IOWA | Department of Inspections, Appeals, & Licensing

Certification of Moderate Sedation Training

To obtain a permit to administer moderate sedation in Iowa, the Iowa Dental Board requires that the applicant submit evidence of having completed board-approved training. The applicant's signature below authorizes the release of any information, favorable or otherwise, directly to the Iowa Dental Board.

Forward this form to the director of your moderate sedation training course. Return the completed form to IDB@Iowa.gov.

Licensee Information

Name: _____ **Email Address**: _____

City, State: _____ **IA License Number**: _____

Signature: _____ **Date**: _____

Moderate Sedation Program

Name of Moderate Sedation Training Program: _____

Street Address: _____

City, State, Zip: _____

Name of Training Director: _____

Email Address: _____

Dates of Training (from – to): _____ **Date Completed**: _____

Type of Training

☐ **Accredited Postgraduate Residency Program** (ADA, AMA, AOA)

Did the training include the sedation of pediatric patients? Yes ☐ No ☐

Did the training include the sedation of medically-compromised patients? Yes ☐ No ☐

☐ **Continuing Education Course**

Did the training include the use of more than one drug in moderate sedation? Yes ☐ No ☐

If yes, please list drugs included in the training: _____

Information about the Training

If you answer "no" to any of the following questions, attach a detailed explanation.

1. Did the applicant satisfactorily complete the above training program? Yes ☐ No ☐
2. Did the program include at least 60 hours of didactic training in pain and anxiety? Yes ☐ No ☐
3. Did the program comply with the guidelines of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students, October 2016? Yes ☐ No ☐
4. Did the program include the management of a minimum of 20 patients? Yes ☐ No ☐
5. Did the program include training that addresses how to rescue patients from a deeper level of sedation than intended, including, but not limited to, intravascular or intraosseous access and reversal medications? Yes ☐ No ☐
6. Did the program include clinical experience in managing compromised airways? Yes ☐ No ☐
7. Did the applicant ever receive a warning, reprimand, or was the applicant placed on probation during the training program? Yes ☐ No ☐
8. Was the applicant ever requested to repeat a portion of the training program? Yes ☐ No ☐

With my signature, I further certify that the above-named applicant has demonstrated competency in administering moderate sedation and airway management. Yes ☐ No ☐

Program Director Signature: _____ **Date**: _____

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