (Retired, Disabled etc.)	3.39%	16
TOTAL		472

Q2 How many dental assistants do you employ or work at your primary location?

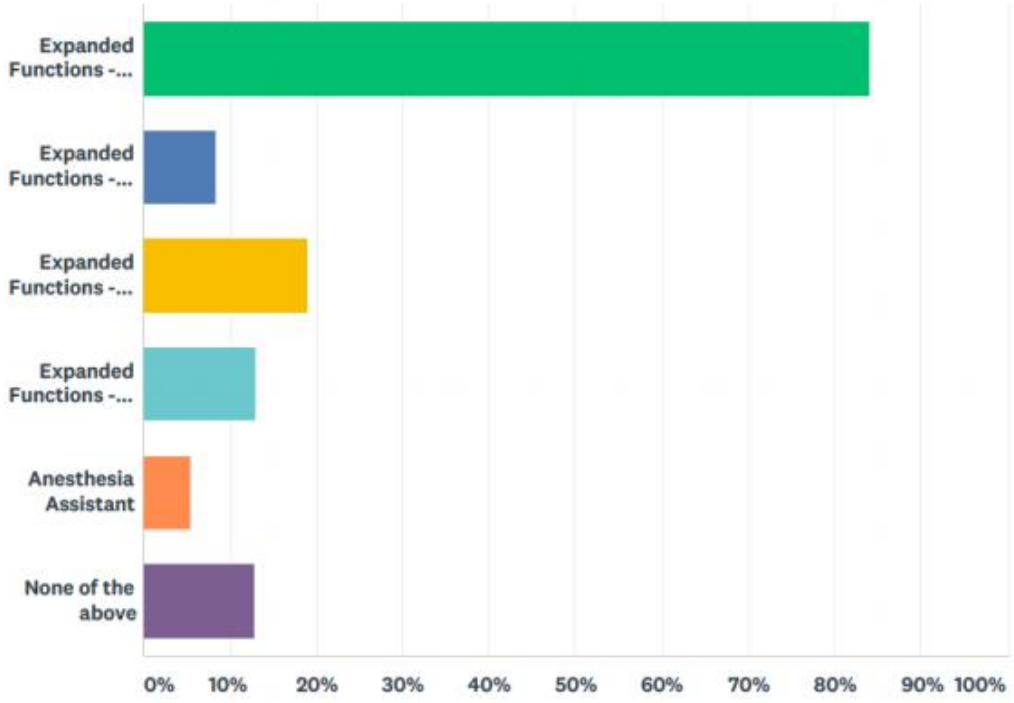
Answered: 469 Sk pped: 3



ANSWER CHOICES	RESPONSES	
0	1.28%	6
1	13.65%	64
2	28.57%	134
3	20.26%	95
4+	33.48%	157
Not App cab e - No onger pract c ng	2.77%	13
TOTAL		469

Q3 Which of the following Oregon certifications does your dental assistant(s) hold? (Check all that apply)

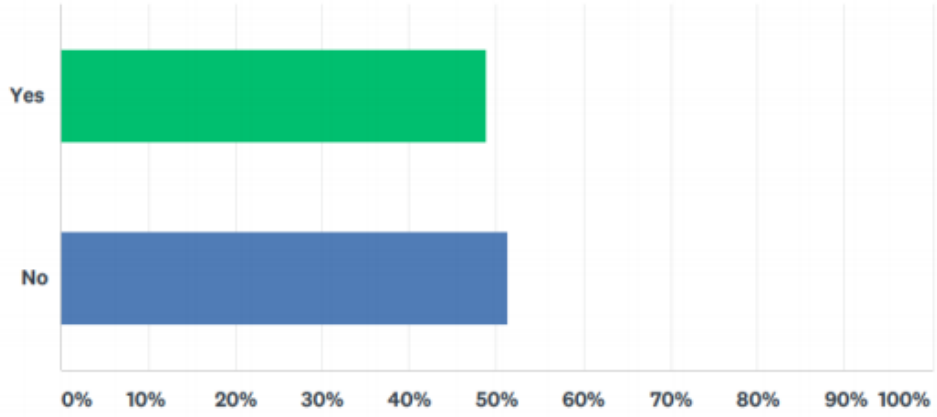
Answered: 461 Sk pped: 11



ANSWER CHOICES	RESPONSES	
Expanded Funct ons - Genera	84.16%	388
Expanded Funct ons - Genera w th Restorat ve Endorsement	8.46%	39
Expanded Funct ons - Orthodont c	19.09%	88
Expanded Funct ons - Prevent ve	13.02%	60
Anesthes a Ass stant	5.42%	25
None of the above	12.80%	59
Tota Respondents: 461		

Q4 Within your practice do you utilize the Dental Assisting National Board's (DANB) signoff sheet to train your dental assistant(s) to perform EFDA duties to obtain certification in Oregon?

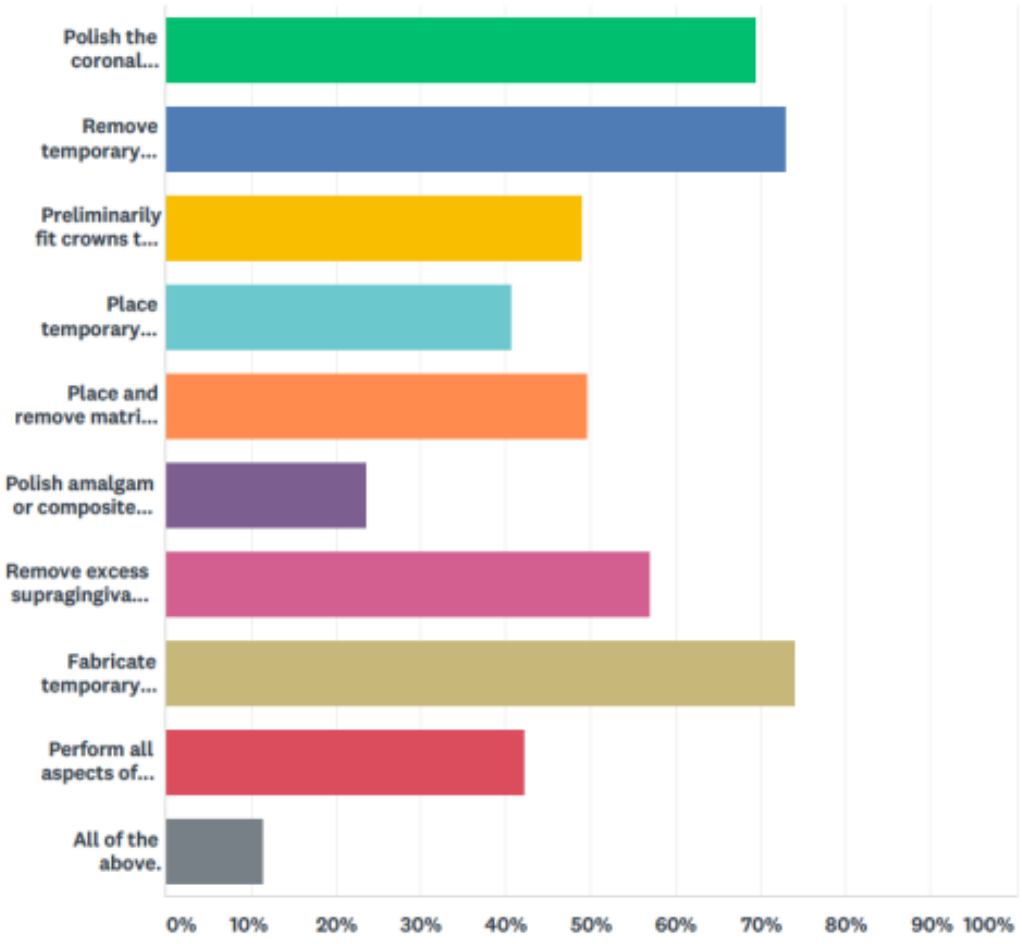
Answered: 462 Sk pped: 10



ANSWER CHOICES	RESPONSES	
Yes	48.70%	225
No	51.30%	237
TOTAL		462

Q5 Which expanded function duties do you allow your assistant(s) to perform once certified in Oregon? (Check all that apply)

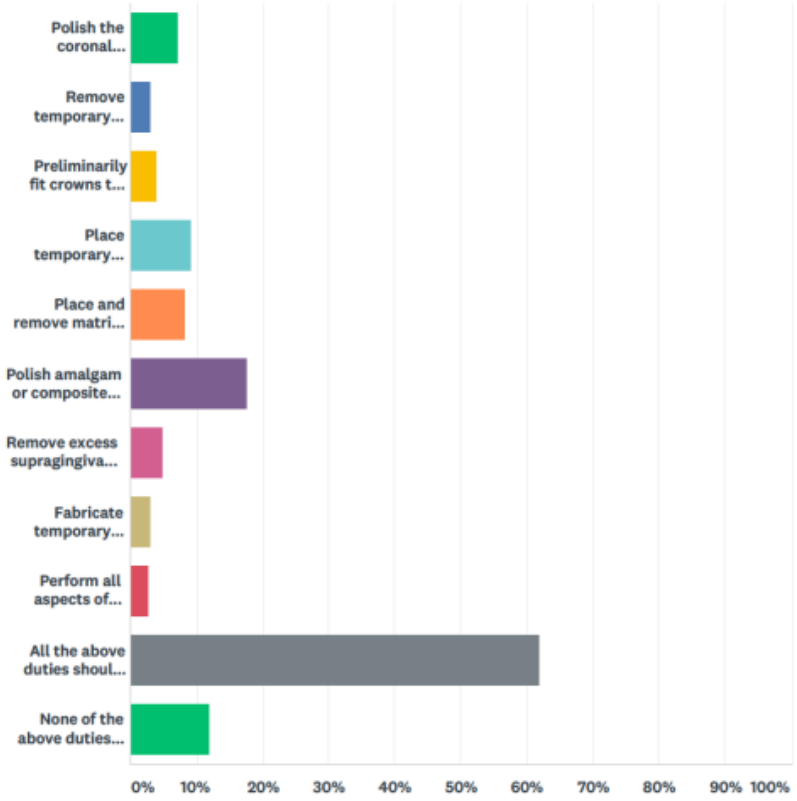
Answered: 409 Sk pped: 63



ANSWER CHOICES	RESPONSES	
Po sh the corona surfaces of teeth w th a brush or rubber cup as part of ora prophy ax s to remove sta ns.	69.44%	284
Remove temporary crowns for f na cementat on and c ean teeth for f na cementat on.	73.11%	299
Pre m nar y f t crowns to check contacts or to adjust occ us on outs de the mouth.	48.90%	200
P ace temporary restorat ve mater a (.e., z nc ox de eugeno based mater a).	40.59%	166
P ace and remove matr x reta ners for a oy and compos te restorat ons.	49.63%	203
Po sh ama gam or compos te surfaces w th a s ow speed hand p ece.	23.72%	97
Remove excess suprag ng va cement from crowns, br dges, bands or brackets w th hand nstrument.	56.97%	233
Fabr cate temporary crowns, and temporar y cement the temporary crown.	74.08%	303
Perform a aspects of teeth wh ten ng procedures.	42.30%	173
A of the above.	11.49%	47

Q6 Which EFDA duties, if any, do you consider obsolete? (Check all that apply)

Answered: 376 Sk pped: 96



ANSWER CHOICES	RESPONSES	
Po sh the corona surfaces of teeth w th a brush or rubber cup as part of ora prophy ax s to remove sta ns.	7.18%	27
Remove temporary crowns for f na cementat on and c ean teeth for f na cementat on.	2.93%	11
Pre m nar y f t crowns to check contacts or to adjust occ us on outs de the mouth.	3.99%	15
P ace temporary restorat ve mater a (.e., z nc ox de eugeno based mater a).	9.31%	35
P ace and remove matr x reta ners for a oy and compos te restorat ons.	8.24%	31
Po sh ama gam or compos te surfaces w th a s ow speed hand p ece.	17.55%	66
Remove excess suprag ng va cement from crowns, br dges, bands or brackets w th hand nstruments.	4.79%	18
Fabr cate temporary crowns, and temporar y cement the temporary crown.	2.93%	11
Perform a aspects of teeth wh ten ng procedures.	2.66%	10
A the above dut es shou d rema n as expanded funct on dut es.	61.97%	233
None of the above dut es shou d rema n expanded funct on dut es.	11.97%	45
Tota Respondents: 376		

Q7 What duties would you like to see added to the expanded functions list?

Answered: 181 Sk pped: 291

The majority of the answers showed that the dentists would like EFDA dental assistants to perform the following duties:

- Local Anesthesia
- Final Impressions
- Pack retraction cord (Already allowed)
- Soft relines (Already allowed)
- Start nitrous oxide
- Periodontal probing

818-035-0040
Expanded Functions of Dental Hygienists

(1) Upon completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, a dental hygienist who completes a Board approved application shall be issued an endorsement to administer local anesthetic agents and local anesthetic reversal agents under the general supervision of a licensed dentist. Local anesthetic reversal agents shall not be used on children less than 6 years of age or weighing less than 33 pounds.

(2) Upon completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, a dental hygienist may administer nitrous oxide under the indirect supervision of a licensed dentist in accordance with the Board's rules regarding anesthesia.

(3) Upon completion of a course of instruction approved by the Oregon Health Authority, Public Health Division, a dental hygienist may purchase Epinephrine and administer Epinephrine in an emergency.

DDH Dentist and Dental Hygienist Compact

Dentist and Dental Hygienist Compact

This project is funded by the Department of Defense.

The following language must be enacted into law by a state to officially join the Dentist and Dental Hygienist Compact.

No substantive changes should be made to the model language. Any substantive changes may jeopardize the enacting state's participation in the Compact.

The Council of State Governments National Center for Interstate Compacts reviews state compact legislation to ensure consistency with the model language. Please direct inquiries to Jessica Thomas at JThomas@csg.org.

DENTIST AND DENTAL HYGIENIST COMPACT

SECTION 1. TITLE AND PURPOSE

This statute shall be known and cited as the Dentist and Dental Hygienist Compact. The purposes of this Compact are to facilitate the interstate practice of dentistry and dental hygiene and improve public access to dentistry and dental hygiene services by providing Dentists and Dental Hygienists licensed in a Participating State the ability to practice in Participating States in which they are not licensed. The Compact does this by establishing a pathway for a Dentists and Dental Hygienists licensed in a Participating State to obtain a Compact Privilege that authorizes them to practice in another Participating State in which they are not licensed. The Compact enables Participating States to protect the public health and safety with respect to the practice of such Dentists and Dental Hygienists, through the State's authority to regulate the practice of dentistry and dental hygiene in the State. The Compact:

A. Enables Dentists and Dental Hygienists who qualify for a Compact Privilege to practice in other Participating States without satisfying burdensome and duplicative requirements associated with securing a License to practice in those States;

B. Promotes mobility and addresses workforce shortages through each Participating State's acceptance of a Compact Privilege to practice in that State;

C. Increases public access to qualified, licensed Dentists and Dental Hygienists by creating a responsible, streamlined pathway for Licensees to practice in Participating States.

D. Enhances the ability of Participating States to protect the public's health and safety;

E. Does not interfere with licensure requirements established by a Participating State;

F. Facilitates the sharing of licensure and disciplinary information among Participating States;

G. Requires Dentists and Dental Hygienists who practice in a Participating State pursuant to a Compact Privilege to practice within the Scope of Practice authorized in that State;

H. Extends the authority of a Participating State to regulate the practice of dentistry and dental hygiene within its borders to Dentists and Dental Hygienists who practice in the State through a Compact Privilege;

I. Promotes the cooperation of Participating State in regulating the practice of dentistry and dental hygiene within those States;

J. Facilitates the relocation of military members and their spouses who are licensed to practice dentistry or dental hygiene;

SECTION 2. DEFINITIONS

As used in this Compact, unless the context requires otherwise, the following definitions shall apply:

A. **"Active-Duty Military"** means any individual in full-time duty status in the active uniformed service of the United States including members of the National Guard and Reserve.

B. **"Adverse Action"** means disciplinary action or encumbrance imposed on a License or Compact Privilege by a State Licensing Authority.

C. **"Alternative Program"** means a non-disciplinary monitoring or practice remediation process applicable to a Dentist or Dental Hygienist approved by a State Licensing Authority of a Participating State in which the Dentist or Dental Hygienist is licensed. This includes, but is not limited to, programs to which Licensees with substance abuse or addiction issues are referred in lieu of Adverse Action.

D. **"Clinical Assessment"** means examination or process, required for licensure as a Dentist or Dental Hygienist as applicable, that provides evidence of clinical competence in dentistry or dental hygiene.

E. **"Commissioner"** means the individual appointed by a Participating State to serve as the member of the Commission for that Participating State.

F. **"Compact"** means this Dentist and Dental Hygienist Compact.

G. **"Compact Privilege"** means the authorization granted by a Remote State to allow a Licensee from a Participating State to practice as a Dentist or Dental Hygienist in a Remote State.

H. **"Continuing Professional Development"** means a requirement, as a condition of License renewal to provide evidence of successful participation in educational or professional activities relevant to practice or area of work.

I. **"Criminal Background Check"** means the submission of fingerprints or other biometric-based information for a License applicant for the purpose of obtaining that applicant's criminal history record information, as defined in 28 C.F.R. § 20.3(d) from the Federal Bureau of Investigation and the State's criminal history record repository as defined in 28 C.F.R. § 20.3(f).

J. **"Data System"** means the Commission's repository of information about Licensees, including but not limited to examination, licensure, investigative, Compact Privilege, Adverse Action, and Alternative Program.

K. **"Dental Hygienist"** means an individual who is licensed by a State Licensing Authority to practice dental hygiene.

L. **"Dentist"** means an individual who is licensed by a State Licensing Authority to practice dentistry.

M. **"Dentist and Dental Hygienist Compact Commission" or "Commission"** means a joint government agency established by this Compact comprised of each State that has enacted the Compact and a national administrative body comprised of a Commissioner from each State that has enacted the Compact.

N. **"Encumbered License"** means a License that a State Licensing Authority has limited in any way other than through an Alternative Program.

O. **"Executive Board"** means the Chair, Vice Chair, Secretary and Treasurer and any other Commissioners as may be determined by Commission Rule or bylaw.

P. **"Jurisprudence Requirement"** means the assessment of an individual's knowledge of the laws and Rules governing the practice of dentistry or dental hygiene, as applicable, in a State.

Q. **"License"** means current authorization by a State, other than authorization pursuant to a Compact Privilege, or other privilege, for an individual to practice as a Dentist or Dental Hygienist in that State.

R. **"Licensee"** means an individual who holds an unrestricted License from a Participating State to practice as a Dentist or Dental Hygienist in that State.

S. **"Model Compact"** the model for the Dentist and Dental Hygienist Compact on file with the Council of State Governments or other entity as designated by the Commission**.**

T. **"Participating State"** means a State that has enacted the Compact and been admitted to the Commission in accordance with the provisions herein and Commission Rules.

U. "**Qualifying License"** means a License that is not an Encumbered License issued by a Participating State to practice dentistry or dental hygiene.

V. **"Remote State"** means a Participating State where a Licensee who is not licensed as a Dentist or Dental Hygienist is exercising or seeking to exercise the Compact Privilege.

W. **"Rule"** means a regulation promulgated by an entity that has the force of law.

X. **"Scope of Practice"** means the procedures, actions, and processes a Dentist or Dental Hygienist licensed in a State is permitted to undertake in that State and the circumstances under which the Licensee is permitted to undertake those procedures, actions and processes. Such procedures, actions and processes and the circumstances under which they may be undertaken may be established through means, including, but not limited to,

statute, regulations, case law, and other processes available to the State Licensing Authority or other government agency.

Y. **"Significant Investigative Information"** means information, records, and documents received or generated by a State Licensing Authority pursuant to an investigation for which a determination has been made that there is probable cause to believe that the Licensee has violated a statute or regulation that is considered more than a minor infraction for which the State Licensing Authority could pursue Adverse Action against the Licensee.

Z. **"State"** means any state, commonwealth, district, or territory of the United States of America that regulates the practices of dentistry and dental hygiene.

AA. **"State Licensing Authority"** means an agency or other entity of a State that is responsible for the licensing and regulation of Dentists or Dental Hygienists.

SECTION 3. STATE PARTICIPATION IN THE COMPACT

A. In order to join the Compact and thereafter continue as a Participating State, a State must:

1. Enact a compact that is not materially different from the Model Compact as determined in accordance with Commission Rules;

2. Participate fully in the Commission's Data System;

3. Have a mechanism in place for receiving and investigating complaints about its Licensees and License applicants;

4. Notify the Commission, in compliance with the terms of the Compact and Commission Rules, of any Adverse Action or the availability of Significant Investigative Information regarding a Licensee and License applicant;

5. Fully implement a Criminal Background Check requirement, within a time frame established by Commission Rule, by receiving the results of a qualifying Criminal Background Check;

6. Comply with the Commission Rules applicable to a Participating State;

7. Accept the National Board Examinations of the Joint Commission on National Dental Examinations or another examination accepted by Commission Rule as a licensure examination;

8. Accept for licensure that applicants for a Dentist License graduate from a predoctoral dental education program accredited by the Commission on Dental Accreditation or another agency permitted by Commission Rule, leading to the Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) degree;

9. Accept for licensure that applicants for a Dental Hygienist License graduate from a dental hygiene education program accredited by the Commission on Dental Accreditation or another agency permitted by Commission Rule;

10. Require for licensure that applicants successfully complete a Clinical Assessment;

11. Have Continuing Professional Development requirements as a condition for License renewal; and

12. Pay a participation fee to the Commission as established by Commission Rule.

B. Providing alternative pathways for an individual to obtain an unrestricted License does not disqualify a State from participating in the Compact.

C. When conducting a Criminal Background Check the State Licensing Authority shall:

1. Consider that information in making a licensure decision;

2. Maintain documentation of completion of the Criminal Background Check and background check information to the extent allowed by State and federal law; and

3. Report to the Commission whether it has completed the Criminal Background Check and whether the individual was granted or denied a License.

D. A Licensee of a Participating State who has a Qualifying License in that State and does not hold an Encumbered License in any other Participating State, shall be issued a Compact Privilege in a Remote State in accordance with the terms of the Compact and Commission Rules. If a Remote State has a Jurisprudence Requirement a Compact Privilege will not be issued to the Licensee unless the Licensee has satisfied the Jurisprudence Requirement.

SECTION 4. COMPACT PRIVILEGE

A. To obtain and exercise the Compact Privilege under the terms and provisions of the Compact, the Licensee shall:

1. Have a Qualifying License as a Dentist or Dental Hygienist in a Participating State;

2. Be eligible for a Compact Privilege in any Remote State in accordance with D, G and H of this section;

3. Submit to an application process whenever the Licensee is seeking a Compact Privilege;

4. Pay any applicable Commission and Remote State fees for a Compact Privilege in the Remote State;

5. Meet any Jurisprudence Requirement established by a Remote State in which the Licensee is seeking a Compact Privilege;

6. Have passed a National Board Examination of the Joint Commission on National Dental Examinations or another examination accepted by Commission Rule;

7. For a Dentist, have graduated from a predoctoral dental education program accredited by the Commission on Dental Accreditation or another agency permitted by Commission Rule, leading to the Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) degree;

8. For a Dental Hygienist, have graduated from a dental hygiene education program accredited by the Commission on Dental Accreditation or another agency permitted by Commission Rule;

9. Have successfully completed a Clinical Assessment for licensure;

10. Report to the Commission Adverse Action taken by any non-Participating State when applying for a Compact Privilege and, otherwise, within thirty (30) days from the date the Adverse Action is taken;

11. Report to the Commission when applying for a Compact Privilege the address of the Licensee's primary residence and thereafter immediately report to the Commission any change in the address of the Licensee's primary residence; and

12. Consent to accept service of process by mail at the Licensee's primary residence on record with the Commission with respect to any action brought against the Licensee by the Commission or a Participating State, and consent to accept service of a subpoena by mail at the Licensee's primary residence on record with the Commission with respect to any action brought or investigation conducted by the Commission or a Participating State.

B. The Licensee must comply with the requirements of subsection A of this section to maintain the Compact Privilege in the Remote State. If those requirements are met, the Compact Privilege will continue as long as the Licensee maintains a Qualifying License in the State through which the Licensee applied for the Compact Privilege and pays any applicable Compact Privilege renewal fees.

C. A Licensee providing dentistry or dental hygiene in a Remote State under the Compact Privilege shall function within the Scope of Practice authorized by the Remote State for a Dentist or Dental Hygienist licensed in that State.

D. A Licensee providing dentistry or dental hygiene pursuant to a Compact Privilege in a Remote State is subject to that State's regulatory authority. A Remote State may, in accordance with due process and that State's laws, by Adverse Action revoke or remove a Licensee's Compact Privilege in the Remote State for a specific period of time and impose fines or take any other necessary actions to protect the health and safety of its citizens. If a Remote State imposes an Adverse Action against a Compact Privilege that limits the Compact Privilege, that Adverse Action applies to all Compact Privileges in all Remote States. A Licensee whose Compact Privilege in a Remote State is removed for a specified period of time is not eligible for a Compact Privilege in any other Remote State until the

specific time for removal of the Compact Privilege has passed and all encumbrance requirements are satisfied.

E. If a License in a Participating State is an Encumbered License, the Licensee shall lose the Compact Privilege in a Remote State and shall not be eligible for a Compact Privilege in any Remote State until the License is no longer encumbered.

F. Once an Encumbered License in a Participating State is restored to good standing, the Licensee must meet the requirements of subsection A of this section to obtain a Compact Privilege in a Remote State.

G. If a Licensee's Compact Privilege in a Remote State is removed by the Remote State, the individual shall lose or be ineligible for the Compact Privilege in any Remote State until the following occur:

1. The specific period of time for which the Compact Privilege was removed has ended; and

2. All conditions for removal of the Compact Privilege have been satisfied.

H. Once the requirements of subsection G of this section have been met, the Licensee must meet the requirements in subsection A of this section to obtain a Compact Privilege in a Remote State.

SECTION 5. ACTIVE-DUTY MILITARY PERSONNEL OR THEIR SPOUSES

An Active-Duty Military individual and their spouse shall not be required to pay to the Commission for a Compact Privilege the fee otherwise charged by the Commission. If a Remote State chooses to charge a fee for a Compact Privilege, it may choose to charge a reduced fee or no fee to an Active-Duty Military individual and their spouse for a Compact Privilege.

SECTION 6. ADVERSE ACTIONS

A. A Participating State in which a Licensee is licensed shall have exclusive authority to impose Adverse Action against the Qualifying License issued by that Participating State.

B. A Participating State may take Adverse Action based on the Significant Investigative Information of a Remote State, so long as the Participating State follows its own procedures for imposing Adverse Action.

C. Nothing in this Compact shall override a Participating State's decision that participation in an Alternative Program may be used in lieu of Adverse Action and that such participation shall remain non-public if required by the Participating State's laws. Participating States must require Licensees who enter any Alternative Program in lieu of discipline to agree not to practice pursuant to a Compact Privilege in any other Participating State during the term of the Alternative Program without prior authorization from such other Participating State.

D. Any Participating State in which a Licensee is applying to practice or is practicing pursuant to a Compact Privilege may investigate actual or alleged violations of the statutes and

regulations authorizing the practice of dentistry or dental hygiene in any other Participating State in which the Dentist or Dental Hygienist holds a License or Compact Privilege.

E. A Remote State shall have the authority to:

1. Take Adverse Actions as set forth in Section 4.D against a Licensee's Compact Privilege in the State;

2. In furtherance of its rights and responsibilities under the Compact and the Commission's Rules issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a State Licensing Authority in a Participating State for the attendance and testimony of witnesses, or the production of evidence from another Participating State, shall be enforced in the latter State by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the State where the witnesses or evidence are located; and

3. If otherwise permitted by State law, recover from the Licensee the costs of investigations and disposition of cases resulting from any Adverse Action taken against that Licensee.

F. Joint Investigations

1. In addition to the authority granted to a Participating State by its Dentist or Dental Hygienist licensure act or other applicable State law, a Participating State may jointly investigate Licensees with other Participating States.

2. Participating States shall share any Significant Investigative Information, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

G. Authority to Continue Investigation

1. After a Licensee's Compact Privilege in a Remote State is terminated, the Remote State may continue an investigation of the Licensee that began when the Licensee had a Compact Privilege in that Remote State.

2. If the investigation yields what would be Significant Investigative Information had the Licensee continued to have a Compact Privilege in that Remote State, the Remote State shall report the presence of such information to the Data System as required by Section 8.B.6 as if it was Significant Investigative Information.

SECTION 7. ESTABLISHMENT AND OPERATION OF THE COMMISSION.

A. The Compact Participating States hereby create and establish a joint government agency whose membership consists of all Participating States that have enacted the Compact. The Commission is an instrumentality of the Participating States acting jointly and not an

instrumentality of any one State. The Commission shall come into existence on or after the effective date of the Compact as set forth in Section 11A.

B. Participation, Voting, and Meetings

1. Each Participating State shall have and be limited to one (1) Commissioner selected by that Participating State's State Licensing Authority or, if the State has more than one State Licensing Authority, selected collectively by the State Licensing Authorities.

2. The Commissioner shall be a member or designee of such Authority or Authorities.

3. The Commission may by Rule or bylaw establish a term of office for Commissioners and may by Rule or bylaw establish term limits.

4. The Commission may recommend to a State Licensing Authority or Authorities, as applicable, removal or suspension of an individual as the State's Commissioner.

5. A Participating State's State Licensing Authority, or Authorities, as applicable, shall fill any vacancy of its Commissioner on the Commission within sixty (60) days of the vacancy.

6. Each Commissioner shall be entitled to one vote on all matters that are voted upon by the Commission.

7. The Commission shall meet at least once during each calendar year. Additional meetings may be held as set forth in the bylaws. The Commission may meet by telecommunication, video conference or other similar electronic means.

C. The Commission shall have the following powers:

1. Establish the fiscal year of the Commission;

2. Establish a code of conduct and conflict of interest policies;

3. Adopt Rules and bylaws;

4. Maintain its financial records in accordance with the bylaws;

5. Meet and take such actions as are consistent with the provisions of this Compact, the Commission's Rules, and the bylaws;

6. Initiate and conclude legal proceedings or actions in the name of the Commission, provided that the standing of any State Licensing Authority to sue or be sued under applicable law shall not be affected;

7. Maintain and certify records and information provided to a Participating State as the authenticated business records of the Commission, and designate a person to do so on the Commission's behalf;

8. Purchase and maintain insurance and bonds;

9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Participating State;

10. Conduct an annual financial review;

11. Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission’s personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

12. As set forth in the Commission Rules, charge a fee to a Licensee for the grant of a Compact Privilege in a Remote State and thereafter, as may be established by Commission Rule, charge the Licensee a Compact Privilege renewal fee for each renewal period in which that Licensee exercises or intends to exercise the Compact Privilege in that Remote State. Nothing herein shall be construed to prevent a Remote State from charging a Licensee a fee for a Compact Privilege or renewals of a Compact Privilege, or a fee for the Jurisprudence Requirement if the Remote State imposes such a requirement for the grant of a Compact Privilege;

13. Accept any and all appropriate gifts, donations, grants of money, other sources of revenue, equipment, supplies, materials, and services, and receive, utilize, and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety and/or conflict of interest;

14. Lease, purchase, retain, own, hold, improve, or use any property, real, personal, or mixed, or any undivided interest therein;

15. Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed;

16. Establish a budget and make expenditures;

17. Borrow money;

18. Appoint committees, including standing committees, which may be composed of members, State regulators, State legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws;

19. Provide and receive information from, and cooperate with, law enforcement agencies;

20. Elect a Chair, Vice Chair, Secretary and Treasurer and such other officers of the Commission as provided in the Commission's bylaws;

21. Establish and elect an Executive Board;

22. Adopt and provide to the Participating States an annual report;

23. Determine whether a State's enacted compact is materially different from the Model Compact language such that the State would not qualify for participation in the Compact; and

24. Perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact.

D. Meetings of the Commission

1. All meetings of the Commission that are not closed pursuant to this subsection shall be open to the public. Notice of public meetings shall be posted on the Commission's website at least thirty (30) days prior to the public meeting.

2. Notwithstanding subsection D.1 of this section, the Commission may convene an emergency public meeting by providing at least twenty-four (24) hours prior notice on the Commission's website, and any other means as provided in the Commission's Rules, for any of the reasons it may dispense with notice of proposed rulemaking under Section 9.L. The Commission's legal counsel shall certify that one of the reasons justifying an emergency public meeting has been met.

3. Notice of all Commission meetings shall provide the time, date, and location of the meeting, and if the meeting is to be held or accessible via telecommunication, video conference, or other electronic means, the notice shall include the mechanism for access to the meeting through such means.

4. The Commission may convene in a closed, non-public meeting for the Commission to receive legal advice or to discuss:

   a. Non-compliance of a Participating State with its obligations under the Compact;

   b. The employment, compensation, discipline or other matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

   c. Current or threatened discipline of a Licensee or Compact Privilege holder by the Commission or by a Participating State's Licensing Authority;

   d. Current, threatened, or reasonably anticipated litigation;

e. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;

f. Accusing any person of a crime or formally censuring any person;

g. Trade secrets or commercial or financial information that is privileged or confidential;

h. Information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

i. Investigative records compiled for law enforcement purposes;

j. Information related to any investigative reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact;

k. Legal advice;

l. Matters specifically exempted from disclosure to the public by federal or Participating State law; and

m. Other matters as promulgated by the Commission by Rule.

5. If a meeting, or portion of a meeting, is closed, the presiding officer shall state that the meeting will be closed and reference each relevant exempting provision, and such reference shall be recorded in the minutes.

6. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

E. Financing of the Commission

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate sources of revenue, donations, and grants of money, equipment, supplies, materials, and services.

3. The Commission may levy on and collect an annual assessment from each Participating State and impose fees on Licensees of Participating States when a Compact Privilege is

granted, to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each fiscal year for which sufficient revenue is not provided by other sources. The aggregate annual assessment amount for Participating States shall be allocated based upon a formula that the Commission shall promulgate by Rule.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any Participating State, except by and with the authority of the Participating State.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the financial review and accounting procedures established under its bylaws. All receipts and disbursements of funds handled by the Commission shall be subject to an annual financial review by a certified or licensed public accountant, and the report of the financial review shall be included in and become part of the annual report of the Commission.

F. The Executive Board

1. The Executive Board shall have the power to act on behalf of the Commission according to the terms of this Compact. The powers, duties, and responsibilities of the Executive Board shall include:

   a. Overseeing the day-to-day activities of the administration of the Compact including compliance with the provisions of the Compact, the Commission's Rules and bylaws;

   b. Recommending to the Commission changes to the Rules or bylaws, changes to this Compact legislation, fees charged to Compact Participating States, fees charged to Licensees, and other fees;

   c. Ensuring Compact administration services are appropriately provided, including by contract;

   d. Preparing and recommending the budget;

   e. Maintaining financial records on behalf of the Commission;

   f. Monitoring Compact compliance of Participating States and providing compliance reports to the Commission;

   g. Establishing additional committees as necessary;

   h. Exercising the powers and duties of the Commission during the interim between Commission meetings, except for adopting or amending Rules, adopting or amending bylaws, and exercising any other powers and duties expressly reserved to the Commission by Rule or bylaw; and

i. Other duties as provided in the Rules or bylaws of the Commission.

2. The Executive Board shall be composed of up to seven (7) members:

a. The Chair, Vice Chair, Secretary and Treasurer of the Commission and any other members of the Commission who serve on the Executive Board shall be voting members of the Executive Board; and

b. Other than the Chair, Vice Chair, Secretary, and Treasurer, the Commission may elect up to three (3) voting members from the current membership of the Commission.

3. The Commission may remove any member of the Executive Board as provided in the Commission's bylaws.

4. The Executive Board shall meet at least annually.

a. An Executive Board meeting at which it takes or intends to take formal action on a matter shall be open to the public, except that the Executive Board may meet in a closed, non-public session of a public meeting when dealing with any of the matters covered under subsection D.4.

b. The Executive Board shall give five (5) business days' notice of its public meetings, posted on its website and as it may otherwise determine to provide notice to persons with an interest in the public matters the Executive Board intends to address at those meetings.

5. The Executive Board may hold an emergency meeting when acting for the Commission to:

a. Meet an imminent threat to public health, safety, or welfare;

b. Prevent a loss of Commission or Participating State funds; or

c. Protect public health and safety.

G. Qualified Immunity, Defense, and Indemnification

1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, both personally and in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the

intentional or willful or wanton misconduct of that person. The procurement of insurance of any type by the Commission shall not in any way compromise or limit the immunity granted hereunder.

2. The Commission shall defend any member, officer, executive director, employee, and representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or as determined by the Commission that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining their own counsel at their own expense; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. Notwithstanding subsection (a), should any member, officer, executive director, employee, or representative of the Commission be held liable for the amount of any settlement or judgment arising out of any actual or alleged act, error, or omission that occurred within the scope of that individual's employment, duties, or responsibilities for the Commission, or that the person to whom that individual is liable had a reasonable basis for believing occurred within the scope of the individual's employment, duties, or responsibilities for the Commission, the Commission shall indemnify and hold harmless such individual, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of the individual.

4. Nothing herein shall be construed as a limitation on the liability of any Licensee for professional malpractice or misconduct, which shall be governed solely by any other applicable State laws.

5. Nothing in this Compact shall be interpreted to waive or otherwise abrogate a Participating State's state action immunity or state action affirmative defense with respect to antitrust claims under the Sherman Act, Clayton Act, or any other State or federal antitrust or anticompetitive law or regulation.

6. Nothing in this Compact shall be construed to be a waiver of sovereign immunity by the Participating States or by the Commission.

SECTION 8. DATA SYSTEM

A. The Commission shall provide for the development, maintenance, operation, and utilization of a coordinated database and reporting system containing licensure, Adverse Action, and the presence of Significant Investigative Information on all Licensees and applicants for a License in Participating States.

B. Notwithstanding any other provision of State law to the contrary, a Participating State shall submit a uniform data set to the Data System on all individuals to whom this Compact is

applicable as required by the Rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Adverse Actions against a Licensee, License applicant or Compact Privilege and information related thereto;

4. Non-confidential information related to Alternative Program participation, the beginning and ending dates of such participation, and other information related to such participation;

5. Any denial of an application for licensure, and the reason(s) for such denial, (excluding the reporting of any criminal history record information where prohibited by law);

6. The presence of Significant Investigative Information; and

7. Other information that may facilitate the administration of this Compact or the protection of the public, as determined by the Rules of the Commission.

C. The records and information provided to a Participating State pursuant to this Compact or through the Data System, when certified by the Commission or an agent thereof, shall constitute the authenticated business records of the Commission, and shall be entitled to any associated hearsay exception in any relevant judicial, quasi-judicial or administrative proceedings in a Participating State.

D. Significant Investigative Information pertaining to a Licensee in any Participating State will only be available to other Participating States.

E. It is the responsibility of the Participating States to monitor the database to determine whether Adverse Action has been taken against a Licensee or License applicant. Adverse Action information pertaining to a Licensee or License applicant in any Participating State will be available to any other Participating State.

F. Participating States contributing information to the Data System may designate information that may not be shared with the public without the express permission of the contributing State.

G. Any information submitted to the Data System that is subsequently expunged pursuant to federal law or the laws of the Participating State contributing the information shall be removed from the Data System.

SECTION 9. RULEMAKING

A. The Commission shall promulgate reasonable Rules in order to effectively and efficiently implement and administer the purposes and provisions of the Compact. A Commission Rule

shall be invalid and have no force or effect only if a court of competent jurisdiction holds that the Rule is invalid because the Commission exercised its rulemaking authority in a manner that is beyond the scope and purposes of the Compact, or the powers granted hereunder, or based upon another applicable standard of review.

B. The Rules of the Commission shall have the force of law in each Participating State, provided however that where the Rules of the Commission conflict with the laws of the Participating State that establish the Participating State's Scope of Practice as held by a court of competent jurisdiction, the Rules of the Commission shall be ineffective in that State to the extent of the conflict.

C. The Commission shall exercise its Rulemaking powers pursuant to the criteria set forth in this section and the Rules adopted thereunder. Rules shall become binding as of the date specified by the Commission for each Rule.

D. If a majority of the legislatures of the Participating States rejects a Commission Rule or portion of a Commission Rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, within four (4) years of the date of adoption of the Rule, then such Rule shall have no further force and effect in any Participating State or to any State applying to participate in the Compact.

E. Rules shall be adopted at a regular or special meeting of the Commission.

F. Prior to adoption of a proposed Rule, the Commission shall hold a public hearing and allow persons to provide oral and written comments, data, facts, opinions, and arguments.

G. Prior to adoption of a proposed Rule by the Commission, and at least thirty (30) days in advance of the meeting at which the Commission will hold a public hearing on the proposed Rule, the Commission shall provide a Notice of Proposed Rulemaking:

1. On the website of the Commission or other publicly accessible platform;

2. To persons who have requested notice of the Commission's notices of proposed rulemaking, and

3. In such other way(s) as the Commission may by Rule specify.

H. The Notice of Proposed Rulemaking shall include:

1. The time, date, and location of the public hearing at which the Commission will hear public comments on the proposed Rule and, if different, the time, date, and location of the meeting where the Commission will consider and vote on the proposed Rule;

2. If the hearing is held via telecommunication, video conference, or other electronic means, the Commission shall include the mechanism for access to the hearing in the Notice of Proposed Rulemaking;

3. The text of the proposed Rule and the reason therefor;

4. A request for comments on the proposed Rule from any interested person; and

5. The manner in which interested persons may submit written comments.

I. All hearings will be recorded. A copy of the recording and all written comments and documents received by the Commission in response to the proposed Rule shall be available to the public.

J. Nothing in this section shall be construed as requiring a separate hearing on each Commission Rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

K. The Commission shall, by majority vote of all Commissioners, take final action on the proposed Rule based on the rulemaking record.

1. The Commission may adopt changes to the proposed Rule provided the changes do not enlarge the original purpose of the proposed Rule.

2. The Commission shall provide an explanation of the reasons for substantive changes made to the proposed Rule as well as reasons for substantive changes not made that were recommended by commenters.

3. The Commission shall determine a reasonable effective date for the Rule. Except for an emergency as provided in subsection L, the effective date of the Rule shall be no sooner than thirty (30) days after the Commission issuing the notice that it adopted or amended the Rule.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency Rule with 24 hours' notice, with opportunity to comment, provided that the usual rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the Rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the Rule. For the purposes of this provision, an emergency Rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or Participating State funds;

3. Meet a deadline for the promulgation of a Rule that is established by federal law or rule; or

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted Rule for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a Rule. A challenge shall be made in writing and delivered to the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

N. No Participating State's rulemaking requirements shall apply under this Compact

SECTION 10. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

A. Oversight

1. The executive and judicial branches of State government in each Participating State shall enforce this Compact and take all actions necessary and appropriate to implement the Compact.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings. Nothing herein shall affect or limit the selection or propriety of venue in any action against a Licensee for professional malpractice, misconduct or any such similar matter.

3. The Commission shall be entitled to receive service of process in any proceeding regarding the enforcement or interpretation of the Compact or Commission Rule and shall have standing to intervene in such a proceeding for all purposes. Failure to provide the Commission service of process shall render a judgment or order void as to the Commission, this Compact, or promulgated Rules.

B. Default, Technical Assistance, and Termination

1. If the Commission determines that a Participating State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated Rules, the Commission shall provide written notice to the defaulting State. The notice of default shall describe the default, the proposed means of curing the default, and any other action that the Commission may take, and shall offer training and specific technical assistance regarding the default.

2. The Commission shall provide a copy of the notice of default to the other Participating States.

C. If a State in default fails to cure the default, the defaulting State may be terminated from the

Compact upon an affirmative vote of a majority of the Commissioners, and all rights, privileges and benefits conferred on that State by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending State of obligations or liabilities incurred during the period of default.

D. Termination of participation in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting State's legislature, the defaulting State's State Licensing Authority or Authorities, as applicable, and each of the Participating States' State Licensing Authority or Authorities, as applicable.

E. A State that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

F. Upon the termination of a State's participation in this Compact, that State shall immediately provide notice to all Licensees of the State, including Licensees of other Participating States issued a Compact Privilege to practice within that State, of such termination. The terminated State shall continue to recognize all Compact Privileges then in effect in that State for a minimum of one hundred eighty (180) days after the date of said notice of termination.

G. The Commission shall not bear any costs related to a State that is found to be in default or that has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting State.

H. The defaulting State may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees.

I. Dispute Resolution

1. Upon request by a Participating State, the Commission shall attempt to resolve disputes related to the Compact that arise among Participating States and between Participating States and non-Participating States.

2. The Commission shall promulgate a Rule providing for both mediation and binding dispute resolution for disputes as appropriate.

J. Enforcement

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions of this Compact and the Commission's Rules.

2. By majority vote, the Commission may initiate legal action against a Participating State

in default in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices to enforce compliance with the provisions of the Compact and its promulgated Rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or the defaulting Participating State's law.

3. A Participating State may initiate legal action against the Commission in the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices to enforce compliance with the provisions of the Compact and its promulgated Rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees.

4. No individual or entity other than a Participating State may enforce this Compact against the Commission.

SECTION 11. EFFECTIVE DATE, WITHDRAWAL, AND AMENDMENT

A. The Compact shall come into effect on the date on which the Compact statute is enacted into law in the seventh Participating State.

1. On or after the effective date of the Compact, the Commission shall convene and review the enactment of each of the States that enacted the Compact prior to the Commission convening ("Charter Participating States") to determine if the statute enacted by each such Charter Participating State is materially different than the Model Compact.

   a. A Charter Participating State whose enactment is found to be materially different from the Model Compact shall be entitled to the default process set forth in Section 10.

   b. If any Participating State is later found to be in default, or is terminated or withdraws from the Compact, the Commission shall remain in existence and the Compact shall remain in effect even if the number of Participating States should be less than seven (7).

2. Participating States enacting the Compact subsequent to the Charter Participating States shall be subject to the process set forth in Section 7.C.23 to determine if their enactments are materially different from the Model Compact and whether they qualify for participation in the Compact.

3. All actions taken for the benefit of the Commission or in furtherance of the purposes of the administration of the Compact prior to the effective date of the Compact or the Commission coming into existence shall be considered to be actions of the

Commission unless specifically repudiated by the Commission.

4. Any State that joins the Compact subsequent to the Commission's initial adoption of the Rules and bylaws shall be subject to the Commission's Rules and bylaws as they exist on the date on which the Compact becomes law in that State. Any Rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that State.

B. Any Participating State may withdraw from this Compact by enacting a statute repealing that State's enactment of the Compact.

1. A Participating State's withdrawal shall not take effect until one hundred eighty (180) days after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing State's Licensing Authority or Authorities to comply with the investigative and Adverse Action reporting requirements of this Compact prior to the effective date of withdrawal.

3. Upon the enactment of a statute withdrawing from this Compact, the State shall immediately provide notice of such withdrawal to all Licensees within that State. Notwithstanding any subsequent statutory enactment to the contrary, such withdrawing State shall continue to recognize all Compact Privileges to practice within that State granted pursuant to this Compact for a minimum of one hundred eighty (180) days after the date of such notice of withdrawal.

C. Nothing contained in this Compact shall be construed to invalidate or prevent any licensure agreement or other cooperative arrangement between a Participating State and a non-Participating State that does not conflict with the provisions of this Compact.

D. This Compact may be amended by the Participating States. No amendment to this Compact shall become effective and binding upon any Participating State until it is enacted into the laws of all Participating States.

SECTION 12. CONSTRUCTION AND SEVERABILITY

A. This Compact and the Commission's rulemaking authority shall be liberally construed so as to effectuate the purposes, and the implementation and administration of the Compact. Provisions of the Compact expressly authorizing or requiring the promulgation of Rules shall not be construed to limit the Commission's rulemaking authority solely for those purposes.

B. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is held by a court of competent jurisdiction to be contrary to the constitution of any Participating State, a State seeking participation in the Compact, or of the United States, or the applicability thereof to any government, agency, person or circumstance is held to be unconstitutional by a court of competent jurisdiction, the validity of the remainder of this Compact and the applicability thereof to any other government, agency,

person or circumstance shall not be affected thereby.

C. Notwithstanding subsection B of this section, the Commission may deny a State's participation in the Compact or, in accordance with the requirements of Section 10.B, terminate a Participating State's participation in the Compact, if it determines that a constitutional requirement of a Participating State is a material departure from the Compact. Otherwise, if this Compact shall be held to be contrary to the constitution of any Participating State, the Compact shall remain in full force and effect as to the remaining Participating States and in full force and effect as to the Participating State affected as to all severable matters.

SECTION 13. CONSISTENT EFFECT AND CONFLICT WITH OTHER STATE LAWS

A. Nothing herein shall prevent or inhibit the enforcement of any other law of a Participating State that is not inconsistent with the Compact.

B. Any laws, statutes, regulations, or other legal requirements in a Participating State in conflict with the Compact are superseded to the extent of the conflict.

C. All permissible agreements between the Commission and the Participating States are binding in accordance with their terms.

ARTICLE

AUGUST 2022

Occupational licensing and interstate migration in the United States

The empirical evidence regarding the effects of state occupational licensing practices on interstate migration in the United States is mixed. This article uses a standardized and established methodology—founded in the tradition of gravity models and common across the social sciences—to evaluate the relationship between occupational licensing and migration flows between states. The analysis focuses on the most general of relationships: the volume of migration from each state to another state as a function of the percentage of workers in licensed occupations. Overall, state licensing rates appear to have no effect on interstate migration flows; as a result, the evidence suggests that federal policy interventions, such as standardizing occupational licensing across the states, are not indicated.

State and local governments both explicitly and implicitly regulate migration in many ways, such as through child custody laws,[1] zoning regulations,[2] and residency requirements for employment.[3] The role of internal borders in restricting migration has been established in both India[4] and the United States.[5] Although these border effects are unlikely to be the result of any single policy, the effect of variations in state occupational licensing regimes on interstate migration in the United States has received the most attention. Over 25 percent of workers in the United States are employed in occupations regulated by state laws. These regulations, however, frequently differ from one state to another and in some cases vary dramatically: Michigan requires 3 years of education and training to become a licensed security guard, while other states require only 11 days; the average length of training among low-income licensed occupations varies from a high of 724 days in Hawaii to a low of 113 days in Pennsylvania; and Louisiana is the only state that requires a license to work as a florist. Such variations are presumed to raise the cost of migrating from one state to another enough to reduce interstate migration. Of consequence is whether any associated reduction in interstate migration reduces the efficiency of regional labor and housing markets and, if so, whether policy interventions are necessary.

The empirical evidence on the effects of licensure on migration is mixed.[6] For example, Johnson and Kleiner estimated cross-sectional models of out-migration among a large sample of licensed occupations (controlling for sources of unobserved heterogeneity) and concluded that interstate variations in licensing requirements reduce migration rates within these occupations by 36 percent relative to members of other occupations.[7] In contrast, Arbury et al. found that a state's adoption of reciprocation and endorsement policies for teachers increases out-migration by just 0.02 percent.[8] DePasquale and Stange examined the effects of participating in the Nurse Licensure Compact (NLC), which allows nurses to practice in other NLC states without obtaining a separate license, and found no effect of adopting the NLC on out-migration or commuting to another state.[9]

Several factors may account for these inconsistencies. First, although many interstate variations in licensing are certainly burdensome, the actual costs of many licensing policies—in terms of direct and indirect costs of time and money—may not be high enough to actually reduce migration.[10] Second, many states have developed reciprocation agreements with neighboring states for specific occupations, thereby reducing the cost of moving between those states (or commuting from one state to a neighboring state for work). Third, occupational licensing may not be the only source of border effects. Even if licensing has a negative effect on migration, other policies may have positive effects that offset any licensing effect. Finally, much of the previous research on licensing uses inconsistent and even idiosyncratic methods that ignore accepted practices for modeling migration flows. Taking these concerns into account, we are agnostic as to the actual relationship between licensing and migration.

Our research has two goals. First, we approach the question of state licensure and interstate migration flows using tried and tested methods. We estimate a modern form of what has traditionally been called a gravity model. The advantage of this approach is that it integrates several salient characteristics of migration flows between states—namely, their spatial dimensions and the simultaneous determination of both in- and out-migration between pairs of states. Second, we discuss the meaning of our results for the narrative that occupational licensing inhibits interstate migration and thereby the efficient operation of regional labor and housing markets. This narrative has gained considerable traction, causing states and the federal government to push for either harmonizing or liberalizing state occupational licensing regimes.[11] Because the empirical evidence supporting these policies is at best unclear—a finding underscored by our models—the pursuit of new policies may have both unintended and undesired consequences. For example, reducing the role of occupational licensing might lead to reduced consumer health and safety protections and, perhaps indirectly, protections against the erosions in income and job security,[12] especially in times of economic crisis.[13]

Background

The early research on licensing and migration emerged as the state regulation of occupations started to increase in the 1950s.[14] These studies were similar in that they all focused on aggregate occupationally specific U.S. interstate migration rates (i.e., Do workers in one type of occupation move more often than those in another type?). Compared with later research, the earlier studies offered more concrete conclusions. To summarize, these investigations made the following points: First, occupations more likely to be licensed have lower rates of interstate migration. Although these studies generally focus on professional occupations, there is some evidence that the effects also apply to nonprofessional occupations. Second, licensed occupations that have reciprocity agreements with other states have higher interstate migration rates compared with similar licensed occupations that do not have such agreements. This effect, however, may be contingent upon having a critical mass of participating states. Third, occupational differences in interstate migration rates and licensing practices may be endogenous with other occupationally specific spatial labor market processes and practices, such as the role of professional associations in developing spatial information networks. Finally, occupations requiring an investment in either developing a local clientele (e.g., dentists) or investing in localized knowledge necessary for successful practice (e.g., lawyers) have lower interstate migration rates. In turn, such highly localized professions may develop more restrictive licensing regulations to protect their considerable investment in those practices.

A limitation of the earlier studies is that they focused on aggregate occupationally specific interstate migration rates. Such an approach ignores how state-specific characteristics, including state-specific licensing practices, affect both in- and out-migration for a particular state. In two similar papers, Kleiner, Gay, and Greene addressed this issue and estimated the effects of state-specific occupational licensing practices on state-specific in- and out-migration rates.[15] They found that licensing barriers reduce both in-migration and out-migration among a large set of widely licensed occupations. They also compared surveyors, which is an occupation characterized by wide variations in licensing practices, with other professional and technical occupations and found that more restrictive licensing practices in surveying reduces in-migration but has no effect on out-migration. Calculated marginal effects of licensing, for specific occupations, are about 5 percent. More recently, Johnson and Kleiner estimated the effect of bar exam difficulty on interstate migration and found large effects.[16]

Recent studies have made important methodological improvements. Three studies use causal methods to estimate how a change in licensing and reciprocation practices affect state-specific out-migration rates among attorneys, nurses, and teachers.[17] The results are either insignificant or uncover only a very small effect for a change in licensing practices on interstate migration. For example, Arbury et al. estimated a difference-in-difference model revealing that a state's adoption of reciprocation and endorsement policies for teachers increases out-of-state migration by only 0.02 percent.[18] Another advance in the research has been to selectively apply some gravity model concepts. Loucks, for example, found that, after controlling for some of the spatial processes indicated by a gravity model, the in-migration of pharmacists is affected by destination-specific licensing practices.[19] Loucks's specification, however, did not consider the effects of origin-specific licensing practices or fully account for the spatial structure of each origin–destination pair.

A study by Mulholland and Young is notable in that it addresses the role of occupational licensing in interstate migration flows within what the authors call a "modified gravity" framework that accounts for spatial structure as well as differences in origin and destination conditions.[20] Similar to our study, the Mulholland–Young analysis finds weak effects on interstate migration of occupational licensing in low- to moderate-income professions, among both the full population and those without a college education. However, their log-odds model specification for each origin–destination pair is unconventional and not directly comparable to the traditional Poisson gravity model log-linear flow-count specification or its conditional logit counterpart that can be derived from discrete choice theory.[21] The Mulholland–Young model also includes intrastate flows that are assigned distances of zero, biasing the estimation of spatial structure effects on migration. One of our goals is to assess the effects of licensing on migration flows between states, excluding intrastate flows and using a conventional specification. As we shall explain, one of the advantages of the specification we used is that it constrains the estimation to reproduce the total flows out of and into each state.

Previous research, then, provides mixed evidence that licensing hinders interstate migration and certainly not enough to raise concerns about licensing's effect on regional labor and housing markets. That said, a weakness of the earlier research is that it uses idiosyncratic methods, which makes it difficult not only to compare results but also to identify which results are more robust than others. Our response is to introduce a standardized and established methodology founded in the tradition of gravity models but also derived from discrete choice theory and commonly used across the social sciences to model flows between regions. Our intuition is that migration from one region to another is determined by the characteristics of the origin, the characteristics of the destination, the distance between the origin and the destination, and the relative spatial arrangement of alternative origins and destinations surrounding both the origin and destination of a migration flow. As a first step toward establishing a more robust body of evidence, our analysis focuses on the most general of relationships—the volume of migration from each state to every other state as a function of the percentage of workers in a licensed occupation.

Empirical strategy

The interstate flow data for our models come from the 2014, 2015, and 2016 IPUMS (originally, the Integrated Public Use Microdata Series) versions of the 1-year American Community Survey (ACS).[22] We pool these data because interstate migration is relatively rare—only about 1.5 percent of the U.S. population migrates between state lines each year. By pooling the data, we seek a balance between (1) an increase in sample size (to 3 percent of the U.S. population); (2) a reduction in yearly oscillations in annual data resulting from the small annual number of migrants between small states located far apart; and (3) improved precision in the estimates versus using the 5-year, 5-percent ACS, which would create a large gap between the last few years of observations in the ACS—specifically, 2018 and 2019—and when the focal independent variable is measured (2013).

From these data we generate seven sets of flows to test whether licensing effects matter for subgroups of the population defined by age, labor force participation, and educational attainment level: (1) all movers, (2) people in the labor force ages 25 to 64, (3) people in the labor force ages 25 to 64 with at least a 4-year college degree, (4) people in the labor force ages 25 to 64 without a 4-year college degree, (5) people in the labor force ages 25 to 39, (6) people in the labor force ages 25 to 39 with at least a 4-year college degree, and (7) people in the labor force ages 25 to 39 without a 4-year college degree. We focus on educational attainment and age rather than on other labor force variables such as income and occupation because the data are cross sectional; both income and occupation are only observed after the move and therefore may change as a result of the move. Education level is more stable before and after a move and is highly correlated with income and occupation.[23]

We expect that people without a 4-year college degree may be more sensitive to licensing costs than others because their wages are generally lower. We speculate that these effects may be weaker for younger workers because, following human capital logic, they have a longer time horizon to recoup these costs. Our expectations are not especially strong for these group differences, however, and there are reasonable arguments in favor of alternative hypotheses. Many workers with a college degree are also in licensed occupations, and although the wages of these workers are relatively high, the costs associated with satisfying state licensing requirements may influence their destination choice. Younger workers may be more deterred from selecting a destination by licensing restrictions than older workers are because younger workers are less likely to have the resources to cover the costs of new licensing requirements.

We use the following equation to measure the effects of licensing on these flows:

$$M_{ij}^{k} = \exp(O_i + D_j + \gamma \ln(d_{ij}) + \delta c_{ij} + \lambda(X_j/X_j) + \beta(L_i/L_j))$$

Where M_{ij}^{k} is the number of people in group *k* moving between state *i* and *j*, $(i \neq j)$, O_i is an origin-state fixed effect, D_j is a destination-state fixed effect, d_{ij} is the great circle distance between state population centroids, c_{ij} is a dummy variable equal to 1 if state *i* and *j* are contiguous, X_j/X_i are the ratios of destination-to-origin variables that may guide the direction of flows between pairs of states not captured by the fixed effects, and L_j/L_i is the ratio of licensing penetration in the destination state relative to the origin state.[24] L_j/L_i implies that licensing in the origin state affects the volume of migration from that state, which is a point not considered in previous research. Higher levels of licensing in the origin state may inhibit out-migration because of the protections associated with licensing and the sunk costs of attaining a license there. We opt for ratio measures of the independent variables because previous research finds they are better suited to capture the likely influence of differences between destination-state and origin-state characteristics on migration choice.[25] We restrict the model to include only the lower 48 states and the District of Columbia because of the remote locations of

Alaska and Hawaii in relation to the remaining conterminous states. Including these outlying states would bias any estimate of spatial interstate distance because of the extreme distances between them and the other 48 states, which would result in a poorer fit for the latter.[26]

We estimate this model as a Poisson regression, which is equivalent to a doubly constrained gravity model in which the origin-state and destination-state fixed effects constrain the predicted outflows and inflows to and from each state to equal the observed outflows and inflows. The model thus has the attractive quality of reproducing the observed net flows between all pairs of states. Additionally, Poisson regression with origin-state fixed effects yields coefficient estimates equivalent to those obtained from a conditional logit model, which links Poisson estimates to the theoretical foundation for the conditional logit in the random utility model and individual utility maximization.[27]

Overdispersion is frequently an issue with Poisson models because the variance of the dependent variable is greater than its mean, producing underestimated standard errors. Quasi-Poisson estimation, which yields the same coefficient estimates with increased standard errors, corrects this problem. An alternative, a negative binomial estimation, has a less restrictive variance assumption than Poisson but does not have the doubly constrained property. Moreover, a negative binomial model gives greater weight to small counts in the estimation of the coefficients.[28] In our case, this would mean that flows between smaller states would be given greater weight than those between larger states, which is an unattractive feature because the larger states account for the majority of interstate migration.

We include a measure of distance to account for the costs of moving, including spatial job search, the actual costs of moving, and the increased cost of moving to locations far from family, friends, and community. Logging distance in the Poisson specification transforms its effect on spatial interaction to a power function, which is typical for a gravity model. We add a contiguity dummy variable to account for the different processes governing short-distance flows across state lines.[29] People who live in counties next to a state line can move to another state and still be within the same labor market and the same metropolitan areas.

The fixed effects capture the influence of factors generating flows from, and attracting flows to, different states. Flows between pairs of states, however, may respond to the relative difference in the values of key variables. For instance, migrants are more likely to leave states with high unemployment rates for states with lower unemployment rates, and these effects will be captured by the origin-state and destination-state dummy variables. The size of a particular flow between two states, however, may also depend on their relative difference in unemployment rates—states with low unemployment rates, for example, may be especially attractive for migrants leaving states with high unemployment rates. Because other researchers have found such variables to successfully predict U.S. interstate migration,[30] we use origin–destination ratios, X_j/X_i, to assess this and other possibilities.

We deploy three such variables. (See table 1 for descriptive statistics.) Two of these capture origin–destination differences in labor market conditions: the 2013 unemployment rate from the U.S. Bureau of Labor Statistics,[31] and 2013 real family income, defined here as the median state family income divided by median state housing costs, with both measures calculated from the American Community Survey microdata downloaded from IPUMS.[32] We use this adjusted measure of family income to account for real income returns to moving. Housing prices have risen much faster than wages in the United States, especially in high-income areas, and this has reduced the returns to migration, especially for low-skilled workers.[33] The third ratio measures state amenities calculated by the U.S. Department of Agriculture in 1999 for counties; we convert the state amenities to state scores by using population-weighted averages of standardized county amenity scores.[34] Higher scores mean high amenity ratings. The components of the amenity score include measures of climate and physical geography characteristics, including topography and water features that most people find desirable. We include amenities because some migration research shows they are drivers of U.S. destination choice, although their importance relative to economic considerations for those in the labor force is a matter of considerable debate.[35] To ensure exogeneity, we use unemployment rates and real family income for 2013.

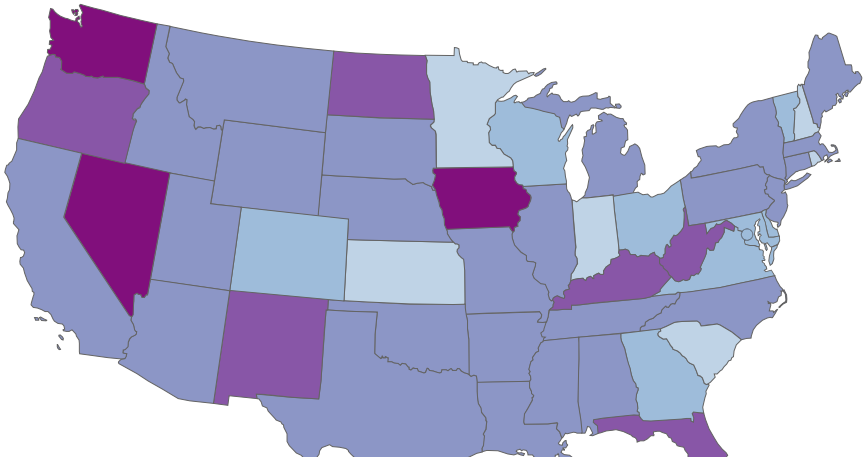
Table 1. Descriptive statistics

Item	Mean	Standard deviation	Minimum	Maximum
Natural logarithm of distance between state *i* and state *j* (in miles)	6.724	0.723	2.982	7.887
Contiguity between state and *i* and state *j* (yes = 1; no = 0)	0.093	0.290	0.000	1.000
Unemployment ratio (unemployment rate in state *i* / unemployment rate in state *j*)	1.070	0.410	0.302	3.310
Real income ratio (real income in state *i* / real income in state *j*)	1.023	0.221	0.524	1.909
Amenity ratio (amenity index in state *i* / amenity index in state *j*)	1.312	1.105	0.084	11.876
Licensing ratio (percentage licensed in state *i* / percentage licensed in state *j*)	1.050	0.333	0.372	2.686

Source: U.S. Census Bureau, American Community Survey; U.S. Bureau of Labor Statistics (unemployment rate); 2013 Harris poll of 9,850 individuals.

The focal explanatory variable is based on a measure of the percentage of all workers employed in a licensed occupation, by state. These percentages are calculated from a 2013 Harris poll of 9,850 individuals that yielded samples representative of state populations and included questions about whether workers required licenses to work in their occupation.[36] Chart 1 maps these licensing rates, and the map shows no obvious pattern.

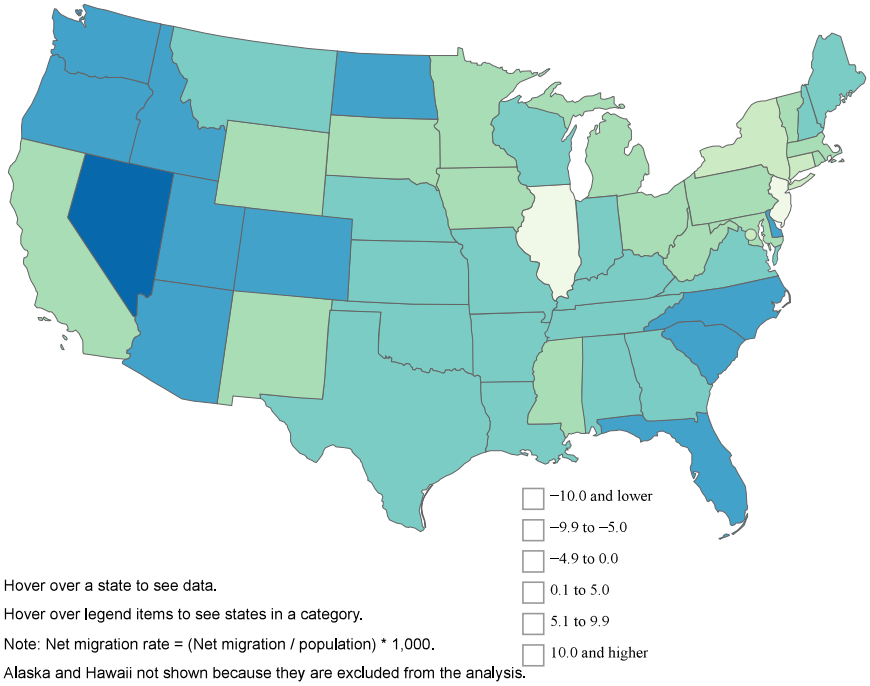
Chart 1. Percentage of jobs that require licensing, by state, 2014–16



View Chart Data

In addition, some states that have above-average regulation of their labor markets actually have very low rates of licensing, such as Minnesota, while states that are generally thought to have less regulated labor markets have relatively high rates of licensing, such as Kentucky and Florida.[37] These state-to-state variations in licensing do not appear to correlate with the most basic measure of interstate migration—net migration. (See chart 2.) Nevada is one of the most highly licensed states and yet has high rates of net in-migration. Kansas and South Carolina have relatively low licensing rates but very different net-migration rates: 1.3 and 8.5, respectively. Migration between states, of course, is shaped by a variety of forces, but it is nonetheless telling that there is frequently a disconnect between licensing and overall migration patterns.

Chart 2. Net migration rate, by state, 2014–16 (all migrants per 1,000 population)



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Results

Table 2 shows the results of the Poisson regression models using the licensing ratio, excluding the origin-state and destination-state fixed-effects parameters. The coefficients are exponentiated to yield marginal multiplicative effects with appropriately adjusted standard errors and confidence limits. In this form, coefficients are assessed as significantly different from 1, a null multiplicative effect. For the estimation, all ratio variables were normalized to a mean of 0 and a standard deviation of 1 to ease interpretation. Thus, a one-standard-deviation increase in the unemployment ratio—that is, an increase of 0.410 in the absolute value of that ratio (see table 1)—reduces the flow of all migrants between *i* and *j* by a factor of 0.399 (see table 2), a decline of almost 60 percent.

Table 2. Effect of licensing on pooled 2014–16 interstate migration flows (exponentiated coefficients)

Item	Statistical measure	Population	Labor force	Labor force with at least a 4-year college degree	Labor force without a 4-year college degree	Labor force ages 25 to 39	Labor force ages 25 to 39 with at least a 4-year college degree	Labor force ages 25 to 39 without a 4-year college degree
Natural logarithm of distance between state *i* and state *j* (in miles)	**Coefficient (exponentiated)**	**0.45220**[1]	**0.47438**[1]	**0.53637**[1]	**0.40145**[1]	**0.49988**[1]	**0.55240**[1]	**0.42014**[1]
	Standard error	0.02034	0.02258	0.02349	0.02907	0.02450	0.02621	0.03384
	Lower value of 95-percent confidence interval	0.43451	0.45383	0.51222	0.37919	0.47643	0.52473	0.39314
	Upper value of 95-percent confidence interval	0.47058	0.49583	0.56163	0.42496	0.52446	0.58151	0.44891
Contiguous	**Coefficient (exponentiated)**	**1.85111**[1]	**1.93891**[1]	**1.87195**[1]	**1.91787**[1]	**2.08578**[1]	**1.99918**[1]	**2.07569**[1]
	Standard error	0.03237	0.03670	0.04034	0.04427	0.04027	0.04534	0.05161
	Lower value of 95-percent confidence interval	1.73736	1.80439	1.72966	1.75855	1.92756	1.82926	1.87618
	Upper value of 95-percent confidence interval	1.97238	2.08358	2.02603	2.09185	2.25716	2.18504	2.29683
Unemployment ratio	**Coefficient (exponentiated)**	**0.39889**[1]	**0.37530**[1]	**0.36115**[1]	**0.41813**[1]	**0.36264**[1]	**0.33665**[1]	**0.42544**[1]
	Standard error	0.09261	0.10665	0.12072	0.12570	0.11594	0.13353	0.14564
	Lower value of 95-percent confidence interval	0.33253	0.30435	0.28491	0.32656	0.28871	0.25889	0.31941
	Upper value of 95-percent confidence interval	0.47811	0.46236	0.45739	0.53460	0.45489	0.43704	0.56546
Real income ratio	**Coefficient (exponentiated)**	**1.11560**	**0.86312**	**0.67835**[2]	**1.51259**[2]	**0.65101**[2]	**0.53657**[1]	**1.19523**
	Standard error	0.10611	0.11877	0.12590	0.15061	0.13275	0.14597	0.17747
	Lower value of 95-percent confidence interval	0.90577	0.68349	0.52967	1.12517	0.50146	0.40267	0.84309
	Upper value of 95-percent confidence interval	1.37302	1.08877	0.86767	2.03073	0.84383	0.71364	1.69067
Amenities ratio	**Coefficient (exponentiated)**	**1.15040**[1]	**1.19935**[1]	**1.13214**[1]	**1.26728**[1]	**1.16685**[1]	**1.10218**[2]	**1.23655**[1]
	Standard error	0.02687	0.02952	0.03099	0.03761	0.03207	0.03420	0.04457
	Lower value of 95-percent confidence interval	1.09109	1.13160	1.06505	1.17671	1.09534	1.03023	1.13233
	Upper value of 95-percent confidence interval	1.21228	1.27045	1.20266	1.36369	1.24211	1.17810	1.34861
Licensing ratio	**Coefficient (exponentiated)**	**1.05816**	**0.99518**	**1.02622**	**0.98472**	**0.97740**	**1.03095**	**0.95225**
	Standard error	0.06917	0.07894	0.08964	0.09240	0.08862	0.10413	0.10832
	Lower value of 95-percent confidence interval	0.92399	0.85248	0.86079	0.82159	0.82146	0.84047	0.77000
	Upper value of 95-percent confidence interval	1.21180	1.16167	1.22324	1.18026	1.16273	1.26423	1.77420
Number of observations: 2,351								
Degrees of freedom: 2,249								

[1] $p < 0.001$.

[2] $p < 0.01$.

Note: Origin-state and destination-state fixed effects not shown. Exponentiated coefficients in bold. Labor force consists of people ages 25 to 64 unless otherwise indicated.
Source: U.S. Census Bureau, American Community Survey.

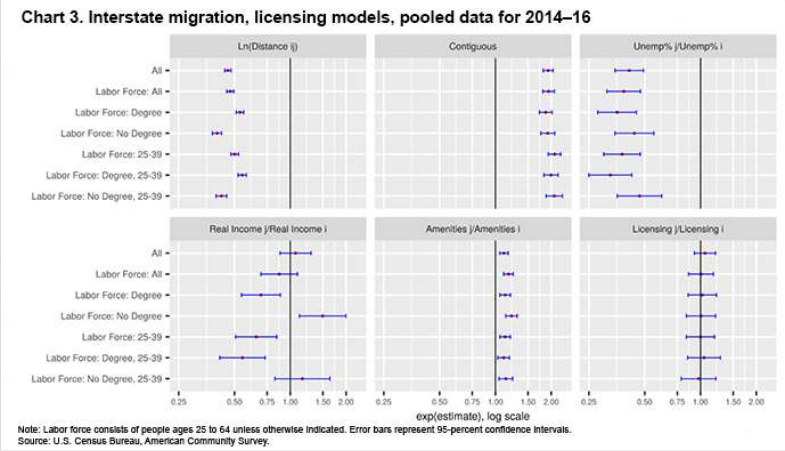
Item	Statistical measure	Population	Labor force	Labor force with at least a 4-year college degree	Labor force without a 4-year college degree	Labor force ages 25 to 39	Labor force ages 25 to 39 with at least a 4-year college degree	Labor force ages 25 to 39 without a 4-year college degree
Null deviance		14,156,051.1	5,113,054.8	2,657,120.9	2,797,241.6	3,182,559.7	1,870,095.9	1,586,568.8
Deviance		1,208,968.8	523,527.1	301,578.4	387,847.3	384,368.0	250,994.5	278,612.2

[1] $p < 0.001$.

[2] $p < 0.01$.

Note: Origin-state and destination-state fixed effects not shown. Exponentiated coefficients in bold. Labor force consists of people ages 25 to 64 unless otherwise indicated.
Source: U.S. Census Bureau, American Community Survey.

Chart 3 shows the coefficients and their confidence intervals to make it easier to compare the different effects across samples. As expected, migration declines with increasing distance and increases with contiguity. Distance is less of a barrier to migration for people with higher levels of human capital and for younger workers. The ratio control variables we used generally produced the expected results: High values of the unemployment rate ratio reduce migration flows between states, while high values of the amenity ratio boost flows. Th unemployment ratio effect is generally similar in magnitude across groups: about a 60-percent decline in the flow for a one-standard-deviation increase in the ratio. Amenity ratios boost migration flows by 10 to 22 percent for a one-standard-deviation increase in the ratio, having the strongest effect for workers without a college degree. The real-income effects align with recent research showing a divergence in the United States between high-skilled workers and low-skilled workers, both in economic terms and in migration patterns.[38] Workers without a college degree favor states where the real-income return to migration is positive. An increase in this ratio of one standard deviation increases their migration between *i* and *j* by almost 50 percent. Workers with a college degree often move to states where that return is lower than in their origin state, possibly because these states are more likely to offer jobs in growth industries or with better prospects for career mobility and income growth.



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The primary variable of interest, the ratio of licensing in the destination state to licensing in the origin state, has no effect on the flows of migrants from origins to destinations. Chart 3 shows that the parameter estimates for licensing across all seven models are close to a value of 1 (the baseline) with very large standard errors. The results are clear: We find that aggregate licensing rates do not affect the flow of people from one state to another. It is important to emphasize that these estimates are net of origin-state and destination-state fixed effects, which arguably address sources of unobserved heterogeneity, such as the occupational makeup of the labor force.

Discussion

Using robust standardized migration modeling procedures, this analysis finds no effect on interstate migration rates resulting from interstate variations in occupational licensing regimes. How do we explain this? First, we note that the early literature shows a link between licensing and migration, but the relationship becomes more tenuous in later studies. Although some of the change in estimates over time may be due to methodological improvements, it is also plausible that occupational licensing practices have become more uniform (or at least less burdensome). Indeed, many large professional occupations, such as nurses, teachers, and lawyers, have moved in this direction in recent years.[39] Second, attaining a license in a potential destination may not be difficult, especially compared with other, more important, factors shaping migration, such as the direct costs of moving a household, job opportunities, cost of living, family ties, and amenities. We conclude that licensing has essentially no effect because it is not that important of a factor compared with other spatial and locational determinants of migration flows accounted for in our gravity model.

These results contrast with a common and influential view that licensing hinders interstate migration, which negatively affects the efficiency of labor and housing markets, and that governments should therefore adjust these policies. We caution against such interventions being made on the basis of the presumed link between licensing and migration. Specifically, we are concerned about the likely unintended consequences, especially because many occupations are already engaged in rationalizing licensing regimes across states. We are also concerned that the present study may contribute to what we perceive as an overemphasis on licensing as the primary regulatory barrier to interstate migration. As stated in the introduction, state and local governments both explicitly and implicitly regulate migration in many ways, such as through child custody laws, zoning regulations, and residency requirements for employment.[40] The role of internal borders in restricting migration has been established in both India and the United States.[41] We are hopeful that by presenting evidence against any link between licensing and migration that interest can shift beyond this one policy impact to look at the broader role of states in regulating migration.

SUGGESTED CITATION:

Thomas J. Cooke, Mark Ellis, and Richard Wright, "Occupational licensing and interstate migration in the United States," *Monthly Labor Review,* U.S. Bureau of Labor Statistics, August 2022, https://doi.org/10.21916/mlr.2022.22

[1] See Thomas J. Cooke, Clara H. Mulder, and Michael Thomas, "Union dissolution and migration," *Demographic Research*, vol. 34, no. 26 (April 2016), pp. 741–60, especially p. 746, https://www.demographic-research.org/volumes/vol34/26/34-26.pdf.

[2] See David Schleicher, "Stuck! The law and economics of residential stagnation," *Yale Law Journal*, vol. 127, no. 1 (October 2017), pp. 78–154, https://www.yalelawjournal.org/article/stuck-the-law-and-economics-of-residential-stagnation.

[3] See Mark Ellis, Richard Wright, and Matthew Townley, "State-scale immigration enforcement and Latino interstate migration in the United States," *Annals of the American Association of Geographers*, vol. 106, no. 4 (March 2016), pp. 891–908, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7526940/pdf/nihms-1590893.pdf.

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February 27, 2023

To: House Committee On Behavioral Health and Health Care

Fr: Nancy Schuberg, Executive Director, Occupational Therapy Licensing Board (OTLB)

RE: Opposition of HB 2736 – Enactment of the OT Compact

At the February 24, 2023, Board meeting, the Occupational Therapy Licensing Board voted unanimously to request approval to Oppose HB 2736. Permission was granted from the Governor's office on February 27, 2023 to Oppose the bill.

The OTLB already achieves most of the compact benefits described in the public hearing:

- Unlike other states, Oregon OTLB processes applications very quickly and most licenses are issued within 24 hours of receiving all the required documents. We provide updates to applicants on their application status and we respond immediately to any questions. As a result, the OTLB has customer service ratings of 98% good or excellent.
- Unlike other states, Oregon State law already requires, and OTLB has adopted rules to expediate licensing for military spouses.
- Information sharing and portability: The National Health Practitioners databank and the NBCOT Action Exchange are already in place and OTLB can check for past discipline that has occurred.
- Public Protection: The OTLB already requires FBI fingerprint background checks for all new applicants and runs LEDS background checks on all licensees prior to renewals.

Fiscal Impact: The OTLB's budget is "Other" funds. The board is self-supported through licensure and related fees. Currently the OT Licensing Board is having raise fees in 23-25 to sustain its operations through 2029, this includes reducing FTE from 1.65 to 1.5 to lower the budget. There are no reserves. The potential impact would likely require further fee increases for Oregon licensees in 25-27 or 27-29. **Oregon licensed OTs and OTAs** will be required to make up the money that is being paid to the compact commission instead of the OTLB, plus the money saved by the licensees benefitting from the compact.

Staff Capacity: With only 1.5 FTE, significant staff time will be required to implement, manage and field questions about the compact. There is also staff/board counsel/board time to adopt rules and update them annually. A board member or administrator from every member state of the compact must be a delegate on the compact commission. Enacting the compact could potentially create more discipline cases as a result of people getting confused about the rules/laws of the compact.

Lack of control over licensing standards: The OTLB must rely on other states to determine if a licensee working under a compact privilege in Oregon is fit to practice. There are also significant legal risks to the state from joining the OT compact.

While there may be additional benefits in joining the OT Compact, until the Compact is implemented more broadly and there is a better idea of the participation costs and specific benefits, the board feels there is not a driver for adoption at this time, and further, adoption could result in greater burden on Oregon OT licensees through increased fees and reduced service levels, the opposite of the intention of the bill. And the underlying problems a Compact is designed to solve, long wait times for state licensure and a pathway for licensure for military spouses, are not current issues in Oregon.

If you have any question, please do not hesitate to contact me at 971-673-0198.

FISCAL IMPACT OF PROPOSED LEGISLATION **Measure: HB 2736**

82nd Oregon Legislative Assembly – 2023 Regular Session
Legislative Fiscal Office
Only Impacts on Original or Engrossed Versions are Considered Official

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Prepared by: Tim Walker
Reviewed by: Haylee Morse-Miller
Date: 02/24/2023

Measure Description:
Enacts interstate Occupational Therapy Licensure Compact.

Government Unit(s) Affected:
Occupational Therapy Licensing Board

Summary of Fiscal Impact:
Costs related to the measure may require budgetary action - See analysis.

Analysis: This measure enacts the Occupational Therapy Licensure Compact, which allows Occupational Therapists and Occupational Therapy Assistants to be licensed in their home state and to practice in other states by compact privilege, either in-person or via telehealth. Compact licensees must meet any jurisprudence requirements established by the remote state but bypass the continuing education and general requirements in the remote state; compact licensees are required to meet continuing education, background check, and other requirements as part of their home state licensing process. States may choose to charge a fee to grant compact privilege.

The measure also establishes the Occupational Therapy Compact Commission. Each state must send a delegate to the Commission, which meets at least annually, and the Commission may levy and collect an annual assessment from each member state, or impose fees on other parties, to cover the cost of Commission activities and operations.

The measure modifies allowable uses for funds in the Oregon Occupational Therapy Licensing Board Account to include use of funds for the purpose of meeting the financial obligations imposed on the State of Oregon as a result of the state's participation in the Occupational Therapy Licensure Compact. This applies to moneys received by OTLB on and after the operative date of the measure. Any assessments levied, or financial obligations imposed under the compact are effective against the State only to the extent that moneys necessary to pay the financial obligation have been deposited in the Occupational Therapy Licensing Board Account.

The measure takes effect on the 91st day after the Legislature adjourns sine die and is largely operative on January 1, 2024.

The Occupational Therapy Licensing Board (OTLB) anticipates a loss of renewal income, endorsement application fee income, and revenue from active licensees who live out of state and use telehealth. OTLB currently licenses a total of 2,680 Occupational Therapists, 634 of which reside outside of Oregon. For the purposes of this fiscal, OTLB assumed that only residents in the neighboring states of Washington and Idaho would choose compact licensure, as well as half of licensees who live outside of the state and practice via telehealth. OTLB estimates a total loss of revenue of $51,800. Compact privileges for licensees are anticipated to be available in late 2023 or early 2024, so the Board anticipates that the full effect of this loss of revenue will not be felt until the 2025-27 biennium.

This loss of income would be partially offset by an increase in privilege to practice fees, which are fees that a remote state may charge privilege holders for working in Oregon. OTLB notes that the Compact Commission does not have a required amount for this fee but that it must be reasonable. For the purposes of this fiscal, OTLB assumes a fee of $75 though the fee has not yet been set; the average amount charged by Boards in other states is $58. A privilege to practice fee of $75 would offset the revenue loss by approximately $18,240, so the Board's total loss of revenue under these assumptions would total approximately $33,560.

OTLB has proposed a fee increase to cover operations in the current biennium. OTLB may need to raise fees in future biennia to cover the loss of revenue and additional costs generated by Compact licensure. The Board currently does not have an ending fund balance to cover the additional expenses or lost revenue.
The annual fee payable to the Compact Commission is not reflected in the fiscal since it has not been officially set by the Compact. Additionally, the Board will be required to send a board member or administrator to an annual commission meeting. It is unclear if the Compact or the Board would be required to cover this cost. OTLB also notes that licensees seeking compact privilege must pay a fee to the Commission to work in a remote state, and that the Occupational Therapy Compact Commission then will send a monthly check to the states for the practice fees collected, though this transfer of funds does not seem to be specifically addressed in this legislation.

This measure warrants a subsequent referral to the Joint Committee on Ways and Means for consideration of its impact on the OTLB Budget.

818-042-0050
Taking of X-Rays — Exposing of Radiographic Images

(1) A Licensee may authorize the following persons to place films/sensors, adjust equipment preparatory to exposing films/sensors, and expose the films and create the images under general supervision:

(a) A dental assistant certified by the Board in radiologic proficiency; or

(b) A radiologic technologist licensed by the Oregon Board of Medical Imaging and certified by the Oregon Board of Dentistry (OBD) who has completed ten (10) clock hours in a Board approved dental radiology course.

(2) A licensee may authorize a dental assistant who has completed a course of instruction approved by the Oregon Board of Dentistry, and who has passed the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry to place films/sensors, adjust equipment preparatory to exposing films/sensors, and expose the films and create the images under the indirect supervision of a dentist, dental therapist, dental hygienist, or dental assistant who holds an Oregon Radiologic Proficiency Certificate. The dental assistant must submit within six months, certification by an Oregon licensed dentist, dental therapist or dental hygienist that the assistant is proficient to take radiographic images.

(3) A dental therapist may not order a computerized tomography scan

818-042-0060
Certification — Radiologic Proficiency

(1) The Board may certify a dental assistant in radiologic proficiency by credential in accordance with OAR 818-042-0120, or if the assistant:

(2) Submits an application on a form approved by the Board, pays the application fee and:

(a) Completes a course of instruction approved by the Oregon Board of Dentistry, in accordance with OAR 333-106-0055 or submits evidence that the Oregon Health Authority, Center for Health Protection, Radiation Protection Services recognizes that the equivalent training has been successfully completed;

(b) Passes the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, Inc. (DANB), or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry; and

(c) Certification by an Oregon licensee that the assistant is proficient to take radiographs.

The proposed solution to this issue is to remove the requirement for a licensee to complete subsection (b):

(b) Passes the written Dental Radiation Health and Safety Examination administered by the Dental Assisting National Board, Inc. (DANB), or comparable exam administered by any other testing entity authorized by the Board, or other comparable requirements approved by the Oregon Board of Dentistry; and

333-106-0055
General Requirements: X-ray Operator Training

(1) The registrant shall assure that individuals who will be operating the X-ray equipment by physically positioning patients or animals, determining exposure parameters, or applying radiation for diagnostic purposes shall have adequate training in radiation safety.

(a) Radiation safety training records shall be maintained by the registrant for each individual who operates X-ray equipment. Records must be legible and meet the requirements in OAR 333-120-0690.

(b) When requested by the Authority, radiation safety training records shall be made available.

(2) Dental X-ray operators who meet the following requirements are considered to have met the requirements in section (1) of this rule:

(a) Currently licensed by the Oregon Board of Dentistry as a dentist, dental therapist, or dental hygienist; or

(b) Is a dental assistant who is certified by the Oregon Board of Dentistry in radiologic proficiency.

(c) Dental radiology students in an approved Oregon Board of Dentistry dental radiology course are permitted to take dental radiographs on human patients during their clinical training, under the direct supervision of a dentist, dental therapist, or dental hygienist currently licensed, or a dental assistant who has been certified in radiologic proficiency by the Oregon Board of Dentistry.

(3) Veterinary X-ray operators who meet the following requirements are considered to have met the requirements in section (1) of this rule:

(a) Currently licensed by the Oregon Veterinary Medical Examining Board as a veterinarian or a certified veterinary technician.

(b) Veterinary students enrolled in a radiology course approved by the Oregon Veterinary Medical Examining Board are permitted to take radiographs on animal patients during their clinical training under the direct supervision of a veterinarian or a certified veterinary technician who is currently licensed.

(4) Diagnostic medical X-ray operators who meet the following requirements are considered to have met the requirements of section (1) of this rule:

(a) Holds a current license from the Oregon Board of Medical Imaging; or

(b) Holds a current limited X-ray machine operator permit from the Oregon Board of Medical Imaging; or

(c) Is a student in an approved school of Radiologic Technology as defined in ORS 688.405 while practicing Radiologic Technology under the direct supervision of a radiologist who is currently licensed with the Oregon Medical Board or a radiologic technologist who is licensed with the Oregon Board of Medical Imaging; or

(d) Is a student in an Oregon Board of Medical Imaging approved limited permit program under a radiologic technologist who is licensed by the Oregon Board of Medical Imaging.

(5) All other types of X-ray operators must have completed an Authority approved radiation use and safety course.

(6) At a minimum, an Authority approved training course shall cover the following subjects:

(a) Nature of X-rays:

(A) Interaction of X-rays with matter;

(B) Radiation units;

(C) X-ray production;

(D) Biological effects of X-rays; and

(E) Risks of radiation exposure.

(b) Principles of the X-ray machine:

(A) External structures and operating console;

(B) Internal structures:

(i) Anode; and

(ii) Cathode.

(C) Operation of an X-ray machine;

(D) Tube warm up;

(E) Factors affecting X-ray emission:

(i) mA;

(ii) kVp;

(iii) Filtration; and

(iv) Voltage waveform.

(c) Principles of radiation protection:

(A) Collimation;

(B) Types of personal protection equipment and who must wear it;

(C) ALARA;

(D) Time, distance, shielding;

(E) Operator safety;

(F) Personal dosimetry:

(i) Types of dosimetry;

(ii) Proper placement of dosimetry; and

(iii) Situations that require dosimetry.

(G) Occupational and non-occupational dose limits.

(d) Radiographic technique:

(A) Factors affecting technique choice:

(i) Thickness of part;

(ii) Body composition;

(iii) Pathology; and

(iv) Film versus computed radiography (CR) and digital radiography (DR).

(B) How to develop an accurate chart;

(C) Low dose techniques;

(D) Pediatric techniques (does not apply to veterinary); and

(E) AEC Techniques.

(e) Darkroom:

(A) Safelights;

(B) Chemical storage;

(C) Film storage; and

(D) Darkroom cleanliness.

(f) Image processing:

(A) Automatic film processing;

(B) Dip tank film processing;

(C) Computed radiography (CR) processing; and

(D) Digital radiography (DR) processing.

(g) Image critique:

(A) Reading room conditions;

(B) Light box conditions;

(C) Image identification;

(D) Artifacts;

(E) Exposure indicators for CR and DR;

(F) Technical parameter evaluation; and

(G) Positioning evaluation.

(h) Veterinary X-ray use (for veterinary courses only):

(A) Types of animal restraints;

(B) Small animal versus large animal;

(C) Film holders; and

(D) Portable X-ray machine safety.

(i) Applicable federal and state radiation regulations including those portions of chapter 333, divisions 100, 101, 103, 106, 111, 120, and 124.

(7) In addition to the training outlined in section (6) of this rule, medical X-ray equipment operators using diagnostic radiographic equipment on human patients, and who are not regulated by the Oregon Board of Medical Imaging, must have 100 hours or more of instruction in radiologic technology including, but not limited to:

(a) Anatomy physiology, patient positioning, exposure and technique; and

(b) Appropriate types of X-ray examinations that the individual will be performing; and in addition

(c) Receive 200 hours or more of X-ray laboratory instruction and practice in the actual use of an energized X-ray unit, setting techniques and practicing positioning of the appropriate diagnostic radiographic procedures that they intend to administer.

(8) All X-ray operators shall be able to demonstrate competency in the safe use of the X-ray equipment and associated X-ray procedures.

(9) When required by the Authority, applications training must be provided to the operator before use of X-ray equipment on patients.

(a) Records of this training must be maintained and made available to the Authority for inspection.

(b) The training may be in any format such as hands-on training by a manufacturer’s representative, video or DVD instruction, or a training manual.

(10) X-ray equipment operators who have received their radiation safety training outside of Oregon will be considered to have met the training requirements in section (5) of this rule, if the Authority's or applicable Oregon Licensing Board's evaluation of their training or training and experience, reveals that they substantially meet the intent of section (6) of this rule.

(22) Perform periodontal assessment.

(23) Place or remove healing caps or healing abutments, except under direct supervision.

(24) Place implant impression copings, except under direct supervision.

(25) Any act in violation of Board statute or rules.

333-106-0055
General Requirements: X-ray Operator Training

(1) The registrant shall assure that individuals who will be operating the X-ray equipment by physically positioning patients or animals, determining exposure parameters, or applying radiation for diagnostic purposes shall have adequate training in radiation safety.

(a) Radiation safety training records shall be maintained by the registrant for each individual who operates X-ray equipment. Records must be legible and meet the requirements in OAR 333-120-0690.

(b) When requested by the Authority, radiation safety training records shall be made available.

(2) Dental X-ray operators who meet the following requirements are considered to have met the requirements in section (1) of this rule:

(a) Currently licensed by the Oregon Board of Dentistry as a dentist, dental therapist, or dental hygienist; or

(b) Is a dental assistant who is certified by the Oregon Board of Dentistry in radiologic proficiency.

(c) Dental radiology students in an approved Oregon Board of Dentistry dental radiology course are permitted to take dental radiographs on human patients during their clinical training, under the direct supervision of a dentist, dental therapist, or dental hygienist currently licensed, or a dental assistant who has been certified in radiologic proficiency by the Oregon Board of Dentistry.

(3) Veterinary X-ray operators who meet the following requirements are considered to have met the requirements in section (1) of this rule:

(a) Currently licensed by the Oregon Veterinary Medical Examining Board as a veterinarian or a certified veterinary technician.

(b) Veterinary students enrolled in a radiology course approved by the Oregon Veterinary Medical Examining Board are permitted to take radiographs on animal patients during their clinical training under the direct supervision of a veterinarian or a certified veterinary technician who is currently licensed.

(4) Diagnostic medical X-ray operators who meet the following requirements are considered to have met the requirements of section (1) of this rule:

(a) Holds a current license from the Oregon Board of Medical Imaging; or

(b) Holds a current limited X-ray machine operator permit from the Oregon Board of Medical Imaging; or

(c) Is a student in an approved school of Radiologic Technology as defined in ORS 688.405 while practicing Radiologic Technology under the direct supervision of a radiologist who is currently licensed with the Oregon Medical Board or a radiologic technologist who is licensed with the Oregon Board of Medical Imaging; or

(d) Is a student in an Oregon Board of Medical Imaging approved limited permit program under a radiologic technologist who is licensed by the Oregon Board of Medical Imaging.

(5) All other types of X-ray operators must have completed an Authority approved radiation use and safety course.

(6) At a minimum, an Authority approved training course shall cover the following subjects:

(a) Nature of X-rays:

(A) Interaction of X-rays with matter;

(B) Radiation units;

(C) X-ray production;

(D) Biological effects of X-rays; and

(E) Risks of radiation exposure.

(b) Principles of the X-ray machine:

(A) External structures and operating console;

(B) Internal structures:

(i) Anode; and

(ii) Cathode.

(C) Operation of an X-ray machine;

(D) Tube warm up;

(E) Factors affecting X-ray emission:

(i) mA;

(ii) kVp;

(iii) Filtration; and

(iv) Voltage waveform.

(c) Principles of radiation protection:

(A) Collimation;

(B) Types of personal protection equipment and who must wear it;

(C) ALARA;

(D) Time, distance, shielding;

(E) Operator safety;

(F) Personal dosimetry:

(i) Types of dosimetry;

(ii) Proper placement of dosimetry; and

(iii) Situations that require dosimetry.

(G) Occupational and non-occupational dose limits.

(d) Radiographic technique:

(A) Factors affecting technique choice:

(i) Thickness of part;

(ii) Body composition;

(iii) Pathology; and

(iv) Film versus computed radiography (CR) and digital radiography (DR).

(B) How to develop an accurate chart;

(C) Low dose techniques;

(D) Pediatric techniques (does not apply to veterinary); and

(E) AEC Techniques.

(e) Darkroom:

(A) Safelights;

(B) Chemical storage;

(C) Film storage; and

(D) Darkroom cleanliness.

(f) Image processing:

(A) Automatic film processing;

(B) Dip tank film processing;

(C) Computed radiography (CR) processing; and

(D) Digital radiography (DR) processing.

(g) Image critique:

(A) Reading room conditions;

(B) Light box conditions;

(C) Image identification;

(D) Artifacts;

(E) Exposure indicators for CR and DR;

(F) Technical parameter evaluation; and

(G) Positioning evaluation.

(h) Veterinary X-ray use (for veterinary courses only):

(A) Types of animal restraints;

(B) Small animal versus large animal;

(C) Film holders; and

(D) Portable X-ray machine safety.

(i) Applicable federal and state radiation regulations including those portions of chapter 333, divisions 100, 101, 103, 106, 111, 120, and 124.

(7) In addition to the training outlined in section (6) of this rule, medical X-ray equipment operators using diagnostic radiographic equipment on human patients, and who are not regulated by the Oregon Board of Medical Imaging, must have 100 hours or more of instruction in radiologic technology including, but not limited to:

(a) Anatomy physiology, patient positioning, exposure and technique; and

(b) Appropriate types of X-ray examinations that the individual will be performing; and in addition

(c) Receive 200 hours or more of X-ray laboratory instruction and practice in the actual use of an energized X-ray unit, setting techniques and practicing positioning of the appropriate diagnostic radiographic procedures that they intend to administer.

(8) All X-ray operators shall be able to demonstrate competency in the safe use of the X-ray equipment and associated X-ray procedures.

(9) When required by the Authority, applications training must be provided to the operator before use of X-ray equipment on patients.

(a) Records of this training must be maintained and made available to the Authority for inspection.

(b) The training may be in any format such as hands-on training by a manufacturer’s representative, video or DVD instruction, or a training manual.

(10) X-ray equipment operators who have received their radiation safety training outside of Oregon will be considered to have met the training requirements in section (5) of this rule, if the Authority's or applicable Oregon Licensing Board's evaluation of their training or training and experience, reveals that they substantially meet the intent of section (6) of this rule.

DANB
Dental Assisting National Board

This application packet includes applications for the following:

- **Oregon Radiologic Proficiency** (ORCR) certificate – Pathway I

When applying for a DANB-issued state certificate, you are responsible for reading, understanding, and complying with the policies and procedures in the ***State Candidate Handbook*****,** available at www.danb.org/About-DANB/Forms-Used-on-This-Site.aspx.

DANB accepts 2022 applications through Dec. 31, 2022.

Eligibility Pathways for Radiologic Proficiency Certificate in Oregon

Performance of radiography procedures by dental assistants is regulated by the Oregon Board of Dentistry (OBD) and requires that dental assistants earn a certificate in radiologic proficiency. The Dental Assisting National Board, Inc. (DANB), on behalf of the OBD, administers the Radiologic Proficiency Certificate program, a service that includes providing information regarding exams and certificates, distributing materials, administering the required exam, and issuing certificates.

A dental assistant must meet the following requirements to earn an Oregon Radiologic Proficiency Certificate:

Pathway I

1. Complete an Oregon Board of Dentistry-approved course of instruction in radiography

   Acceptable documentation includes:
   - Copy of transcript, diploma, radiology course completion certificate OR
   - Signed and dated letter (on letterhead) from a school/course provider verifying completion of the radiology course

AND

2. Pass the DANB Radiation Health and Safety (RHS®) exam

   Documentation of passing is already on file with DANB and does not need to be submitted.

AND THEN

3. Obtain verification from an Oregon licensed dentist or dental hygienist that the dental assistant is proficient to take radiographs within six months of first being authorized to take radiographs*

   **A dentist or dental hygienist may authorize a dental assistant who has completed the course and written exam requirements to perform radiographic procedures under the indirect supervision of a dentist, dental hygienist or dental assistant who holds an Oregon Radiologic Proficiency Certificate; the dental assistant must submit verification of proficiency within six months of first being authorized to perform radiography.*

AND THEN

4. Apply to DANB for the Oregon Radiologic Proficiency Certificate.

Pathway II

1. Be certified in radiography in another state that has training and certification requirements substantially similar to Oregon's requirements

   OR

   Obtain verification from a licensed dentist of having been employed for at least 1,000 hours (outside the state of Oregon) in the past two years as a dental assistant taking radiographs

AND THEN

2. Apply to DANB for the Oregon Radiologic Proficiency Certificate.

Inquiries regarding exams, certificates, eligibility requirements and applications should be addressed to DANB.

Inquiries regarding the state dental practice act should be addressed to: Oregon Board of Dentistry, 1500 SW 1st Ave., Ste. #770, Portland, OR 97201; 1-971-673-3200.

Application Statements

Please read the following Application Statements carefully. The Application Statements apply to all DANB-administered national and state-specific exams, certificate and certification renewal applications. The candidate's signature on the application indicates understanding and agreement to be legally bound by these statements.

1. I hereby apply to the Dental Assisting National Board, Inc. (DANB) for examination, a certificate and/or certification, in accordance with and subject to the procedures and policies of DANB and the regulations and requirements of any state agency on behalf of which DANB administers an exam or certificate program. Under penalty of perjury, I declare that the information provided on my application is true. I have read and agree to the requirements and conditions set forth in the DANB application packet, and the Candidate Handbook or State Candidate Handbook if applicable, covering eligibility for and the administration of exams, certificates, the certification process, and DANB policies, including but not limited to DANB's Code of Professional Conduct and DANB's Disciplinary Policy & Procedures. I agree to disqualification from the exam, to denial of an exam result, certificate or certification, and to forfeiture and return to DANB of any exam result, certificate granted me by DANB, in the event that any of the answers or statements made by me in this application are false, or in the event that I violate any DANB rules or policies. I agree to comply with any investigation in which I am named, and I authorize DANB to make whatever inquiries and investigations it deems necessary to verify my eligibility, credentials or professional standing.
2. I hereby release DANB, its directors, officers, examiners and agents from any and all liability arising out of or in connection with any action or omission by any of them in connection with this application, the certification process, any exam administered by DANB, any scoring relating thereto, the failure to issue me an exam result, certificate, or any demand for forfeiture or return of such exam result, certificate, and I agree to indemnify DANB and said persons and hold them harmless from any lawsuit, complaint, claim, loss, damage, cost or expense, including attorneys' fees, arising out of or in connection with said credentialing activities which include all DANB-administered exams and certificates. I UNDERSTAND THAT THE DECISION AS TO WHETHER I HAVE MET REQUIREMENTS FOR ADMISSION TO A DANB-ADMINISTERED EXAM OR RECEIPT OF A DANB-ADMINISTERED EXAM RESULT, CERTIFICATE OR CERTIFICATION RESTS SOLELY AND EXCLUSIVELY WITH DANB AND THAT THE DECISION OF DANB IS FINAL. Notwithstanding the above, should I file suit against DANB, I agree that any such action shall be governed by and construed under the laws of the State of Illinois without regard to conflicts of law. I further agree that any such action shall be brought in the Circuit Court of Cook County in the State of Illinois, or the United States District Court for the Northern District of Illinois; I consent to the jurisdiction of such state and federal courts; and I agree that the venue of such courts is proper. I further agree that should I not prevail in any such action, DANB shall be entitled to all costs, including reasonable attorneys' fees, incurred in connection with the litigation.
3. I understand that except as provided below, this application and any information or material received or generated by DANB in connection with this application or the exam process will be kept confidential and will not be released unless I have authorized such release or the release is required by law. I understand that DANB will verify receipt of any DANB exam application and the date received, on request. I further understand and agree that DANB may also provide verification to anyone by phone, by mail or on DANB's website regarding whether I hold any DANB certifications, any DANB certificates of knowledge-based competence and any state-specific certificates administered by DANB on behalf of a state, regulatory body. Phone and mail verification will be provided to anyone upon request and will consist of oral or written confirmation of whether I hold any DANB-administered credentials and the effective dates for each credential. Online verification through DANB's website may consist of online display of my name, the DANB-administered credentials I hold and dates earned, current DANB certification status, and my city and state of residence. My full address will not be posted online by DANB. I further understand and agree that DANB may, from time to time, provide my name, address, phone number to third parties (including but not limited to official DANB affiliates, potential employers; dental conference sponsors; federal, national or state organizations; or legislative committees or task forces proposing or information stakeholders of legislation). I further understand that this consent will remain in effect unless and until I submit a written request to have this information omitted from release. I understand that if I do not want DANB to display my city and state of residence as part of the online verification process, then I must submit a written request for omission of this information to the following address: DANB Communications Department, 444 N. Michigan Ave., Suite 900, Chicago, IL 60611. I understand that my name, credentials held [issued by DANB as described above] and current DANB certification status will be displayed for everyone; opting out of display of information is only possible for an individual's city and state.
4. I understand that by providing my email address on the application form, or by providing it through my online DANB account, I am consenting to receive email messages from DANB and its official affiliates related to their products and services or news affecting the oral healthcare profession. I understand that DANB agrees not to provide my email address to any other third party, excluding federal, national or state regulatory bodies, without my consent, and that I can request removal from DANB's email distribution list by following the directions contained in the Privacy Policy section of DANB's Terms and Conditions of Use of DANB.org, located at www.danb.org.
5. I authorize DANB to release my exam results and credential status to state regulatory agencies. Individuals cannot opt out of DANB release of exam results or credential status to state regulatory agencies. I also authorize DANB to use information from my application and exam(s) for statistical analysis, providing that any personal identification is deleted.
6. I understand that I can be disqualified from taking or continuing to sit for an exam, from receiving exam results or certificate and from obtaining certification if DANB determines through proctor observation, statistical analysis or any other means that I was engaged in collaborative, disruptive or other unacceptable behavior before, during the administration of, or following the exam.
7. I understand that the content of all DANB exams is proprietary and strictly confidential information. I hereby agree that I will not disclose, either directly or indirectly, any question or any part of any question from the exam to any person or entity. I understand that the unauthorized receipt, retention, possession, copying or disclosure of any DANB exam materials, including but not limited to the content of any exam question, before, during or after the exam may subject me to legal action. Such legal action may result in monetary damages and/ or disciplinary action including rescinding exam results and denying or revoking certification. I agree to comply with any investigation regarding my behavior, acts or omissions, related to DANB exams, certificates and/or certifications.
8. I understand that for each application submitted, DANB will process the appropriate payment. If I fail to show up for an exam for which I have applied, and there is no documented DANB-accepted emergency, and I failed to comply with DANB cancellation policies, I am still obligated to pay the full exam fee. I further understand that taking the exam and then revoking payment constitutes the wrongful use of DANB products and services and I may be subjected to legal action. I am obligated to pay for the exam whether I pass or fail. I agree not to dispute the exam fee. Exam results will be rescinded if the exam fee is not paid in full.

2022 Oregon Radiologic Proficiency Certificate Application – Pathway I

This application will be accepted through Dec. 31, 2022.

Candidate must sign, date and submit all required documentation and nonrefundable certificate fee to DANB. **Incomplete applications will be denied.**

Required documents include:
a. Proof of completion of OBD-approved radiology course
b. Completed and signed Radiologic Proficiency Verification form (see page 5)

OR-RAD1 Certificate
3884c10

Mail or fax completed application and supporting documentation to DANB. Full payment is required at the time of application

Section A: Signature and Date (Please sign and date with a pen.)

I hereby affirm that my answers to all questions are true and correct, I have met all eligibility requirements, and I will comply with all DANB and OBD policies and procedures. I further affirm that I have read and understood the Application Statements contained in this packet, and I intend to be legally bound by them. I understand that the certificate fee is not refundable under any circumstances. I hereby apply in accordance with the rules and regulations governing the certificate. I hereby agree that prior or subsequent to issuance, the OBD or DANB may investigate my eligibility and may refuse to issue the certificate and such refusal may not and shall not be questioned by me in any court of law or equity or other tribunal, nor shall I have any claim in the event of such refusal to a return of the certificate fee accompanying the application.

Signature

Date

Section B: Candidate Information (Please type or print with a pen.)

Last Four SSN

Date of Birth

Name (**must match current ID exactly**):

Last First Middle Name/Initial

Prior Name (if applicable) Email **(required)**

Home Address City State Zip

Phone Numbers **(at least one is required)**:

Office Home Cell

Section C: Eligibility Requirements

CODA-Accredited Program Code

See https://www.danb.org/en/The-Dental-Community/Dental-Assistants/Dental-Assisting-Programs/CODA-Accredited-Dental-Assisting-Programs.aspx

Oregon Approved-Radiography Course Code

See https://www.oregon.gov/dentistry/Pages/dental-assistants.aspx for a list of instructors approved by the Oregon Board of Dentistry

Section D: Payment (Please type or print with a pen.)

☐ Check/Money Order payable to DANB (must include candidate's name and be in U.S. dollars)

☐ Credit Card Authorization (VISA, MasterCard, Discover & American Express accepted): Amount **$50.00**

OR-CR Certificate
3884c10

Credit Card Number CVV Expiration /

Cardholder's Name

Cardholder's Billing Address City

State Zip Daytime Phone Number

Cardholder's Signature

By signing, the cardholder acknowledges intent to apply for the certificate shown above in the amount of the total shown hereon and agrees to perform the obligations set forth in the cardholder's agreement with the issuer. (See the *Application Statements* for further requirements.)

2022 Radiologic Proficiency Verification Form

This form will be accepted through Dec. 31, 2022.

Must be filled out completely by dentist or dental hygienist licensed in the state of Oregon.

A dentist or dental hygienist may authorize a dental assistant who has completed the course and written exam requirements to perform radiographic procedures under the indirect supervision of a dentist, dental hygienist or dental assistant who holds an Oregon Radiologic Proficiency Certificate. The applicant for the Oregon Clinical Radiologic Proficiency Certificate must submit this form within six months of first being authorized by a licensed dentist or dental hygienist to expose radiographs.

Section A: Dentist of Dental Hygienist's Information

Licensed Dentist's or Hygienist's Name

Email (required)

License Number

Phone number

Dental Practice Address

City

State

Zip

Section B: Work Experience

A licensed dentist or dental hygienist, licensed in the state of Oregon (license will be verified by DANB staff), can assess the proficiency of a dental assistant to take radiographs in the state of Oregon.

Candidate's Name

By signing this form, I attest that the above-named candidate is proficient in taking radiographs.

Dentist/Dental Hygienist's Signature

Date

DANB • 444 N. Michigan Ave., Suite 900 • Chicago, IL 60611
Questions? 800-367-3262 or danbmail@danb.org
Fax: 312-642-8507
Do not submit twice or you will be charged twice.

Application Checklist

Have you:

- ☐ Read the instructions and information in this application packet?
- ☐ Read and agreed to be bound by Oregon and DANB rules, regulations, policies and procedures as noted in this application packet? (See *Application Statements*, p. 3)
- ☐ Enclosed a completed certificate application, including:
    - o Candidate Information section completed in its entirety?
    - o Signature and date?
    - o Proof of completion of a course of instruction in radiography?
    - o Completed and signed Radiologic Proficiency Verification form
- ☐ Enclosed the certificate fee or provided credit card information?
- ☐ Made a copy of your entire application packet for your records?
- ☐ Addressed your envelope OR prepared your information to be faxed?

Mail to:
Dental Assisting National Board, Inc. (DANB)
444 N. Michigan Ave., Suite 900
Chicago, IL 60611

Fax credit card payments only to:
DANB
1-312-642-8507

If you have not:

• completed the application in full,
• enclosed, signed and dated your application,
• included required supporting documentation, and
• provided payment (check, money order, cashier's check) or payment information (credit card)

your application will be considered incomplete and will not be processed.

Incomplete certificate applications will be denied, and the $50 nonrefundable certificate fee will be retained by DANB.

Add to the Next (2021) Licensing, Standards and Competency Committee Meeting Agenda

At the October 7, 2020 Licensing, Standards and Competency Committee meeting. These 3 items were moved to this meeting's agenda. The logic behind it was that due to the covid-19 pandemic gripping the country, it was not a good idea to add more barriers into the rules because there already was a dental assistant worker shortage in Oregon. (SP)

At 10/7/2020 Lic Meeting- All 3 of these motions were made and at the 10/23/2020 Board Meeting the Board voted to move them to this Committee Meeting agenda.

Goin moved and Dr. Pham seconded that the Committee recommend that the Board move OAR 818-042-0080 as presented to the next regularly scheduled Licensing, Standards and Competency Meeting for further review. The motion passed unanimously.

818-042-0080

Certification — Expanded Function Dental Assistant (EFDA)

The Board may certify a dental assistant as an expanded function assistant:

(1) By credential in accordance with OAR 818-042-0120, or

(2) If the assistant submits a completed application, pays the fee and provides evidence of;

(a) Certification of Radiologic Proficiency (OAR 818-042-0060); and satisfactory completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association; or

(b) Certification of Radiologic Proficiency (OAR 818-042-0060); and passage of the Oregon Basic, Infection Control or Certified Dental Assisting (CDA) examination, and the Expanded Function Dental Assistant examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board; and certification by a**n Oregon** licensed dentist that the applicant has successfully polished six (6) amalgam or composite surfaces, removed supra-gingival excess cement from four (4) crowns and/or fixed partial dentures (bridges) with hand instruments; placed temporary restorative material in three (3) teeth; preliminarily fitted four (4) crowns to check contacts or to adjust occlusion outside the mouth; removed four (4) temporary crowns for final cementation and cleaned teeth for final cementation; fabricated four (4) temporary crowns and/or fixed partial dentures (bridges) and temporarily cemented the crowns and/or fixed partial dentures (bridges); polished the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis in six (6) patients; placed matrix bands on four (4) teeth prepared for Class II restorations. **The dental assistant must submit within six months' certification by a licensed dentist**

that the dental assistant is proficient to perform all the expanded function duties in subsection (b). If no expanded function certificate is issued within the six months, the dental assistant is no longer able to continue to perform expanded function duties until EFDA certification is achieved.

Dr. Pham moved and Dr. Goin seconded that the Committee recommend that the Board move OAR 818-042-0110 as amended to the next regularly scheduled Licensing, Standards and Competency Meeting for further review. The motion passed unanimously.

818-042-0110

Certification— Expanded Function Orthodontic Dental Assistant (EFODA)

The Board may certify a dental assistant as an expanded function orthodontic assistant:

(1) By credential in accordance with OAR 818-042-0120, or

(2) Completion of an application, payment of fee and satisfactory evidence of;

(a) Completion of a course of instruction in a program in dental assisting accredited by the American Dental Association Commission on Dental Accreditation; or

(b) Passage of the Oregon Basic, Infection Control, Certified Dental Assistant (CDA) or Certified

Orthodontic Assistant (COA) examination, and Expanded Function Orthodontic Assistant examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board; and certification by a**n Oregon** licensed dentist that the applicant has successfully placed and ligated orthodontic wires on ten (10) patients and removed bands/brackets and remaining adhesive using an ultrasonic, hand scaler or a slow speed handpiece from teeth on four

(4) patients. **The dental assistant must submit within six months' certification by a licensed dentist that the dental assistant is proficient to perform all the expanded function orthodontic duties in subsection (b). If no expanded function certificate is issued within the six months, the dental assistant is no longer able to continue to perform expanded function orthodontic duties until EFODA certification is achieved.**

Dr. Goin moved and Dr. Pham seconded that the Committee recommend that the Board move OAR 818-042-0113 as presented to the next regularly scheduled Licensing, Standards and Competency Meeting for further review. The motion passed unanimously.

818-042-0113

Certification — Expanded Function Preventive Dental Assistants (EFPDA)

The Board may certify a dental assistant as an expanded function preventive dental assistant:

(1) By credential in accordance with OAR 818-042-0120, or

(2) If the assistant submits a completed application, pays the fee and provides evidence of;

(a) Certification of Radiologic Proficiency (OAR 818-042-0060); and satisfactory completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association; or

(b) Certification of Radiologic Proficiency (OAR 818-042-0060); and passage of the Oregon Basic or Infection Control examination, and Certified Preventive Functions Dental Assistant (CPFDA) examination, or the Expanded Function Dental Assistant (EFDA) examination, or the Coronal Polish (CP) examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board; and certification by an Oregon licensed dentist that the applicant has successfully polished the coronal surfaces of teeth with a brush or rubber cup as part oforal prophylaxis to remove stains on six (6) patients. The dental assistant must submit within six months' certification by a licensed dentist that the dental assistant is proficient to perform all the expanded function preventive duties in subsection (b). If no expanded function preventive certificate is issued within the six months, the dental assistant is no longer able to continue to perform expanded function preventive duties until EFPDA certification is achieved.

From: PRISBY Stephen *OBD <Stephen.PRISBY@oregondentistry.org>
Sent: Tuesday, January 5, 2021 1:17 PM
To: Adam Block <ablock@danb.org>
Subject: Re: Question RE: Phlebotomy by DAs

Adam,

The Board concluded that an Anesthesia Assistant with IV Therapy could perform phlebotomy for dental procedures such as PRF/PRP.

It is on the agenda to be discussed further at our next Licensing, Standards and Competency Committee meeting. No meeting date has been set yet, and realistically any change on this would not occur for over a year.

Please let me know if you have any questions.

Go Bears! (I am from Chicago).

Sincerely,
Stephen

Stephen Prisby
Executive Director
Oregon Board of Dentistry
1500 SW 1st Ave., Suite #770
Portland, Or 97201
p 971-673-3200
f 971-673-3202
www.Oregon.gov/Dentistry

From: Adam Block <ablock@danb.org>
Sent: Tuesday, January 5, 2021 9:20 AM
To: PRISBY Stephen *OBD <Stephen.PRISBY@oregondentistry.org>
Subject: Question RE: Phlebotomy by DAs

Good morning Stephen,

We received a question from a stakeholder asking which states allow dental assistants to perform phlebotomy and whether there are educational requirements to do so.

I noted that Oregon requires an Anesthesia Assistant with IV Therapy Certificate to "complete a course in intravenous access or phlebotomy approved by OBD" to receive this certificate and to initiate IV infusion. However, the list of allowable functions for this level of Anesthesia Assistant does not include phlebotomy (i.e. drawing blood). I don't see anything in the scope of practice that seems like it's a synonym for phlebotomy or would encompass phlebotomy. I conclude from this that the Anesthesia Assistant with IV Therapy Certificate is **not** allowed to perform phlebotomy. Is that a correct conclusion?

If you can provide any insight into whether this function – i.e., phlebotomy – may be performed by dental assistants in Oregon, it would be most appreciated.

Thank you and happy new year!

Adam Block
Government Relations Associate
ablock@danb.org

Dental Assisting National Board, Inc.
444 N. Michigan Ave., Suite 900
Chicago, IL 60611
P: 1-800-367-3262, ext. 357
F: 312-642-8507
www.danb.org

818-042-0115
Expanded Functions — Certified Anesthesia Dental Assistant
(1) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant, who possesses a Certified Anesthesia Dental Assistant certificate from the Oregon Board of Dentistry to:
(a) Administer medications into an existing intravenous (IV) line of a patient under sedation or anesthesia under direct visual supervision.
(b) Administer emergency medications to a patient in order to assist the licensee in an emergent situation under direct visual supervision.
(c) Perform phlebotomy for dental procedures.
(2) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant to dispense to a patient, oral medications that have been prepared by the dentist and given to the anesthesia dental assistant by the supervising dentist for oral administration to a patient under Indirect Supervision.
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.020(1), 679.025(1) & 679.250(7)
History:
OBD 2-2016, f. 11-2-16, cert. ef. 3-1-17
OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06
OBD 1-2001, f. & cert. ef. 1-8-01

818-042-0117
Initiation of IV Line
Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the Indirect Supervision of a dentist holding the appropriate anesthesia permit. **A Certified Anesthesia Dental Assistant may also perform phlebotomy for dental procedures.**
Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.020(1), 679.025(1) & 679.250(7)
History:
OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06
OBD 1-2001, f. & cert. ef. 1-8-01

From: Rebekah Allison
To: ROBINSON Haley * OBD
Subject: OBD approved IV or Phlebotomy Course
Date: Tuesday, June 7, 2022 3:15:03 PM
Attachments: image002.png
image003.png
image004.png
image006.png

Haley,

I continue to struggle with my attempts to get my Anesthesia Dental Assistants enrolled in an intravenous access or phlebotomy course that is approved by the OBD. Below is a list of the board approved courses and my bulleted lists explains the problems I am having with each option.

- The two courses at PCC have either not been offered or have been canceled for over a year
- Becksford Health Services' website is "under repair" and I have no way of contacting them to find out anything about the courses they offer or they ways in which a person can take a course
- Resuscitation Group only provides IV initiation training if you enroll in their Anesthesia Assistant Training Program, which my assistants don't need because they have already passed their DAANCE training and have their AnA through the OBD
- Dr. Jeffery Kobernick is not currently offering any training but his receptionist says that he hopes to offer something "in the future"

I'd like to understand what options we have if none of the board approved courses are active?

Board Approved IV or Phlebotomy Courses – Anesthesia Dental Assistants

Course Title	Program	Approved
Intro to IV Therapy	Portland Community College	8/22/2002
Phlebotomy Skills	Portland Community College	10/2006
Phlebotomy	Becksford Health Services (formerly Medtexx Medical Corp)	10/10/2008
IV Therapy	Becksford Health Services (formerly Medtexx Medical Corp)	10/10/2008
Anesthesia Assistant Training Program	Resuscitation Group (Vancouver, WA) https://www.resuscitationgroup.com/	2/15/2019
Anesthesia Assistant Training Program/IV Access Course	Dr. Jeffrey Kobernik	4/24/2020

Thank you for any help you might be able to provide!

[redacted] **Rebekah Allison** (She/Her)

Practice Administrator
Office: 503-652-8080 Direct: 503-652-7878
Email: rallison@ciosc.net

Clackamas Implant & Oral Surgery Center
11211 SE Sunnyside RD | Clackamas, OR 97015
www.clackamasoralsurgery.com

Memorandum

DATE: June 3, 2022

TO: Oregon Board of Dentistry Meeting- June 17, 2022 Attendees

FROM: Angela M. Smorra, D.M.D., Dental Investigator, Oregon Board of Dentistry

SUBJECT: Phlebotomy & Blood Draw Procedures

Enclosures:

(1) Proposed draft rule change
(2) Current DPA DA
(3) Email Communications related to PRF/PRP
(4) Phlebotomy definition- Oxford Dictionary
(5) Current list of OBD Approved IV Therapy Courses

Dear Oregon Board of Dentistry;

The Board staff have fielded a few inquiries to determine if the Dental Practice Act allows dental assistants and dental hygienists to perform blood draws and phlebotomy procedures prior to harvesting PRF/PRP. As it stands now, an anesthesia assistant, who has completed one of the OBD approved IV therapy courses may perform phlebotomy procedures related to PRP/PRF and autologous blood concentrate. The Board discussed this at our October 23, 2020 Board Meeting and concluded that an Anesthesia Assistant with IV Therapy could perform phlebotomy for dental procedures such as PRF/PRP; at that time, the Board also referred the matter to the next Licensing Standards and Competency Committee. Since that date, the Licensing Standards and Competency Committee has not met, however, a meeting is scheduled to take place later this year. It will be beneficial for the Board, and the Committee, to review the qualifications, training, and/ or credentials it will require of DAs, DTs and DHs prior to them performing phlebotomy procedures.

PRF/PRP is primarily used in dentistry promote healing after oral surgery procedures. Medical spas advertise procedures in which PRP/PRF is combined with dermal fillers to improve facial volume. Medical spas also advertise the use of PRP with facial micro needling. As the Board does not individually approve Botox courses (other than to evaluate that the Licensee completed 20 hours of hands on clinical courses related to Botulinum/ dermal fillers with a AGD PACE, or ADA CERP approved provider) the Board cannot be certain which techniques and treatment modalities are being taught in all courses.

The Oxford dictionary defines phlebotomy as the “surgical opening or puncture of a vein in order to withdraw blood or *introduce a fluid*, or (historically) as part of the procedure of letting blood.” While the current DPA doesn’t allow a DA, DH, or DT to perform injections aimed at improving facial esthetics, I have had communication from multiple dental hygienists asking if the DPA allows them to perform Botox and dermal injections. Any proposed rules should precisely define the allowed procedure as a *phlebotomy blood draw,* in an effort to discourage interpretation that the DPA now allows introduction of fluids/ injectable components of products other than local anesthetics by qualified DH’s and DT’s. The Board may also consider specifying products

obtained through a phlebotomy blood draw are only intended to be used by the dentist, for procedures within the scope of practice of dentistry.

Additional input from the Board prior to this being forwarded to the next Licensing Standards & Competency Committee would be appreciated.

Warm Regards,
Angela M. Smorra D.M.D.

Enclosure (1) Draft Rules Language:

Dental Assistants (Division 42):

818-042-0117 Initiation of IV Line and Phlebotomy Blood Draw

(1) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the Indirect Supervision of a dentist holding the appropriate anesthesia permit.

(2) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may perform a phlebotomy blood draw under the Indirect Supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

Dental Hygienists (Divison 35):

OAR 818-035-0030(1)(d) allows dental hygienists to "Perform all functions delegable to dental assistants and expanded function dental assistants providing that the dental hygienist is appropriately trained". If the Board/Committee wishes to define the training required for a DH to initiate an IV infusion line and/or perform a phlebotomy blood draw, rules would need to be crafted for Division 35 that spell out the specific training and supervision that is required.

818-035-0030 - Additional Functions of Dental Hygienists

(1) In addition to functions set forth in ORS 679.010, a dental hygienist may perform the following functions under the general supervision of a licensed dentist:
(a) Make preliminary intra-oral and extra-oral examinations and record findings;
(b) Place periodontal dressings;
(c) Remove periodontal dressings or direct a dental assistant to remove periodontal dressings;
(d) Perform all functions delegable to dental assistants and expanded function dental assistants providing that the dental hygienist is appropriately trained;
(e) Administer and dispense antimicrobial solutions or other antimicrobial agents in the performance of dental hygiene functions.
(f) Prescribe, administer and dispense fluoride, fluoride varnish, antimicrobial solutions for mouth rinsing or other non-systemic antimicrobial agents.
(g) Use high-speed handpieces to polish restorations and to remove cement and adhesive material.
(h) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.
(i) Perform all aspects of teeth whitening procedures.

(2) A dental hygienist may perform the following functions at the locations and for the persons described in ORS 680.205(1) and (2) without the supervision of a dentist:
(a) Determine the need for and appropriateness of sealants or fluoride; and
(b) Apply sealants or fluoride.
(3) In addition to functions set forth in ORS 679.010, a dental hygienist may perform the following functions under the indirect supervision of a licensed dentist:
(a) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the indirect supervision of a dentist holding the appropriate anesthesia permit.
(b) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental hygienist may perform a phlebotomy blood draw under the indirect supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

Dental Therapists (Division 38):
Currently, there is no rule within Division 38 that grants Dental Therapists the authority to perform all functions delegable to dental assistants and expanded function dental assistants, although there is overlap in some of the duties that were enshrined in statute and translated into rule in Division 38. The Board may want to consider adding rules that allow Dental Therapists the same freedom to function as dental assistants that is currently allowed for Dental Hygienists as in OAR 818-035-0030(1)(d) above. Alternatively, the Board may want to include in Division 38 the same language as suggested above, specifically outlining the training required to initiate an IV infusion line and/or perform a phlebotomy blood draw:

… a dental therapist may perform the following functions under the indirect supervision of a licensed dentist:
(a) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental therapist may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the indirect supervision of a dentist holding the appropriate anesthesia permit.
(b) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a dental therapist may perform a phlebotomy blood draw under the indirect supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

Enclosure (2): Current DPA 818-042-0015, 818-042-0016, 818-042-0017

818-042-0115 Expanded Functions – Certified Anesthesia Dental Assistant (1) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant, who possesses a Certified Anesthesia Dental Assistant certificate from the Oregon Board of Dentistry to: (a) Administer medications into an existing intravenous (IV) line of a patient under sedation or anesthesia under direct visual supervision. (b) Administer emergency medications to a patient in order to assist the licensee in an emergent situation under direct visual supervision. (2) A dentist holding the appropriate anesthesia permit may verbally authorize a Certified Anesthesia Dental Assistant to dispense to a patient, oral medications that have been prepared by the dentist and given to the anesthesia dental assistant by the supervising dentist for oral administration to a patient under Indirect Supervision.

818-042-0116 Certification – Anesthesia Dental Assistant The Board may certify a person as an Anesthesia Dental Assistant if the applicant submits a completed application, pays the certification fee and shows satisfactory evidence of: (1) Successful completion of: (a) The "Oral and Maxillofacial Surgery Anesthesia Assistants Program" or successor program, conducted by the American Association of Oral and Maxillofacial Surgeons; or (b) The "Oral and Maxillofacial Surgery Assistants Course" or successor course, conducted by the California Association of Oral and Maxillofacial Surgeons (CALAOMS), or a successor entity; or (c) The "Certified Oral and Maxillofacial Surgery Assistant" examination, or successor examination, conducted by the Dental Assisting National Board or other Board approved examination; or (d) The Resuscitation Group – Anesthesia Dental Assistant course; or (e) Other course approved by the Board; and (2) Holding valid and current documentation showing successful completion of a Healthcare Provider BLS/CPR course, or its equivalent.

818-042-0117 Initiation of IV Line Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the Indirect Supervision of a dentist holding the appropriate anesthesia permit.

Enclosure (3): Email Communications related to PRF/PRP

From: Dominique Endres <dominique_endres@yahoo.com>
Sent: Monday, May 16, 2022 10:45 AM
To: CARTER Bernie * OBD <Bernie.Carter@obd.oregon.gov>
Subject: Inquiring about necessary certifications for PRP/PRF

Good Morning,

It was a pleasure speaking to you on the phone today. As per our discussion, I am currently an EFDA who is interested in getting phlebotomy certified in order for my doctor to incorporate PRP/PRF into our practice. We do not currently have IV sedation options available, only local anesthetic. I would not be drawing blood for any sort of IV line, only for centrifuge purposes. In reviewing the rules that we discussed over the phone, it sounds as though the information is specific to drawing blood for IV line purposes. So my question is, do I need to have a phlebotomy certificate as well as be an IV DA in order to draw blood for PRP/PRF? I look forward to hearing your response.

Thank You,
Dominique J.

From: Adam Block <ablock@danb.org>
Sent: Tuesday, January 5, 2021 9:20 AM
To: PRISBY Stephen *OBD <Stephen.PRISBY@oregondentistry.org>
Subject: Question RE: Phlebotomy by DAs

Good morning Stephen,

We received a question from a stakeholder asking which states allow dental assistants to perform phlebotomy and whether there are educational requirements to do so.

I noted that Oregon requires an Anesthesia Assistant with IV Therapy Certificate to "complete a course in intravenous access or phlebotomy approved by OBD" to receive this certificate and to initiate IV infusion. However, the list of allowable functions for this level of Anesthesia Assistant does not include phlebotomy (i.e. drawing blood). I don't see anything in the scope of practice that seems like it's a synonym for phlebotomy or would encompass phlebotomy. I conclude from this that the Anesthesia Assistant with IV Therapy Certificate is **not** allowed to perform phlebotomy. Is that a correct conclusion?

If you can provide any insight into whether this function – i.e., phlebotomy – may be performed by dental assistants in Oregon, it would be most appreciated.

Thank you and happy new year!

Adam Block
Government Relations Associate
ablock@danb.org

Dental Assisting National Board, Inc.
444 N. Michigan Ave., Suite 900
Chicago, IL 60611
P: 1-800-367-3262, ext. 357
F: 312-642-8507
www.danb.org

Hello Adam,

The Board discussed this at our October 23, 2020 Board Meeting and concluded that an Anesthesia Assistant with IV Therapy could perform phlebotomy for dental procedures such as PRF/PRP. It is on the agenda to be discussed further at our next regularly scheduled Licensing Standards and Competency Committee meeting. Please let me know if you have any questions.

Thank you,

Haley Robinson
Office Manager
Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, OR 97201
Telephone: 971-673-3200
FAX: 971-673-3202
www.oregon.gov/dentistry

Enclosure (4): Oxford Dictionary Phlebotomy definition

phle·bot·o·my

/flə ˈbädəmē/

noun

the surgical opening or puncture of a vein in order to withdraw blood or introduce a fluid, or (historically) as part of the procedure of letting blood.

Feedback

Translations and more definitions

Enclosure (5): Current list of OBD Approved IV Therapy Courses- DANB website

Oregon Anesthesia Dental Assistant with IV Therapy

Current OBD-Approved IV Therapy Course Providers

Program: **Portland Community College**
Course Title: Intro to IV Therapy
Course Approved: August 2002

Program: **Portland Community College**
Course Title: Phlebotomy Skills
Course Approved: October 2006

Program: **Becksford Health Services**
(Previously under the name Medtexx Medical Corp)
Course Title: Phlebotomy
Course Approved: October 2008

Program: **Becksford Health Services**
(Previously under the name Medtexx Medical Corp)
Course Title: IV Therapy
Course Approved: October 2008

Program: **The Resuscitation Group**
Course Title: Anesthesia Assistant Training Program
Course Approved: February 2019

Program: **Dr. Jeffrey Kobernik**
Course Title: Anesthesia Assistant Training Program/IV Access Course
Course Approved: April 2020

List last updated December 2021.

From: NYE Ingrid * OBD
To: PRISBY Stephen *OBD; ROBINSON Haley * OBD; VANDEBERG Samantha * OBD
Subject: FW: Tweaks to rules
Date: Monday, July 26, 2021 10:36:28 AM
Attachments: image001.png
image002.png

Please see below for my nitpicking about the rules from last year. If it is true that SOS won't let us have a (1) without a (2) then I would revise my suggestions from this:

Additional Functions of EFPDAs
~~(1)~~ Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Preventive Dental Assistant may perform the following functions under the indirect supervision of a dentist or dental hygienist providing that the procedure is checked by the dentist or dental hygienist prior to the patient being dismissed:
~~(2)~~ **(1)** Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a dentist or dental hygienist.
Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.250(7)
Hist.: OBD 2-2018, f. 10/04/18, ef. 1/1/19

To this:

Additional Functions of EFPDAs
~~(1)~~ Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Preventive Dental Assistant may perform the following functions under the indirect supervision of a dentist or dental hygienist providing that the procedure is checked by the dentist or dental hygienist prior to the patient being dismissed:
~~(2)~~ Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a dentist or dental hygienist.
Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.250(7)
Hist.: OBD 2-2018, f. 10/04/18, ef. 1/1/19

Basically the issue is that, the way it is now, it looks like (1) and (2) are separate, when really,

(2) should be a subsection of (1), and (1) should not have a number at all. Alternately, it should all be one big block of text, with no numbers at all. Everywhere we see this type of language elsewhere in the rules, we have it formatted one of those two ways. Please see OAR 818-042-0090 for an example of when it has been numbered correctly, and OAR 818-042-0117 of when we have not used numbers at all:

818-042-0090
Additional Functions of EFDAs

Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association, or other course of instruction approved by the Board, a certified Expanded Function Dental Assistant may perform the following functions under the indirect supervision of a dentist or dental hygienist providing that the procedure is checked by the dentist or dental hygienist prior to the patient being dismissed:

(1) Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a dentist or dental hygienist.

(2) Apply temporary soft relines to complete dentures for the purpose of tissue conditioning.

(3) Place retraction material.

Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.025(2)(j) & 679.250(7)
Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 6-2014, f. 7-2-2014, cert. ef. 8-1-2014; OBD 6-2015, f. 7-9-15, cert. ef. 10-01-15; OBD 2-2018, f. 10/04/18, ef. 1/1/19

818-042-0117
Initiation of IV Line

Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a Certified Anesthesia Dental Assistant may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the Indirect Supervision of a dentist holding the appropriate anesthesia permit.

Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.020(1), 679.025(1) & 679.250(7)
Hist.: OBD 1-2001, f. & cert. ef. 1-8-01; OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06

Thanks!!

Ingrid Nye

Investigator
Pronouns: she, her, hers

OREGON BOARD OF DENTISTRY
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OBD TELEPHONE HOURS: MONDAY – FRIDAY, 7:30AM – 4:00PM.

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Please consider the environment before printing this e-mail.

From: Ingrid Nye
Sent: Friday, March 13, 2020 8:39 AM
To: Teresa Haynes <Teresa.Haynes@state.or.us>
Subject: Tweaks to rules

OAR 818-042-0113
Certification — Expanded Function Preventive Dental Assistants (EFPDA)
The Board may certify a dental assistant as an expanded function preventive dental assistant:
(1) By credential in accordance with OAR 818-042-0120, or
(2) If the assistant submits a completed application, pays the fee and provides evidence of;
(a) Certification of Radiologic Proficiency (OAR 818-042-0060); and satisfactory completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association; or
(b) Certification of Radiologic Proficiency (OAR 818-042-0060); and passage of the Oregon Basic or Infection Control examination, and Certified Preventive Functions Dental Assistant (CPFDA) examination, or the Expanded Function Dental Assistant examination, or the Coronal Polish (CP) examination, or equivalent successor examinations, administered by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board; and certification by an Oregon licensed dentist that the applicant has successfully polished the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains on six **(6)** patients.
Stat. Auth.: ORS 679
Stats. Implemented: ORS 679
Hist.: OBD 2-2016, f. 11-2-16, cert. ef. 3-1-17, OBD 2-2019, f. 10/29/2019, cert. ef. 1/1/2020

OAR 818-042-0114
Additional Functions of EFPDAs
~~(1)~~ Upon successful completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental

Association, or other course of instruction approved by the Board, a certified Expanded Function Preventive Dental Assistant may perform the following functions under the indirect supervision of a dentist or dental hygienist providing that the procedure is checked by the dentist or dental hygienist prior to the patient being dismissed:
~~(2)~~ **(1)** Apply pit and fissure sealants provided the patient is examined before the sealants are placed. The sealants must be placed within 45 days of the procedure being authorized by a dentist or dental hygienist.
Stat. Auth.: ORS 679
Stats. Implemented: ORS 679.250(7)
Hist.: OBD 2-2018, f. 10/04/18, ef. 1/1/19

OAR 818-001-0002
Definitions
As used in OAR Chapter 818:
. . . . . .
(17) "BLS for Healthcare Providers or its Equivalent" the ~~CPR~~ **BLS** certification standard is the American Heart Association's BLS Healthcare Providers Course or its equivalent, as determined by the Board. This initial ~~CPR~~ **BLS** course must be a hands-on course; online ~~CPR~~ **BLS** courses will not be approved by the Board for initial ~~CPR~~ **BLS** certification. After the initial ~~CPR~~ **BLS** certification, the Board will accept a Board-approved BLS for Healthcare Providers or its equivalent Online Renewal course for license renewal. A ~~CPR~~ **BLS** certification card with an expiration date must be received from the ~~CPR~~ **BLS** provider as documentation of ~~CPR~~ **BLS** certification. The Board considers the ~~CPR~~ **BLS** expiration date to be the last day of the month that the ~~CPR~~ **BLS** instructor indicates that the certification expires.

Ingrid Nye

Examination & Licensing Manager
Oregon Board of Dentistry

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Please consider the environment before printing this e-mail.

In reviewing the current rules and then looking back at our previous rule in 2019, it appears that the rule change the Board did in 2019 (that went into effect January 2020) could be interpreted to look like only dental assistants who are EFODAs are able to take impressions. The original 2019 rule allowed for EFODAs and *all other DAs* to take impressions, with exceptions.

The intent of the January 2020 rule change was to make *all* types of scans and impressions permissible for *all* DAs to perform. The Board failed to notice that impressions were still listed in the EFODAs duties as an expanded function. This rule change has made it look like only EFODAs could take impressions. This has made it confusing for some organizations to believe their assistants can take scans or impressions if their assistants are not EFODA certified. To make it less confusing, an official rule change is required to remove **818-042-0100(j),** or otherwise amend **818-042-0100.**

To clarify, it is the Board's intent that *all* dental assistants, who have been properly trained and supervised, are allowed to take scans and impressions. It is also the Board's intent that all dental assistants who are properly trained and supervised on taking impression may *currently* do so.

Division 42 Dental Assistant rules are going to be reviewed extensively based on the final results of HB2996 and HB322 during the current 2023 legislative session.

Question: Can my dental assistant take traditional and digital impressions?

Answer: A dentist is responsible for assuring that a dental assistant has been properly trained, has demonstrated proficiency, and is supervised in all the duties the assistant performs in the dental office. Dental assistants, under indirect supervision, may take physical impressions and obtain digital scans for the fabrication of dental devices and oral appliances. It is the supervising dentist's responsibility to ensure impressions are accurate, properly supervised, and clinically acceptable.

Chapter 818

Division 42
DENTAL ASSISTING

818-042-0100
Expanded Functions —Orthodontic Assistant (EFODA)

(1) An EFODA may perform the following duties while under the indirect supervision of a licensed dentist:

(a) Remove orthodontic bands and brackets and attachments with removal of the bonding material and cement. An ultrasonic scaler, hand scaler or slow speed handpiece may be used. Use of a high speed handpiece is prohibited;

(b) Select or try for the fit of orthodontic bands;

(c) Recement loose orthodontic bands;

(d) Place and remove orthodontic separators;

(e) Prepare teeth for bonding or placement of orthodontic appliances and select, pre-position and cure orthodontic brackets, attachments and/or retainers after their position has been approved by the supervising licensed dentist;

(f) Fit and adjust headgear;

(g) Remove fixed orthodontic appliances;

(h) Remove and replace orthodontic wires. Place and ligate archwires. Place elastic ligatures or chains as directed; **and**

(i) Cut arch wires.~~; and~~

~~(j) Take impressions for study models or temporary oral devices such as, but not limited to, space maintainers, orthodontic retainers and occlusal guards.~~

(2) An EFODA may perform the following duties while under the general supervision of a licensed dentist:

(a) An expanded function orthodontic assistant may remove any portion of an orthodontic appliance causing a patient discomfort and in the process may replace ligatures and/or separators if the dentist is not available, providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate.

(b) An EFODA may recement orthodontic bands if the dentist is not available and the patient is in discomfort, providing that the patient is rescheduled for follow-up care by a licensed dentist as soon as is reasonably appropriate.

Statutory/Other Authority: ORS 679
Statutes/Other Implemented: ORS 679.025(2)(j) & 679.250(7)
History:
OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12
OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00

Division 42
DENTAL ASSISTING

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

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

(2) A dental hygienist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental hygienist in providing dental hygiene services and the dentist is not in the office to provide indirect supervision. A dental hygienist with an Expanded Practice Permit may hire and supervise dental assistants who will render assistance to the dental hygienist in providing dental hygiene services.

(3) A dental therapist who works under general supervision may supervise dental assistants in the dental office if the dental assistants are rendering assistance to the dental therapist in providing dental therapy services.

(4) The supervising licensee is responsible for assuring that all required licenses, permits or certificates are current and posted in a conspicuous place.

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

Dental assistants may take physical impressions and digital scans.

Statutory/Other Authority: ORS 679 & 680
Statutes/Other Implemented: ORS 679.025(2)(j), 679.250(7) & ORS 679.600
History:
OBD 1-2022, amend filed 06/21/2022, effective 07/01/2022
OBD 2-2016, f. 11-2-16, cert. ef. 3-1-17
OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12

Oregon Board of Dentistry
Unit 23
PO Box 4395
Portland, Oregon 97208-4395
(971) 673-3200

APPLICATION FOR APPROVAL AS AN INSTRUCTOR
IN RADIOLOGIC PROFICIENCY FOR DENTAL ASSISTANTS
Instructor Permit Fee $40

NAME OF PERSON CONDUCTING COURSE:
(NAME OF SCHOOL AFFILIATED WITH, IF APPLICABLE)

_____

_____

MAILING ADDRESS: _____

City_____State _____ Zip_____

Phone _____

PLEASE LIST QUALIFICATIONS BELOW AND SUBMIT COPIES OF CURRENT LICENSES AND/OR CERTIFICATES THAT APPLY:

_____

_____

_____

INSTRUCTOR QUALIFICATIONS:

Instructors should have background in and current knowledge of dental radiology, and shall have passed either the American Dental Association's National Board examination or the Radiation Health and Safety examination conducted by the Dental Assisting National Board (DANB). Instructor must have one of the following credentials:

- Dentist with an Oregon license;
- Dental Hygienist with an Oregon license; or
- Dental Assistant holding an Oregon Certificate of Radiological Proficiency and continuous employment for the past two years as a chairside assistant or in an educational setting with taking of radiographs as a primary function.

You may obtain information about the written Radiation Health and Safety Examination from DANB by calling 1-800-367-3262.

I certify this application is correct and agree to teach the course to the goals and objectives outline provided in the course description.

_____ _____
Date Signature

OREGON BOARD OF DENTISTRY
1600 SW 4th AVENUE
SUITE 770
PORTLAND, OR 97201
971-673-3200

RADIATION USE AND SAFETY COURSE FOR DENTAL ASSISTANTS

I. COURSE DESIGN and REQUIRED COMPONENTS

This course should be presented in a series of lectures and discussion followed by a practical application of principles in the dental setting.

All persons taking radiographs shall follow the correct infection control protocol.

This course offers instruction regarding operator training as required by the State of Oregon, Health Division, "Rules for the Control of Radiation:"

> OAR 333-106-055 (1) *The registrant shall assure that individuals who will be operating the X-ray equipment shall have adequate training in radiation safety. Adequate training in radiation safety means instruction in the following subjects:*
>
> *(a) Nature of X-rays*
> *(b) Interaction of X-rays with matter*
> *(c) Radiation units*
> *(d) Principles of the X-ray machine*
> *(e) Biological effects of X-ray*
> *(f) Principles of radiation protection*
> *(g) Low dose techniques*
> *(h) Applicable radiation regulation including those portions of Divisions 100, 101, 103, 106, 111 and 120.*
> *(i) Darkroom and film processing*
> *(j) Film critique"*

Required Course Components

This course must include sufficient material and allotted time to adequately cover the requirements of OAR 333-106-055 as explained above and sufficient information regarding techniques of dental radiology to assure that the dental assistant can practice safely in the dental office and in accordance with all Oregon laws and rules regarding operation of x-ray machines and taking of radiographs on actual patients.

This course is only one of three parts necessary to receive an Oregon Certificate of Radiological Proficiency. Oregon Administrative Rule 818-042-0060 states the three steps to obtaining a certificate:

- *Complete a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board;*

- *Pass a clinical examination*; and*

- *Pass the Dental Radiation Health and Safety (RHS) examination administered by the Dental Assisting National Board, Inc. (DANB).*

  ** Instructions regarding Oregon's clinical examination can be obtained from DANB (1-800-367-3262).*

Suggested Texts:

"Radiographic Imaging for Dental Auxiliaries", Third Edition, Miles.
"Fundamentals of Dental Radiography", Third Edition, Manson-Hing.
"Radiology for Dental Auxiliaries", Seventh Edition, Frommer.

II. INSTRUCTOR QUALIFICATIONS

Instructors should have background in and current knowledge of dental radiology, and shall have passed either the American Dental Association's National Board examination or the Radiation Health and Safety examination conducted by the Dental Assisting National Board (DANB). Instructor must have one of the following credentials:

- Dentist with an Oregon license;
- Dental Hygienist with an Oregon license; or
- Dental Assistant holding an Oregon Certificate of Radiological Proficiency and continuous employment for the past two years as a chairside assistant or in an educational setting with taking of radiographs as a primary function.

III. APPROVED CURRICULUM

A. THE DISCOVERY AND HISTORY OF X-RADIATION

Instructional Goals**:**
The goal is to develop knowledge and understanding of the discovery, adaptation and use of x-radiation and to relate this information directly and/or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:
1. Name the discoverer of x-radiation and the date this discovery was made;
2. Describe the early use and experimentation with x-radiation for dentistry in America and Europe; and
3. Describe the physiological effects of x-radiation on those who first worked with radiation and the effects on operators today.

B. RADIATION PHYSICS

Relates to OAR 333-106-055 (1) (a) Nature of x-rays; (b) Interaction of x-rays with matter; and (f) Principles of radiation protection.

Instructional Goals:
The goal is to develop understanding and knowledge of the physical properties of radiation and its interaction with other matter and to relate this information directly and/or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:
1. Describe the detailed structure of an atom;
2. Explain the ionizing process and name two types of ionizing radiation;
3. Describe the characteristics of electromagnetic radiation and relate this information to a diagram or picture of the spectrum;
4. Explain the inverse square law and how it is applied in dental radiology;
5. Compare the properties of x-radiation with those of light;
6. Describe the difference of x-ray absorption between lead and acrylic; and
7. Explain the difference between primary and secondary radiation.

C. BIOLOGICAL EFFECTS OF RADIATION AND X-RAY PROTECTION

Relates to OAR 333-106-055 (1) (e) Biological effects of x-rays; (g) Low does techniques; and (h) Applicable radiation regulation.

Instructional Goals**:**
The goal is to develop understanding of the biological effects of x-radiation, knowledge of protective devices and skill in the use of “Regulations for Control of Radiation" of the State of Oregon and to relate this information directly and/or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:
1. Describe the short and long range biological effects of radiation on living cells and tissues according to:
    a. least and most sensitive tissues
    b. acute and chronic exposure
    c. latent period
    d. cumulative effects;

2. Describe the nature, application and protective results of the following:
    a. long versus short cone
    b. collimator
    c. aluminum filter
    d. speed factor of the film
    e. lead apron with or without a cervical collar;
3. Describe the implications of film distance;
4. Describe the appropriate design and wall structure of operatories;
5. Describe proper operator techniques needed to prevent operator exposure;
6. Explain the use of the film badge;
7. Explain the importance of an accurate and recent health history and describe conditions that would limit patient exposure;
8. Describe precautions necessary for a pregnant patient or operator at various stages of the pregnancy;
9. Demonstrate an understanding of the need to reduce errors and film retakes; and
10. Explain the reasons for a "radiation survey" and list the "Oregon State Safety Rules."

D. THE DENTAL X-RAY UNIT

Relates to OAR 333-106-055 (1) (c) Radiation units; and (d) Principles of the x-ray machine.

Instructional Goals:
The goal is to develop understanding and knowledge of the components that are essential for generation and control of x-radiation and to relate this information directly and/or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:
1. Identify the primary source of energy for an x-ray machine;
2. Define voltage and amperage;
3. Explain the use of the transformer;
4. Label all the components of the x-ray tube on a diagram;
5. Explain how high voltage electrical current affects the cathode and anode;
6. Identify the main source of electrons in the x-ray tube and explain why a transformer is needed;
7. Describe "thermionic emission effect;"
8. Label a diagram showing the conversion of electrical energy to x-radiation; and
9. Explain radiation units, i.e., sieverts and grays.

E. DENTAL X-RAY MACHINE FUNCTION/OPERATION

Relates to OAR 333-106-055 (1) (d) Principles of the x-ray machine.

Instructional Goals**:**
The goal is to develop knowledge and skill in the function and operation of the three basic parts of the x-ray machine: the control panel, tube head and indicating device and to relate this information directly and/or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:
1. Demonstrate and explain the operation of the control panel and exposure switch, timer calibration in impulses;
2. Demonstrate horizontal and vertical angulation;
3. Discuss the advantages and disadvantages of the following indicating devices:
    a. closed cone
    b. short and long cylinder
    c. rectangular indicator
4. Demonstrate manipulation of the indicating device.

F. DENTAL X-RAY FILM

Relates to OAR 333-106-055 (1) (g) Low does techniques.

Instructional Goals**:**
The goal is to develop knowledge of the characteristics of the x-ray film base and emulsion and skill in handling the different sizes of screen and non-screen films, storage and record keeping and to relate this information directly and/or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:
1. Identify screen and non-screen film and describe their use;
2. Identify various sizes of intra and extra oral film and describe the appropriate uses for each size;
3. Describe the advantages and disadvantages of low, high and ultra speed films;
4. Define and describe film base and emulsion;

5. Explain the reaction of the emulsion to exposure to an x-ray beam;
6 Identify other sources of energy that also affect film emulsion;
7. Differentiate between paper and polyester packets and explain the color coding;
8. Describe film shelf-life according to storage conditions;
9. Describe the uses of double-file packets; and
10. Explain the use and composition of duplicating film.

G. INTRA-ORAL RADIOGRAPHIC TECHNIQUES

Instructional Goals:
The goal is to develop skill in the intra-oral placement of film and cone positioning, using both paralleling and bisecting techniques, to produce diagnostic quality radiographs of both adult and child dentition and to relate this information directly and/or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:
1. Demonstrate an understanding of tooth anatomy and alignment., Especially as it relates to the long axis of teeth, proximal contacts, occlusal relationships, root positions and root length;
2. Demonstrate knowledge and correct placement of various types of film holders and tabs;
3. Select appropriate film size for specific exposures and according to the patient's mouth;
4. Select the appropriate exposure time, ma and kvp based upon physiological variables;
5. Demonstrate proper film placement and cone positioning for each film in a full-mouth series according to paralleling and bisecting techniques;
6. Demonstrate the ability to adapt film placement and cone positioning when oral anatomy interferes with standard techniques;
7. Utilize all safety techniques previously learned to reduce radiation exposure to both the operator and patient;
8. Identify exposure errors in processed film;
9. Describe measures needed to correct exposure errors; and
10. Demonstrate all of the above points by exposing 4 fmx's on dexter.

H. THE DARKROOM

Relates to OAR 333-106-055 (1) (i) Darkroom and film processing.

Instructional Goals**:**
The goal is to become familiar with darkroom equipment and supplies and to develop skill in darkroom maintenance and to relate this information directly and/or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:
1. Explain the nature and purpose of the safe light and describe the results of light "leaks";
2. Describe the structure, arrangement and general contents of processing tanks;
3. Describe the chemical components of developing and fixing solutions, explaining the differences between powder and liquid concentrates;
4. Describe how solutions become exhausted and how often additional chemicals can be added to old solutions to replenish them;
5. Explain the need for changing solutions and cleaning tanks;
6. Explain the need for water circulation and temperature control;
7. Demonstrate use of film holders; and
8. Describe the advantages and disadvantages of automatic film processing.

I. FILM PROCESSING AND MOUNTING

Relates to OAR 333-106-055 (1) (i) Darkroom and film processing.

Instructional Goals:
The goal is to develop knowledge and skill in the processing and mounting of dental radiographs and to relate this information directly and/or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:
1. List the four basic steps in film processing;
2. Describe the effects of time and temperature variables during processing on dental x-ray film;
3. Demonstrate the ability to properly unwrap and clamp film to processing holders, properly labeling each holder;
4. Properly process exposed film according to the process described in items “1” and “2” above;
5. Identify processing errors when present and how to correct them;
6. Select an appropriate film mount for the number and type of processed radiographs;
7. Mount dental radiographs correctly to arch, quadrant and tooth sequence;
8. Identify and correct errors in film mounting and explain possible consequences of those errors; and
9. Describe the use and maintenance of view boxes.

J. RADIOGRAPHIC INTERPRETATION

Relates to OAR 333-106-055 (1) (j) Film critique.

Instructional Goals:
The goal is to develop knowledge and skill in identifying diagnostic qualities of radiographs; recognition of normal and abnormal oral conditions; and to understand the ethical and legal implications of radiographs and to relate this information directly and/or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:
1. Describe and identify the following radiographic qualities and list the basic factors which can influence these qualities:
    a. density
    b. contrast
    c. image sharpness and shape
    d. shadow casting
2. When given a film that is not diagnostic relative to factors listed in item number 1 (above), identify the errors and describe the causes;
3. Relate exposure errors to radiographic interpretations;
4. Identify major oral landmarks and normal oral conditions on radiographs; and
5 Describe the legal and ethical implications of dental radiographs according to:
    a. the dental history and record
    b. treatment planning
    c. ownership
    d. patient identification
    e. referral/ consultation
    f. disagreement/ legal action

K. ADDITIONAL RADIOGRAPHIC TECHNIQUES

Instructional Goals:
The goal is to develop knowledge and skill in additional radiographic techniques and to relate this information directly and/or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to demonstrate techniques used for periapical film placement other than the use of a film holder with cone guide and describe advantages and disadvantages of each of the following:

1. Cotton roll/ hand-held,
2. Hemostat,
3. Bite blocks (wood and plastic); and
4. Snap-a-Ray

L. BASIC SKILL DEVELOPMENT

Instructional Goals:
The student will be able to ensure mastery of previously learned information and skills and increase proficiency and efficiency and to relate this information directly and/ or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:

1. Correctly identify major oral landmarks as seen on any intra or extra oral film;
2. Analyze the quality of dental radiographs relative to exposure and development and describe corrections as needed;
3. Demonstrate the ability to expose periapical and bitewing film on manikins, using techniques previously taught;
4. Increasing accuracy and speed on all skills; and
5. Demonstrate the ability to solve problems independently.

M. DENTAL RADIOGRAPHY FOR PATIENTS

Instructional Goals:
The goal is to apply all previously learned knowledge and skills to the exposure and development of patient dental radiographs and to relate this information directly and/or indirectly to "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:

1. Read and correctly interpret an order from a dentist requesting patient x-rays;
2. Read, interpret and correctly respond to items found in the patient's medical and dental histories as related to radiology;
3. Demonstrate consistent application of standards as described in the Oregon Health Division publication “Oregon Rules for the Control of Radiation;”
4. Demonstrate consistent understanding and application of the principles of safety and the prevention of disease transmission;
5. Demonstrate understanding of the Oregon rules and regulations that apply to dental radiography;
6. Demonstrate professional courtesy and standards when working with patients;

7. Place, expose, develop and mount radiographs utilizing increasing proficiency and efficiency, especially as related to:
    a. correct patient management
    b. selection of film and technique
    c. unit settings
    d. correct film placement and exposure to reduce the number of needed retakes
    e. correct processing and mounting of film;

8. Identify errors and make corrections on needed retakes;
9. Record all important information in the patient's chart at the time of appointment and obtain necessary signatures;
10. Demonstrate film placement and stabilization in edentulous areas; and
11. Select and expose films utilizing various film placement and tube angulation to meet a specific problem, i.e.:
    a. crowded or overlapping teeth
    b. excessively long roots
    c. impacted teeth
    d. small mouth/constricted arch
    e. shallow palate/floor of the mouth
    f. presence of tori
    g. small child, age 4 or under

N. ALTERNATIVE RADIOGRAPHIC TECHNIQUES

Instructional Goal:
The goal is to develop knowledge and skill in alternative radiographic techniques and to relate this information directly and/or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:
1. Describe occlusal film technique according to type of film, placement and exposure Angulation;
2. Identify and describe situations where occlusal film would be appropriate;
3. Compare diagnostic usefulness of occlusal film compared to periapical film. Identify the various essential parts of a panoramic machine;
4. Describe the advantages and disadvantages of panoramic film;
5. Load and unload panoramic film cassettes;

6· Properly position patients of varying ages and sizes in the panoramic chair and unit and expose the film;
7. Identify panoramic film problems and describe needed corrective measures;
8. Describe additional extra-oral film techniques and their uses;
9. Describe dental radiographic procedures used in endodontics procedures and explain how root images can be separated; and
10. Correctly expose radiographs using distal oblique and mandibular third molar techniques.

O. PATIENT MANAGEMENT

Instructional Goal:
The goal is to develop awareness and skill in patient management needed to obtain diagnostic dental radiographs and to relate this information directly and/or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:

1. Explain the importance of communicating with the patient at an understandable level, including:
    a. explaining why disabled patients and geriatric patients must be treated with courtesy and respect;
    b. describing "show and tell" method of communication.
    c. explaining why the operator should pay attention to the patient during radiography.

2. Discuss patient management problems and techniques associated with:
    a. the very young
    b. the elderly
    c. patients who are afraid or uncooperative
    d. the handicapped patient.
3. Discuss the questions patients ask about dental radiography and how some questions can be answered by the auxiliaries and others only by the dentist.

P. BASIC RADIOGRAPHIC INTERPRETATION

Instructional Goal:
The goal is to develop introductory level knowledge and skill in the interpretation of radiographic findings and to relate this information directly and/or indirectly to patient and operator "Radiation Health and Safety."

To meet this goal the dental auxiliary will be able to:

1. Identify unerupted and missing teeth of both primary and permanent dentition;
2 Identify in general terms the type of dental work present in the mouth;
3. Locate and describe oral lesions according to radiolucency, capacity, size and location; and
4. Demonstrate correct charting and recording of radiographic findings as directed by the dentist.

Enrolled
House Bill 3223

Sponsored by Representatives PHAM H, JAVADI, Senators GELSER BLOUIN, MANNING JR; Representative LEVY E, Senator CAMPOS

CHAPTER .....

AN ACT

Relating to dental assistants; and prescribing an effective date.

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

SECTION 1. Section 2 of this 2023 Act is added to and made a part of ORS chapter 679.

SECTION 2. (1) In adopting rules related to the requirements for certification as a dental assistant, including any type of expanded function dental assistant, the Oregon Board of Dentistry may require an applicant for certification to pass a written examination. If passage of a written examination is required for certification as a dental assistant, including any type of expanded function dental assistant, the board may accept the results of any examination that is:

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

(B) Administered by a dental education program in this state that is approved by the Commission for Continuing Education Provider Recognition of the American Dental Association, or its successor organization, and approved by the board by rule; or

(C) An examination comparable to an examination described in subparagraph (A) or (B) of this paragraph that is administered by a testing agency approved by the board by rule; and

(b) Offered in plain language in English, Spanish and Vietnamese.

(2) The board may not require an applicant for certification as a dental assistant, including any type of expanded function dental assistant, to complete more than one written examination for certification as that type of dental assistant.

SECTION 3. Section 2 of this 2023 Act applies to applications for certification as a dental assistant, including any type of expanded function dental assistant, submitted on or after the operative date specified in section 4 of this 2023 Act.

SECTION 4. (1) Section 2 of this 2023 Act becomes operative on July 1, 2025.

(2) The Oregon Board of Dentistry may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the board to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the board by section 2 of this 2023 Act.

SECTION 5. (1) The Oregon Board of Dentistry shall convene an advisory committee of at least seven members to study the dental assistant workforce shortage and to review the requirements for dental assistant certification in other states. The committee shall provide

advice to the board on a quarterly basis on how to address the dental assistant workforce shortage in this state.

(2)(a) In appointing members to the advisory committee, the board shall prioritize diversity of geographic representation, background, culture and experience.

(b) A majority of the members appointed to the committee must have experience working as dental assistants.

SECTION 6. This 2023 Act takes effect on the 91st day after the date on which the 2023 regular session of the Eighty-second Legislative Assembly adjourns sine die.

Passed by House March 16, 2023

Repassed by House June 24, 2023

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

.....
Dan Rayfield, Speaker of House

Passed by Senate June 24, 2023

.....
Rob Wagner, President of Senate

Received by Governor:

.....M.,....., 2023

Approved:

.....M.,....., 2023

.....
Tina Kotek, Governor

Filed in Office of Secretary of State:

.....M.,....., 2023

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Secretary of State