

PUBLIC PACKET

**OREGON BOARD
OF
DENTISTRY**

**BOARD MEETING
JUNE 27, 2014**



This Page

Left Blank

APPROVAL OF MINUTES

This Page

Left Blank

OREGON BOARD OF DENTISTRY
Special Board Meeting Minutes
April 24, 2014

MEMBERS PRESENT: Jonna E. Hongo, D.M.D., President
 Brandon Schwindt, D.M.D., Vice-President
 Todd Beck, D.M.D.
 Mary Davidson, M.P.H., R.D.H.
 Alton Harvey, Sr.
 Norman Magnuson, D.D.S.
 James Morris
 Patricia Parker, D.M.D.
 Julie Ann Smith, D.D.S., M.D.
 Matt Tripp, R.D.H.

STAFF PRESENT: Patrick D. Braatz, Executive Director
 Paul Kleinstub, D.D.S., M.S., Dental Director/Chief Investigator

ALSO PRESENT Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT: None

Call to Order: The meeting was called to order by the President at 8:00 p.m. at the Board office; 1500 SW 1st Ave., Suite 770, Portland, Oregon.

EXECUTIVE SESSION:

The Board entered into Executive Session pursuant to ORS 192.660(2)(i), to review and evaluate the employment related performance of the chief executive officer of any public body, a public officer, employee or staff member who does not request an open hearing. No final action will be taken in Executive Session.

OPEN SESSION: The Board returned to Open Session.

9:20 p.m.

No Actions were taken.

ADJOURNMENT

The meeting was adjourned at 9:21 p.m.

Approved by the Board June 27, 2014.

Brandon J. Schwindt, D.M.D.
President

This Page

Left Blank

**OREGON BOARD OF DENTISTRY
MINUTES
April 25, 2014**

MEMBERS PRESENT: Jonna E. Hongo, D.M.D., President
Brandon Schwindt, D.M.D., Vice-President
Todd Beck, D.M.D.
Mary Davidson, M.P.H., R.D.H.
Alton Harvey, Sr.
Norman Magnuson, D.D.S.
James Morris
Patricia Parker, D.M.D.
Julie Ann Smith, D.D.S., M.D.
John Tripp, R.D.H.

STAFF PRESENT: Patrick D. Braatz, Executive Director
Paul Kleinstub, D.D.S., M.S., Dental Director/Chief Investigator
Daryll Ross, Investigator (portion of meeting)
Harvey Wayson, Investigator (portion of meeting)
William Herzog, D.M.D., Consultant (portion of meeting)
Michelle Lawrence, D.M.D., Consultant (portion of meeting)
Stephen Prisby, Office Manager (portion of meeting)
Lisa Warwick, Office Specialist (portion of meeting)

ALSO PRESENT: Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT: Joseph Young, D.M.D.; Rick Asai, D.M.D., ODA; Gail Aamodt, R.D.H., Pacific University; Lisa Rowley, R.D.H., Pacific University; Lynn Ironside, R.D.H., ODHA; Scott Hansen, D.M.D., ODA; Heidi Jo Grubbs, R.D.H.; Christina Swartz, ODA; Debby Magnuson, guest; Alec Shebiel, ODHA; Robynne Peterson, ODAA

Call to Order: The meeting was called to order by the President at 7:39 a.m. at the Board office; 1500 SW 1st Ave., Suite 770, Portland, Oregon.

NEW BUSINESS

MINUTES

Dr. Smith moved and Dr. Magnuson seconded that the minutes of the February 28, 2014 Board meeting be approved as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

ASSOCIATION REPORTS

Oregon Dental Association

Dr. Hanson stated that this past ODC was one of the most successful ever. He added that the ODA's Mission of Mercy will be July 11-12 this year. He also thanked Dr. Magnuson and Dr. Parker for serving on the Board.

Oregon Dental Hygienists' Association

On May 2nd and 3rd in Springfield, there will be a conference for Expanded Practice Hygienists and those that want to learn more about it. On June 24th Kelli Swanson Jacks will be installed as president of American Dental Hygiene Association.

Oregon Dental Assistants Association

There was no new news.

COMMITTEE AND LIAISON REPORTS

WREB Liaison Report

Dr. Magnuson stated that there was a light report, with the 2015 exams released early this year. Fees are remaining the same for the 2015 year. The future seems to have a lot of great things coming up.

AADB Liaison Report

Dr. Parker attended the AADB Mid-Year Meeting April 6 & 7 in Chicago. Many interesting topics, including sedation, which Dr. Parker stated she had included in a report for the Board to review.

ADEX Liaison Report

Dr. Parker reported that in June there will be a strategic planning meeting.

COMMITTEE MEETING REPORTS

DENTAL HYGIENE COMMITTEE MEETING REPORT

Ms. Davidson stated that the Dental Hygiene Committee met on March 6, 2014. Ms. Davidson stated that the minutes of that meeting were included for the Board's review and had been presented to the Rules Committee at the April 24th meeting and are being moved forward and will be discussed at that meeting.

COMMUNICATION COMMITTEE MEETING REPORT

Dr. Beck stated that the Communication Committee met on March 10, 2014 to discuss ways to improve communication between the Board and our licensees and associations.

Dr. Hongo stated that she was supportive of these ideas and that we also need to continue to make licensees and associations aware of the different ways the OBD staff communicates with its licensees. Dr. Magnuson stated that he thought it might be a good idea to have a newsletter that had no discipline in it and instead focus on Board matters, policies and relevant matters.

Dr. Beck stated that there is still a lot of pushback on the publishing of names in the newsletter. Prior to names being published, doctors would read the newsletter to see the latest news and

updates. Now that there are names, many licensees are not reading it because they don't want to see the names of colleagues. He believes listing names of disciplined licensees is punitive and not helpful.

RULES OVERSIGHT COMMITTEE REPORT

Dr. Schwindt stated that the Rules Oversight Committee met the evening of April 24, 2014. The committee made the following recommendations to the Board:

OAR 818-026-0050 Minimal Sedation Permit

Dr. Schwindt moved and Dr. Beck seconded that the Board send OAR 818-026-0050 to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

OAR 818-026-0055 – Dental Hygiene and Dental Assisting Procedures Performed under Nitrous Oxide or Minimal Sedation

Dr. Schwindt moved and Ms. Davidson seconded that the Board send OAR 818-026-0055 to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

OAR 818-026-0060 – Moderate Sedation Permit

Dr. Schwindt moved and Dr. Smith seconded that the Board send OAR 818-026-0060 to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

OAR 818-026-0065 – Deep Sedation

Dr. Schwindt moved and Mr. Tripp seconded that the Board send OAR 818-026-0065 to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

OAR 818-026-0070 – General Anesthesia Permit

Dr. Schwindt moved and Dr. Parker seconded that the Board send OAR 818-026-0070 to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

OAR 818-035-0030 – Additional Functions of Dental Hygienists

Dr. Schwindt moved and Mr. Harvey seconded that the Board send OAR 818-035-0030 to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

OAR 818-035-0040 – Expanded Functions of Dental Hygienists

Dr. Schwindt moved and Ms. Davidson seconded that the Board send OAR 818-035-0040 to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

OAR 818-042-0040 – Prohibited Acts

Dr. Schwindt moved and Dr. Beck seconded that the Board send OAR 818-042-0040 to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

OAR 818-042-0050 – Taking of X-rays- Exposing of Radiographs

Dr. Schwindt moved and Mr. Magnuson seconded that the Board send OAR 818-042-0050 to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

OAR 818-042-0060 – Certification – Radiologic Proficiency

Dr. Schwindt moved and Dr. Smith seconded that the Board send OAR 818-042-0060 to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

OAR 818-042-0090 – Additional Functions of EFDAs

Dr. Schwindt moved and Dr. Smith seconded that the Board send OAR 818-042-0090 to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

OAR 818-042-0120 – Certification by Credential

Dr. Schwindt moved and Dr. Magnuson seconded that the Board send OAR 818-042-0120 to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

OAR 818-042-0130 – Application for Certification by Credential

Dr. Schwindt moved and Dr. Smith seconded that the Board send OAR 818-042-0130 to a public rulemaking hearing as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

EXECUTIVE DIRECTOR'S REPORT

Budget Status Report

Mr. Braatz stated that the budget is performing as expected and that we've just ended a large revenue stream of the dental renewal period and are entering another smaller revenue period of new licensure applications.

Customer Service Survey Report

Mr. Braatz stated that he had attached a chart which shows the OBD State Legislatively Mandated Customer Service Survey Results from Nov 1, 2013 – March 31, 2014.

The results of the survey show that the OBD continues to receive positive comments from the majority of those that return the surveys. The booklet containing the written comments that are on the survey forms, which staff has reviewed, are available on the table for Board members to review.

Board and Staff Speaking Engagements

Thursday, April 3, 2014 - Dr. Paul Kleinstub, Dental Director/Chief Investigator and Mr. Braatz made a presentation at the Oregon Dental Conference regarding "Record Keeping."

Thursday, April 3, 2014 - Dr. Paul Kleinstub, Dental Director/Chief Investigator and Mr. Braatz made a presentation at the Oregon Dental Conference regarding "Staying out of Trouble with the OBD."

Monday, April 21, 2014 - Teresa Haynes, Licensing Manager and Mr. Braatz made a License Application Presentation to the graduating Dental Hygiene Students at Lane County Community College in Eugene.

2014 Dental License Renewal

Mr. Braatz stated that the following were the final numbers on the March 2014 Dental Renewal: 1906 Renewal notices Mailed; 1775 – Renewed as of April 14, 2014; 118 – Expired (69 Out of State, 49 in Oregon); 27 – Retired; 3 – Resigned. He stated that these were in line with previous years categories.

AADB & AADA Mid-Year Meeting

Mr. Braatz presented an update to the Board about the American Association of Dental Administrators (AADA) and the American Association of Dental Boards (AADB) Meetings as well as the National Dental Examiners Advisory Forum that was, April 6-7, 2014, in Chicago, IL. Mr. Braatz stated that it was a very good meeting focused on anesthesia. Mr. Braatz stated that he too was surprised about the number of deaths that occur in dental offices. He added that the meetings were very informative. He stated that we should pay attention to the case with the FTC and the Supreme Court, as it could have an impact on all state dental boards.

CAFR 2013 Gold Star Certificate

Mr. Braatz stated that the State Controller's Office has once again issued the OBD a FY 2013 Gold Star Certificate signifying that the OBD has provided accurate and complete fiscal year end information in a timely manner.

HPSP Newsletter – March 2014

Mr. Braatz attached the most recent newsletter from the HPSP Program for the Board's review. He stated that if there were any questions that the Board should direct those questions to Mr. Wayson or himself to answer them.

Oregon's Obligated Service Health Providers Report 2014

Mr. Braatz stated that attached the Board would find a report for the Oregon Healthcare Workforce Institute that he wanted share with the Board for informational purposes.

Secretary of State's Audit – Health Related Licensing Boards

Mr. Braatz stated that attached the Board would find the recently released Secretary of State's Office Audit of the Health Care Regulatory Boards. The report was most favorable with a few minor recommendations that he can discuss with the Board in depth if requested. He asked the Board to note that the OBD was mentioned a few times in the report with positive comments about procedures that the OBD uses.

SB 1519 Implementation

Mr. Braatz stated that the following were the results of the implementation of Senate Bill 1519:

- On March 4, 2014 notification letters were sent to 10 licensees who received Notices of Proposed Disciplinary Action regarding a violation of OAR 818-012-0040(4) failure to do weekly spore testing, those Notices will be dismissed at the Board Meeting to be held on April 25, 2014.
- On March 5, 2014 notification letters were sent to 14 licensees who had received Notices of Proposed Disciplinary Action regarding a violation of OAR 818-012-0040(4)

failure to do weekly spore testing and had signed a Consent Order agreeing to be disciplined. The letters stated that the Board will issue an Order of Refund at the Board Meeting to be held on April 25, 2014, returning the Civil Penalty that was assessed in their cases and the notation that they have been disciplined by the Board will be removed from the Board's Web site within the next 30 to 60 days. (\$45,000)

- On March 6, 2014 notification letters were sent to 10 licensees who received Notices of Proposed Disciplinary Action regarding a violation of OAR 818-012-0040(4) failure to do weekly spore testing and other violations. The letters stated that an Amended Notice or Proposed Disciplinary Action will be issued at the Board Meeting to be held on April 25, 2014, removing the allegation regarding OAR 818-012-0040(4) failure to do weekly spore testing.
- On March 6, 2014 notification letters were sent to 2 licensees who had received Notices of Proposed Disciplinary Action regarding a violation of OAR 818-012-0040(4) failure to do weekly spore testing along with other violations of the Oregon Dental Practice Act and had signed a Consent Order agreeing to be disciplined. The letters stated that the Board that any information found in the Consent Order regarding the violation of OAR 818-012-0040 (4) failure to do weekly spore testing will be redacted from that Consent Order on the Board's Web site within the next 30 to 60 days.
- On March 6, 2014 notification letters were sent to 4 licensees who had received Notices of Proposed Disciplinary Action regarding a violation of OAR 818-012-0040(4) failure to do weekly spore testing along with other violations of the Oregon Dental Practice Act and had signed a Consent Order agreeing to be disciplined. The letters stated that the Board will issue an Order of Refund at the Board Meeting to be held on April 25, 2014, returning the Civil Penalty that was assessed in their case and that any information found in the Consent Order regarding the violation of OAR 818-012-0040 (4) failure to do weekly spore testing will be redacted from that Consent Order on the Board's Web site within the next 30 to 60 days. (\$21,000)
- In cases regarding dental licensees that the Board voted on February 28, 2014 to issue a Notice of Proposed Disciplinary Action that involved only a violation of OAR 818-012-0040(4) failure to do weekly spore testing, the Board will rescind those Notices of Proposed Disciplinary action at their meeting on April 25, 2014.
- All pending cases or investigations regarding dental licensees that were in the process of being investigated on or before March 4, 2014 and involved only a violation of OAR 818-012-0040(4) failure to do weekly spore testing will no longer be subject to disciplinary action by the Board through January 1, 2015 per an agreement with the Oregon Dental Association.

The Board will be reviewing a number of issues surrounding the cases that are affected by SB 1519 in Executive Session today and then acting upon those cases in Open Session later in the meeting.

2015 Meeting Dates

Mr. Braatz stated that he had attached a draft of the proposed meeting dates for 2015 and that if acceptable; the Board needs to adopt the dates.

Mr. Harvey moved and Dr. Beck seconded that the Board adopt the 2015 calendar as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

Newsletter

Mr. Braatz reminded the board that it is time to consider another newsletter and articles are welcome from the Board Members.

EXECUTIVE SESSION: The Board entered into Executive Session pursuant to ORS 192.606 (1)(f), (h) and (k); ORS 676.165; ORS 676.175 (1), and ORS 679.320 to review records exempt from public disclosure, to review confidential investigatory materials and investigatory information, and to consult with counsel.

The Board entered Open Session.

Prescription Authority for Hygienists

Dr. Magnuson moved and Mr. Harvey seconded that the Board accept the AAG's opinion regarding the prescription duties for hygienist. Furthermore that the Board work with the ODHA and the ODA to develop language that would correct the statutes and then set up a taskforce consisting of the association representatives and board members to develop new rules that will address hygienists' prescription duties. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

UNFINISHED BUSINESS

OTHER BUSINESS

Yakima Valley Community College – Restorative Curriculum Approval

Dr. Magnuson moved and Dr. Smith seconded that the Board approve the curriculum. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Smith, and Mr. Tripp voting aye. Dr. Parker recused herself.

Pacific University – Local Anesthesia & Nitrous Oxide Course Approval

Ms. Davidson moved and Dr. Smith seconded that the Board approve the course as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

Election of Officers

Dr. Hongo nominated Dr. Schwindt for Board President and Dr. Beck seconded the nomination. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

Dr. Hongo nominated Mr. Harvey for Vice President and Dr. Smith seconded the nomination. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

Dr. Schwindt presented Dr. Hongo with a plaque thanking Dr. Hongo for her year as presiding as President of the Oregon Board of Dentistry.

Dr. Hongo presented plaques to Dr. Magnuson, Dr. Parker and Ms. Davidson each for their 8 years of continued service to the Board. Mr. Braatz also added that for him and the Board staff, they will be greatly missed and it's been a great pleasure to work with them.

EXECUTIVE SESSION: The Board entered into Executive Session pursuant to ORS 192.606 (1)(f), (h) and (k); ORS 676.165; ORS 676.175 (1), and ORS 679.320 to review records exempt from public disclosure, to review confidential investigatory materials and investigatory information, and to consult with counsel.

PERSONAL APPEARANCES AND COMPLIANCE ISSUES

Licensee appeared pursuant to his Consent Orders in case number **2008-0013**.

LICENSING ISSUES

OPEN SESSION: The Board returned to Open Session.

CONSENT AGENDA

2014-0177, 2014-0161, 2014-0160, 2014-0158, 2014-0179, 2014-0178, 2014-0157, 2014-0184, 2014-0162, 2014-0166, 2014-0159, 2014-0181, 2014-0175 and 2014-0154 Dr. Smith move and Dr. Beck seconded that the above referenced cases be closed with No Further Action or No Violation per the staff recommendations. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

COMPLETED CASES

2014-0004, 2013-0076, 2013-0133, 2013-0077, 2014-0092, 2014-0091, 2012-0219, 2014-0038, 2014-0016, 2014-0133, 2014-0123, 2014-0019, 2013-0088 and 2013-0089 Dr. Smith and Dr. Magnuson seconded that the above referenced cases be closed with a finding of No Violation of the Dental Practice Act or No Further Action per the Board recommendations. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

ANGLE, DARRELL L., D.D.S. 2014-0081

Dr. Beck moved and Mr. Harvey seconded that the Board issue a Notice of Proposed License Suspension unless Licensee presents at the Board offices for an interview no later than 5/7/14 and, if cases 2011-0184, 2012-0031, 2012-0147, 2012-0172, and 2013-0035 are not resolved, the current case will be added for hearing purposes. The motion passed with Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Schwindt recused himself.

2013-0053

Mr. Morris moved and Mr. Harvey seconded that the Board close the matter with a **STRONGLY** worded Letter of Concern addressing the issue of ensuring that heat sterilizing devices are tested for proper function on a weekly basis, and that when treatment complications occur, there is clear documentation that the patient is informed of the complication. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

BORROMEO, ALFRED M., D.D.S. 2013-0011

Mr. Tripp moved and Dr. Smith seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded and pay a \$2,000.00 civil penalty. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0068

Dr. Magnuson moved and Mr. Harvey seconded that the Board close the matter with a **STRONGLY** worded Letter of Concern addressing the issue of ensuring that heat sterilization devices are tested weekly with a biological monitoring system. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2014-0024

Dr. Parker moved and Dr. Beck seconded that the Board close the case with a Letter of Concern reminding to Licensee to assure a protocol is in place that teeth to be extracted are clearly documented and double checked prior to their actual removal. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

HAGEMAN, MARK R., D.D.S. 2013-0087

Ms. Davidson moved and Dr. Smith seconded that the Board Issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded and pay a \$4,000.00 civil penalty. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

HENDY, JOHN A., D.D.S. 2013-0020

Dr. Magnuson moved and Dr. Smith seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the licensee a Consent Order in which the licensee would agree to be reprimanded, to pay a \$4,000.00 civil penalty, and to not perform molar endodontics until completion of at least 12 hours of Board approved hands-on continuing education in molar endodontics. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0029

Mr. Harvey moved and Dr. Smith seconded that the Board close the matter with a **STRONGLY** worded Letter of Concern addressing the issue of ensuring that heat sterilizing devices are tested for proper function on a weekly basis. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0054

Dr. Beck moved and Dr. Magnuson seconded that the Board, in regards to Respondent #1, issue a Letter of Concern indicating that timely periodontal probing be maintained, PARQ be documented, appropriate treatment be rendered in a timely manner and when a referral is indicated, it be made promptly and documented; in regards to Respondent #2, issue a Letter of Concern indicating that timely periodontal probing be maintained, PARQ be documented and appropriate treatment be rendered in a timely manner. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Hongo recused herself.

HSU, RICHARD PAO-YUAN, D.M.D. 2012-0019, 2014-0124 & 2014-0072

Mr. Morris moved and Dr. Smith seconded that the Board move to issue a Notice of Proposed License Suspension. The motion passed with Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Schwindt recused himself.

2013-0059

Mr. Tripp moved and Dr. Magnuson seconded that the Board close the matter with a **STRONGLY** worded Letter of Concern addressing the issue of ensuring that heat sterilization devices are tested weekly with a biological monitoring system and that when obtaining informed consent from a patient for future treatment, there is no question that the patient understands what treatment is going to be provided. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0064

Dr. Magnuson moved and Ms. Davidson seconded that the Board close the matter with a **STRONGLY** worded Letter of Concern reminding the Licensee to ensure that heat sterilization devices are tested weekly with a biological monitoring system. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2010-0133

Dr. Parker moved and Dr. Beck seconded that the Board issue an Order of Examination requiring Licensee to submit to, fully cooperate with, and successfully complete a multi-faceted residential substance use disorder evaluation by a Board approved provider and submit to, and fully cooperate with, a mental health evaluation by a Board approved provider. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2014-0054

Mr. Davidson moved and Dr. Smith seconded that the Board close the case with a **STRONGLY** worded Letter of Concern addressing the issue of ensuring that when informed consent is obtained prior to providing medication or treatment, PARQ or its equivalent is documented in the patient records. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

WILSON, TODD C., D.D.S. 2012-0179

Mr. Harvey moved and Dr. Smith seconded that the Board with respect to Respondent #1, move to close the matter with a finding of No Violation of the Dental Practice Act, and with respect Respondent #2, move to issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, a \$1,000.00 civil penalty, and ten hours of community

service to be completed within 60 days. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2014-0068

Dr. Beck moved and Dr. Smith seconded that the Board close the case with a **Strongly Worded Letter of Concern** addressing the issues of ensuring that PARQ is documented in the patient record and that assistants under his direction adhere strictly to the rules of the Dental Practice Act and perform only the duties for which they are certified. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0160

Mr. Morris moved and Dr. Smith seconded that the Board close the case with a **STRONGLY WORDED LETTER of CONCERN** reminding the Licensee that the completion of a license renewal application is a very serious matter and just because the Licensee does not approve of the use of fluoride in public drinking water is not a reason to make a “joke” regarding practicing in communities that have fluoride in their water, and making a statement that the Licensee is in possession of fluoriated water which in the Licensee’s mind is an illegal drug and thus the Licensee has to report that to the Board. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0217

Mr. Tripp moved and Dr. Parker seconded that the Board close the matter with a finding of no violation. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, and Mr. Tripp voting aye. Dr. Smith recused herself.

PERKINS, ANDREA L., R.D.H. 2014-0088

Dr. Magnuson moved and Dr. Harvey seconded that the Board issue a Notice of Proposed Disciplinary Action and offer a Consent Order incorporating a reprimanded, civil penalty in the amount \$1,500.00, complete ten hours of community service within 60 days and successfully complete the balance of the 34 hours of continuing education for the licensure periods 10/1/09 to 9/30/11 and 10/1/11 to 9/30/13, within 6 months of the effective date of this Order, unless the Board grants an extension, and advises the Licensee in writing. This ordered continuing education is in addition to the 36 hours continuing education required for the licensure period October 1, 2015 to September 30, 2017. As soon as possible following completion of the continuing education the Licensee shall provide the Board with documentation certifying completion of the courses. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2012-0189

Dr. Parker moved and Mr. Harvey seconded that the Board close the matter with a **STRONGLY** worded Letter of Concern reminding Licensee to ensure that heat sterilization devices are tested weekly with a biological monitoring system. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0106

Ms. Davidson moved and Dr. Smith seconded that the Board pursuant to Section 3, (1) of SB 1519, close the matter with a **STRONGLY** worded Letter of Concern addressing the issue of ensuring that heat sterilizing devices are tested for proper function on a weekly basis. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr.

Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0082

Dr. Beck moved and Mr. Harvey seconded that the Board close the matter with a finding of no violation. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0025

Dr. Magnuson moved and Ms. Davidson seconded that the Board close the case with a finding of No Violation. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0066

Dr. Beck moved and Dr. Smith seconded that the Board close the matter with a Letter of Concern reminding Licensee to assure that she certifies the patient's health history and evaluate the patient prior to administering nitrous oxide. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

PREVIOUS CASES REQUIRING BOARD ACTION

ANGLE, DARREL L., D.D.S. 2012-0147

Mr. Morris moved and Dr. Magnuson seconded that the Board issue an Third Amended Notice of Proposed Disciplinary Action and offer Licensee a re-worded Consent Order, incorporating a reprimand, a \$3,919.98 restitution payment to patient CK, a \$3,500.00 restitution payment to patient TS, a \$15,000.00 civil penalty, complete three hours of continuing education in record keeping, and, within two years of the effective date of the Order, at the completion of treatment for 20 patients, but prior to debanding, submit the cases for a review by a Board approved orthodontist and bear the cost of that review. The motion passed with Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Schwindt recused himself.

AOTO, CHARLES E., D.D.S. 2011-0158

Mr. Tripp moved and Dr. Parker seconded that the Board issue a Third Amended Notice of Proposed Disciplinary Action and offer Licensee a re-worded Consent Order incorporating a reprimand and prohibition from restoring dental implants until completion of a Board approved hands-on mentor program. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

BERG, GEOFFREY A., D.M.D. 2012-0009

Dr. Magnuson moved and Mr. Harvey seconded that the Board pursuant to Section 3, (1) of SB 1519, rescind the vote taken on February 28, 2014 and issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded, pay a \$5,000.00 civil penalty to be paid within 60 days, and be prohibited from placing any dental implants, teaching or training on dental implants until completion of a Board approved Mentor Program focused on comprehensive diagnosis and treatment planning and the placement of dental implants. The motion passed with Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Schwindt recused himself.

2012-0083 & 2012-0167

Dr. Parker moved and Mr. Harvey seconded that the Board issue a letter directing Licensee to follow the recommendations of the assigned mentor; meet with a Board approved pediatric dentist for the purpose of reviewing primary pulp therapy by 5/25/14; complete, with his entire staff, the record keeping course provided by Dr. Persichetti by 6/25/14; complete a Board approved composite restorative course by 10/25/14; and enroll in and complete the OAGD hands-on, participation pediatric course offered 10/31/14 - 11/1/14. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

CHUNG, PAUL D.D.S. 2012-0116

Ms. Davidson moved and Dr. Parker seconded that the Board issue an Amended Notice of Proposed Disciplinary Action and offer Licensee a re-worded Consent Order, both excluding reference to failure to test sterilization devices. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0030

Dr. Schwindt moved and Dr. Smith seconded that the Board pursuant to Section 3, (1) of SB 1519, rescind the vote taken on February 28, 2014 and close the matter with a STRONGLY worded Letter of Concern addressing the issue of ensuring that heat sterilizing devices are tested for proper function on a weekly basis. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0015

Mr. Harvey moved and Mr. Tripp seconded that the Board rescind the vote of 8/26/13, issue an Order of Dismissal dismissing the Notice of Proposed License Revocation, dated 8/28/13, and return the case for further investigation. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

GERHARDS, MICHAEL C., D.D.S. 2012-0194

Dr. Beck moved and Dr. Smith seconded that the Board issue an Amended Notice of Proposed Disciplinary Action and offer Licensee a re-worded Consent Order, incorporating a reprimand and a \$740.00 restitution payment to patient MEB. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2008-0013

Mr. Morris moved and Dr. Smith seconded that the Board accommodate licensees request. The motion failed with a tied vote 4-4. Dr. Beck and Dr. Schwindt recused themselves.

LIND, STEVEN D.M.D. 2012-0105

Mr. Tripp moved and Mr. Harvey seconded that the Board issue an Amended Notice of Proposed Disciplinary Action and offer Licensee a re-worded Consent Order, incorporating a reprimand and a prohibition from placing implants until completion of a Board approved Mentor Program focused on placement of dental implants. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

MATZ, DOUGLAS J., D.M.D. 2012-0168

Dr. Magnuson moved and Mr. Harvey seconded that the Board pursuant to Section 3, (1) of SB 1519, rescind the vote taken on February 28, 2014 and issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded and pay a \$1,000.00 civil penalty to be paid within 30 days. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

McKIM, JOHN P., D.M.D., 2011-0207

Dr. Parker moved and Mr. Harvey seconded that the Board issue an Amended Notice of Proposed Disciplinary Action and offer Licensee a re-worded Consent Order, incorporating a reprimand and a \$5,000.00 civil penalty, restitution payment of \$732.00 to patient PJ, and three hours of continuing education in record keeping within six months. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

MIYAMOTO-SHEMALO, MIKA D.M.D. 2011-0034

Mr. Davidson moved and Dr. Parker seconded that the Board issue an Amended Notice of Proposed Disciplinary Action and accept the Consent Order offered by the Licensee incorporating a reprimand and a \$5,000.00 civil penalty. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

NORDSTROM, MARC A., D.M.D. 2013-0001

Dr. Schwindt moved and Mr. Tripp seconded that the Board issue an Amended Notice of Proposed Disciplinary Action and offer Licensee a re-worded Consent Order, incorporating a reprimand and a \$1,091.00 restitution payment to patient MG. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Smith, and Mr. Tripp voting aye. Dr. Parker recused herself.

2013-0056

Mr. Harvey moved and Dr. Smith seconded that the Board pursuant to Section 3, (1) of SB 1519, rescind the vote taken on February 28, 2014 and close the matter with a STRONGLY worded Letter of Concern addressing the issue of ensuring that heat sterilizing devices are tested for proper function on a weekly basis. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0058

Dr. Beck moved and Dr. Smith seconded that the Board issue an Amended Notice of Proposed Disciplinary Action. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2014-0062

Mr. Morris moved and Dr. Magnuson seconded that the Board issue an Order of Dismissal dismissing the Notice of Proposed License Revocation, issued 11/5/14, and close the matter with a Letter of Concern reminding Licensee that he assure his adherence to Board orders. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0008

Mr. Tripp moved and Dr. Parker seconded that the Board, pursuant to Section 3, (1) of SB 1519, rescind the vote taken on February 28, 2014 and close the matter with a STRONGLY worded Letter of Concern addressing the issue of ensuring that heat sterilizing devices are tested for proper function on a weekly basis. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

DISMISSALS**2012-0085**

Dr. Magnuson moved and Ms. Davidson seconded that the Board issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action, issued 8/22/13, and close the matter with a Letter of Concern reminding Licensee to ensure that heat sterilization devices are tested weekly with a biological monitoring system. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2012-0216

Dr. Parker moved and Dr. Smith seconded that the Board issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action, issued 12/27/13, and close the matter with a Letter of Concern reminding Licensee to ensure that heat sterilization devices are tested weekly with a biological monitoring system. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2012-0126

Ms. Davidson moved and Dr. Parker seconded that the Board issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action, issued 12/30/13, and close the matter with a Letter of Concern reminding Licensee to ensure that heat sterilization devices are tested weekly with a biological monitoring system. The motion passed with Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Schwindt recused himself.

2012-0042

Dr. Schwindt moved and Ms. Davidson seconded that the Board issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action, issued 12/30/13, and close the matter with a Letter of Concern reminding Licensee to ensure that heat sterilization devices are tested weekly with a biological monitoring system. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2012-0005

Mr. Harvey moved and Dr. Beck seconded that the Board issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action, issued 6/26/13, and close the matter with a Letter of Concern reminding Licensee to ensure that heat sterilization devices are tested weekly with a biological monitoring system and that all treatment provided is documented in the patient record. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0132

Dr. Beck moved and Dr. Parker seconded that the Board issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action, issued 1/6/14, and the Final Default Order, dated

2/28/14, and close the matter with a Letter of Concern reminding Licensee to ensure that heat sterilization devices are tested weekly with a biological monitoring system. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0002

Mr. Morris moved and Ms. Davidson seconded that the Board issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action, issued 10/22/13, and close the matter with a Letter of Concern reminding Licensee to ensure that heat sterilization devices are tested weekly with a biological monitoring system. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2014-0070

Mr. Tripp moved and Dr. Smith seconded that the Board issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action, issued 12/27/13, and close the matter with a Letter of Concern reminding Licensee to ensure that heat sterilization devices are tested weekly with a biological monitoring system. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2013-0045

Dr. Magnuson moved and Dr. Parker seconded that the Board issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action, issued 12/27/13, and close the matter with a Letter of Concern reminding Licensee to ensure that heat sterilization devices are tested weekly with a biological monitoring system. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2012-0184

Dr. Parker moved and Ms. Davidson seconded that the Board issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action, issued 10/22/13, and close the matter with a Letter of Concern reminding Licensee to ensure that heat sterilization devices are tested weekly with a biological monitoring system. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

2012-0095

Ms. Davidson moved and Dr. Parker seconded that the Board issue an Order of Dismissal, dismissing the Notice of Proposed Disciplinary Action, issued 7/1/13, and close the matter with a Letter of Concern reminding Licensee to ensure that heat sterilization devices are tested weekly with a biological monitoring system. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

REFUNDS

ADAMS, BRANNICK D., D.D.S, 2012-0152

Dr. Schwindt moved and Dr. Magnuson seconded that the Board issue an Order of Refund and refund Licensee the amount of \$3,000.00. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

WU, JULIANI, D.D.S, WU, KEVIN (HONG), D.D.S. 2012-0003

Mr. Harvey moved and Dr. Smith seconded that the Board issue Orders of Refund and refund Respondent #5 the amount of \$2,000.00 and Respondent #6 the amount of \$2,000.00. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

CHVATAL, BRAD A., D.M.D. 2013-0039

Dr. Beck moved and Mr. Tripp seconded that the Board issue an Order of Refund and refund Licensee the amount of \$6,000.00. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

ELLIOTT/WILLIAM S., D.M.D. 2013-0139

Mr. Morris moved and Dr. Parker seconded that the Board issue an Order of Refund and refund Licensee the amount of \$5,000.00. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

HALD, TAMARA S., D.D.S. 2010-0068

Mr. Tripp moved and Dr. Parker seconded that the Board issue an Order of Refund and refund Licensee the amount of \$6,000.00. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

KIM, MICHAEL Y., D.D.S. 2012-0228

Dr. Magnuson moved and Ms. Davidson seconded that the Board issue an Order of Refund and refund Licensee the amount of \$6,000.00. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

PRICE, JILL M., D.M.D. 2014-0067

Dr. Parker moved and Dr. Smith seconded that the Board issue an Order of Refund and refund Licensee #2 the amount of \$6,000.00. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

MONTROSE, ALAN M., D.M.D. 2012-0210

Ms. Davidson moved and Dr. Beck seconded that the Board issue an Order of Refund and refund Licensee the amount of \$6,000.00. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

NOUREDINE, HADI A., D.M.D. 2012-0188

Mr. Harvey moved and Dr. Magnuson seconded that the Board issue an Order of Refund and refund Licensee the amount of \$6,000.00. The motion passed with Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye. Dr. Schwindt recused himself.

OVER, LARRY M., D.M.D. 2013-0005

Dr. Schwindt moved and Dr. Beck seconded that the Board issue an Order of Refund and refund Licensee the amount of \$6,000.00. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, and Mr. Tripp voting aye. Dr. Smith recused herself.

SABIN, MICHAEL J., D.M.D. 2012-0209

Dr. Beck moved and Mr. Morris seconded that the Board issue an Order of Refund and refund Licensee the amount of \$3,000.00. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

TRAN, KHIET M., D.D.S. 2014-0069

Mr. Morris moved and Dr. Magnuson seconded that the Board issue an Order of Refund and refund Licensee the amount of \$6,000.00. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

VELEY, CHRISTOPHER W., D.M.D. 2013-0004

Mr. Tripp moved and Dr. Beck seconded that the Board issue an Order of Refund and refund Licensee the amount of \$3,000.00. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

LICENSURE AND EXAMINATION

Request for Approval: General Anesthesia Permit – R. Bryan Bell, D.D.S.

Dr. Parker moved and Dr. Beck seconded that the Board approve the General Anesthesia Permit Application. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker and Mr. Tripp voting aye. Dr. Smith recused herself.

Request for Non-resident Permit: J. Wayland, D.D.S.

Ms. Davidson moved and Ms Smith seconded that the Board grant the non-resident permit. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

Request for Non-resident Permit: N. Foley, D.M.D.

Dr. Beck moved and Dr. Smith seconded that the Board grant the non-resident permit. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

Request for C.E. Extension: E. Chung, D.D.S.

Dr. Schwindt moved and Ms. Davidson seconded that the Board grant the requested CE extension for Dr. Chung. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

Specialty Exam Change

Dr. Magnuson moved and Ms. Davidson seconded that the Board approve the changes as presented. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

Ratification of Licenses Issued

As authorized by the Board, licenses to practice dentistry and dental hygiene were issued to applicants who fulfilled all routine licensure requirements. It is recommended the Board ratify issuance of the following licenses. Complete application files will be available for review during the Board meeting.

Mr. Harvey moved and Dr. Magnuson seconded that licenses issued be ratified as published. The motion passed with Dr. Schwindt, Dr. Beck, Ms. Davidson, Mr. Harvey, Dr. Magnuson, Mr. Morris, Dr. Parker, Dr. Smith, and Mr. Tripp voting aye.

Dental Hygiene

H6683	SHAUNA C GEIGER, R.D.H.	3/10/2014
H6684	SARAH E HILLER, R.D.H.	3/14/2014
H6685	BARBARA M VINBERG, R.D.H.	3/27/2014
H6686	FABIANA BATISTA GARCIA, R.D.H.	4/9/2014
H6687	KINDYL M VON HEER, R.D.H.	4/9/2014
H6688	AUDREY D RICHARDS, R.D.H.	4/9/2014
H6689	SHELLEY A WESTRE, R.D.H.	4/9/2014
H6690	ANGELA J COPLEY, R.D.H.	4/10/2014

Dentists

D9996	BENJAMIN J BROWN, D.M.D.	3/10/2014
D9997	WADE F MARKERT, D.D.S.	3/10/2014
D9998	WHITNEY TEAL NAGY, D.D.S.	3/10/2014
D9999	ANDY STEIN, D.M.D.	3/10/2014
D10000	SAFFA F ALANI, D.D.S.	3/10/2014
D10001	DANIEL A BROWN, D.D.S.	3/10/2014
D10002	JOSEPH P SCHMIDT, D.D.S.	3/14/2014
D10003	BRENDEN C BELL, D.D.S.	3/14/2014
D10004	THOMAS R PETERS, D.D.S.	3/19/2014
D10005	JOSEPH Y CHUNG, D.D.S.	3/19/2014
D10006	WILLIAM HU, D.M.D.	3/19/2014
D10007	JENETTE D INTRACHAT, D.D.S.	3/27/2014
D10008	SUSAN MARIE WELLMAN, D.M.D.	4/1/2014
D10009	MEGAN ELLEN MILLER, D.D.S.	4/9/2014
D10010	GAYATRI RAINA, D.M.D.	4/9/2014
D10011	SAMUEL P ZINK, D.M.D.	4/9/2014

Announcement

Dr. Hongo referred the following 2 items to Committees:

To Licensing & Standards- The issue of Chantax/Smoking cessation and what/how board deals with it.

To Anesthesia- The Issues of nitrous, anxiolysis & minimal sedation – How can rules be combined or eliminated to clarify.

ADJOURNMENT

The meeting was adjourned at 3:05 p.m. Dr. Hongo stated that the next Board meeting would take place on June 27, 2014.

Approved by the Board June 27, 2014.

Brandon J. Schwindt, D.M.D.
President

ASSOCIATION REPORTS

Nothing to report under this tab

COMMITTEE REPORTS

Nothing to report under this tab

**EXECUTIVE
DIRECTORS
REPORT**

This Page

Left Blank

EXECUTIVE DIRECTOR'S REPORT

June 27, 2014

Board Member Appointments

Governor Kitzhaber reappointed Board Member Alton Harvey, Sr. for another term that will expire on April 6, 2018.

Governor Kitzhaber appointed Gary Underhill, DMD of Enterprise to succeed Dr. Norman Magnuson who served two terms on the Board for a term to expire April 1, 2018 and appointed Amy Fine, DMD of Medford to succeed Dr. Patricia Parker who served two terms on the Board for a term to expire April 1, 2018.

Members Harvey, Underhill and Fine, were all confirmed by the Oregon State Senate on May 28, 2014 and began their term of office on June 1, 2014.

OBD Budget Status Report

Attached is the latest budget report for the 2013 - 2015 Biennium. This report, which is from July 1, 2013 through April 30, 2014, shows revenue of \$1,234,410.69 and expenditures of \$1,195,573.54. We have completed one dental and one dental hygiene renewal cycle as well as one new license application cycle and we are in the midst of the next license application cycle and in July we will start the next dental hygiene renewal cycle.

We are basically at the half way point in the budget and I think the Budget Revenue is performing as expected. Our expenditures are a little higher with the addition of a second consultant and the increased expenditures associated with the move to the new office. But I am watching this closely as we cannot exceed our expenditure authority unless we go to the Legislative E-Board and I would like to avoid that if at all possible.

Because of the timing of the Board Meeting and the close of the May Financials which is June 13, 2014, I expect that I will have an additional handout at the meeting that will then reflect 11 months of the fiscal year which will give us an even better picture of where we are at this time.

If Board members have questions on this budget report format, please feel free to ask me.

Attachment #1

Customer Service Survey

Attached is a chart which shows the OBD State Legislatively Mandated Customer Service Survey Results from July 1, 2013 – March 31, 2014.

The results of the survey show that the OBD continues to receive positive comments from the majority of those that return the surveys. The booklet containing the written comments that are on the survey forms, which staff has reviewed, are available on the table for Board members to review. **Attachment #2**

Board and Staff Speaking Engagements

Teresa Haynes and I made a License Application Presentation to the graduating Dental Students at the OHSU Dental School in Portland on Thursday, May 1, 2014.

Teresa Haynes and I made a License Application Presentation to the graduating Dental Hygiene Students at the PCC in Portland on Friday, May 2, 2014.

Teresa Haynes and I made a License Application Presentation to the graduating Dental Hygiene Students at the Mt. Hood Community College in Gresham on Monday, May 19, 2014.

Dr. Paul Kleinstub Dental Director/Chief Investigator and I made a presentation to the Graduating Dental Hygiene Students at PCC in Portland on Friday, May 23, 2014.

Teresa Haynes and I made a License Application Presentation to the graduating Dental Hygiene Students at the Carrington College in Portland on Monday, June 9, 2014.

AADB/AADA/ Annual Meeting

The Board needs to authorize my attendance at the American Association of Dental Administrators (AADA) Meeting to be held Sunday-Monday October 5-6, 2014 and the American Association of Dental Boards (AADB) Meeting to be held Tuesday-Wednesday, October 7-8, 2014, in San Antonio, TX. Senior Assistant Attorney General Lori Lindley will be attending the Board Attorneys' Roundtable Meeting that is held in conjunction with the AADB Meeting and Dr. Jonna Hongo and Mary Davidson, M.P.H., R.D.H., E.P.P. who are the Dental and Dental Hygiene Liaisons, will be authorized by me to attend the AADB meeting.

Course Evaluations from the ODC Meeting

I have included the course evaluations that were received from the ODA regarding the two presentations that Dr. Kleinstub and I made at the 2014 ODC. It appears that both of the courses were well received and I have recently been asked by the ODA if we would be willing to do presentations again at the 2015 ODC. **Attachment #3**

Senate Bill 1519 Implementation

The following is the disposition of the 46 cases on which the Board of Dentistry completed action in compliance with Senate Bill 1519 (Chapter 16 2014 Oregon Laws).

In 11 cases, the Board issued Notices of Proposed Disciplinary Action. With the passage of Senate Bill 1519 (Chapter 16 2014 Laws), the Board withdrew those Notices with Orders of Dismissal. In compliance with the new law, the Board removed all reference to the 11 cases and corresponding licensees from the OBD Website. Further, in compliance with the Oregon Public Records Law, the Notices of Proposed Disciplinary Action and the Orders of Dismissal are deemed public records and copies of these documents regarding these 11 cases can be obtained by a written or e-mail request to the OBD.

In 16 cases the Board issued Notices of Proposed Disciplinary Action, the licensees signed Consent Orders to resolve the matters and the licensees paid the civil penalties. These cases

were completed disciplinary cases prior to the effective date of Senate Bill 1519 (Chapter 16 2014 Oregon Laws). The Board issued Orders of Refund and sent checks to the licensees. In compliance with the new law, the Board removed all reference to the 11 cases and corresponding licensees from the OBD Website. Further, in compliance with the Oregon Public Records Law, the Notices of Proposed Disciplinary Action, the Consent Orders and the Orders of Refund are deemed public records and copies of these documents regarding these 11 cases can be obtained by a written or e-mail request to the OBD.

In three cases, the Board voted to issue Notices of Proposed Disciplinary Action, however, with the passage of Senate Bill 1519 (Chapter 16 2014 Oregon Laws), the Board did not issue the Notices. At its subsequent meeting the Board voted to rescind its earlier vote and close the matters with Letters of Concern. Letters of Concern are not disciplinary, are not considered public records, and no information is posted on the OBD Website.

For nine cases, the Board issued Notices of Proposed Disciplinary Action, but the licensees did not sign a Consent Order to resolve the matters. Following the passage of Senate Bill 1519 (Chapter 16 2014 Oregon Laws), the Board issued Amended Notices of Proposed Disciplinary Action removing reference to the testing of sterilization devices. The Amended Notices allege other violations of the Oregon Dental Practice Act. In compliance with the new law, the Board removed all documents with references to the testing of sterilization devices from its OBD Website. Further, in compliance with the Oregon Public Records Law, Notices of Proposed Disciplinary Action, are deemed public records and copies of such documents regarding these nine cases can be obtained by a written or e-mail request to the OBD.

In four cases the Board issued Notices of Proposed Disciplinary Action and the licensees signed Consent Orders, but with the passage of Senate Bill 1519 (Chapter 16 2014 Oregon Laws), the Board directed these licensees not to pay the civil penalties. In compliance with the new law, the Board removed all documents with references to the testing of sterilization devices from its OBD Website. Further, in compliance with the Oregon Public Records Law, Notices of Proposed Disciplinary Action, are deemed public records and copies of such documents regarding these four cases can be obtained by a written or e-mail request to the OBD.

In two cases, the Board voted to issue Notices of Proposed Disciplinary Action, however, with the passage of Senate Bill 1519 (Chapter 16 2014 Oregon Laws), the Board did not issue the Notices. At its subsequent meeting the Board voted to rescind its earlier votes and issued Notices of Proposed Disciplinary Action with no reference to the testing of sterilization devices.

For one case, the Board issued Notice of Proposed Disciplinary Action, the Licensee signed a Consent Order, and the licensee paid a civil penalty. However, the civil penalty accounted for multiple violations of the Dental Practice Act. In compliance with the new law, the Board removed all documents with references to the testing of sterilization devices from its OBD Website. Further, in compliance with the Oregon Public Records Law, Notices of Proposed Disciplinary Action, are deemed public records and copies of such documents regarding these four cases can be obtained by a written or e-mail request to the OBD.

Finally, those cases published in the OBD Newsletter with reference to the testing of sterilization devices, were removed from the electronic version of the OBD Newsletter found on the OBD Website.

Discussion on Dates for Strategic Planning Session

Now that we have a the new members appointed to the OBD it would be a good time for us to try to find dates this fall so that the Board could once again hold a Strategic Planning Session the last one was held in October of 2007. Board Members should look at their calendars and see if there are some dates in Late September or in October that may work. The last time we did a Friday night arrival and then worked all day Saturday and then a departure on Sunday.

Newsletter

It is time to consider another newsletter and articles are welcome from the Board Members.



BOARD OF DENTISTRY
Fund 3400 BOARD OF DENTISTRY
For the Month of APRIL 2014

REVENUES

<u>Budget</u> <u>Obj</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date</u> <u>Activity</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to</u> <u>Date</u>	<u>Monthly Avg to</u> <u>Spend</u>
0205	OTHER BUSINESS LICENSES	32,210.00	1,153,055.00	2,376,611.00	1,223,556.00	115,305.50	87,396.86
0210	OTHER NONBUSINESS LICENSES AND FEES	200.00	3,750.00	15,772.00	12,022.00	375.00	858.71
0505	FINES AND FORFEITS	-66,000.00	55,000.00	136,085.00	81,085.00	5,500.00	5,791.79
0605	INTEREST AND INVESTMENTS	458.79	3,612.83	7,890.00	4,277.17	361.28	305.51
0975	OTHER REVENUE	1,030.00	18,992.86	24,447.00	5,454.14	1,899.29	389.58
		-32,101.21	1,234,410.69	2,560,805.00	1,326,394.31	123,441.07	94,742.45

TRANSFER OUT

<u>Budget</u> <u>Obj</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date</u> <u>Activity</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to</u> <u>Date</u>	<u>Monthly Avg to</u> <u>Spend</u>
2443	TRANSFER OUT TO OREGON HEALTH	97,532.50	100,277.50	215,500.00	115,222.50	10,027.75	8,230.18
		97,532.50	100,277.50	215,500.00	115,222.50	10,027.75	8,230.18

PERSONAL SERVICES

<u>Budget</u> <u>Obj</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date</u> <u>Activity</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to</u> <u>Date</u>	<u>Monthly Avg to</u> <u>Spend</u>
3110	CLASS/UNCLASS SALARY & PER DIEM	41,277.00	379,534.31	940,701.00	561,166.69	37,953.43	40,083.34
3160	TEMPORARY APPOINTMENTS	0.00	0.00	15,434.00	15,434.00	0.00	1,102.43
3170	OVERTIME PAYMENTS	517.74	4,011.56	13,384.00	9,372.44	401.16	669.46
3180	SHIFT DIFFERENTIAL	14.25	83.25	114.00	30.75	8.33	2.20
3210	ERB ASSESSMENT	8.25	82.50	212.00	129.50	8.25	9.25
3220	PUBLIC EMPLOYEES' RETIREMENT SYSTEM	5,541.03	54,731.80	133,173.00	78,441.20	5,473.18	5,602.94
3221	PENSION BOND CONTRIBUTION	2,386.33	23,191.33	52,001.00	28,809.67	2,319.13	2,057.83
3230	SOCIAL SECURITY TAX	3,157.00	28,913.11	73,795.00	44,881.89	2,891.31	3,205.85
3250	WORKERS' COMPENSATION ASSESSMENT	25.40	213.15	434.00	220.85	21.32	15.78
3260	MASS TRANSIT	213.68	2,111.14	5,414.00	3,302.86	211.11	235.92
3270	FLEXIBLE BENEFITS	8,719.79	85,410.77	209,350.00	123,939.23	8,541.08	8,852.80
		61,860.47	578,282.92	1,444,012.00	865,729.08	57,828.29	61,837.79

SERVICES and SUPPLIES

<u>Budget</u> <u>Obj</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date</u> <u>Activity</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to</u> <u>Date</u>	<u>Monthly Avg to</u> <u>Spend</u>
4100	INSTATE TRAVEL	2,055.84	23,061.60	55,994.00	32,932.40	2,306.16	2,352.31
4125	OUT-OF-STATE TRAVEL	4,372.43	20,008.83	23,487.00	3,478.17	2,000.88	248.44

<u>Budget</u> <u>Obj</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date</u> <u>Activity</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to</u> <u>Date</u>	<u>Monthly Avg to</u> <u>Spend</u>
4150	EMPLOYEE TRAINING	0.00	3,905.00	8,877.00	4,972.00	390.50	355.14
4175	OFFICE EXPENSES	2,158.79	40,676.78	86,657.00	45,980.22	4,067.68	3,284.30
4200	TELECOMM/TECH SVC AND SUPPLIES	1,221.41	14,141.56	26,077.00	11,935.44	1,414.16	852.53
4225	STATE GOVERNMENT SERVICE CHARGES	52.05	37,129.28	75,916.00	38,786.72	3,712.93	2,770.48
4250	DATA PROCESSING	144.74	2,079.48	4,702.00	2,622.52	207.95	187.32
4275	PUBLICITY & PUBLICATIONS	-1,219.07	16,622.79	22,866.00	6,243.21	1,662.28	445.94
4300	PROFESSIONAL SERVICES	9,479.59	66,942.66	104,922.00	37,979.34	6,694.27	2,712.81
4315	IT PROFESSIONAL SERVICES	3,630.00	12,925.00	22,503.00	9,578.00	1,292.50	684.14
4325	ATTORNEY GENERAL LEGAL FEES	6,636.70	46,473.58	176,916.00	130,442.42	4,647.36	9,317.32
4400	DUES AND SUBSCRIPTIONS	0.00	5,030.45	10,888.00	5,857.55	503.05	418.40
4425	FACILITIES RENT & TAXES	6,971.71	69,165.33	152,950.00	83,784.67	6,916.53	5,984.62
4475	FACILITIES MAINTENANCE	0.00	3,878.45	877.00	-3,001.45	387.85	-214.39
4575	AGENCY PROGRAM RELATED SVCS & SUPP	1,980.62	38,701.44	104,286.00	65,584.56	3,870.14	4,684.61
4650	OTHER SERVICES AND SUPPLIES	824.44	22,666.08	46,577.00	23,910.92	2,266.61	1,707.92
4700	EXPENDABLE PROPERTY \$250-\$5000	0.00	368.92	1,782.00	1,413.08	36.89	100.93
4715	IT EXPENDABLE PROPERTY	40.81	3,338.89	6,411.00	3,072.11	333.89	219.44
		38,350.06	427,116.12	932,688.00	505,571.88	42,711.61	36,112.28

SPECIAL PAYMENTS

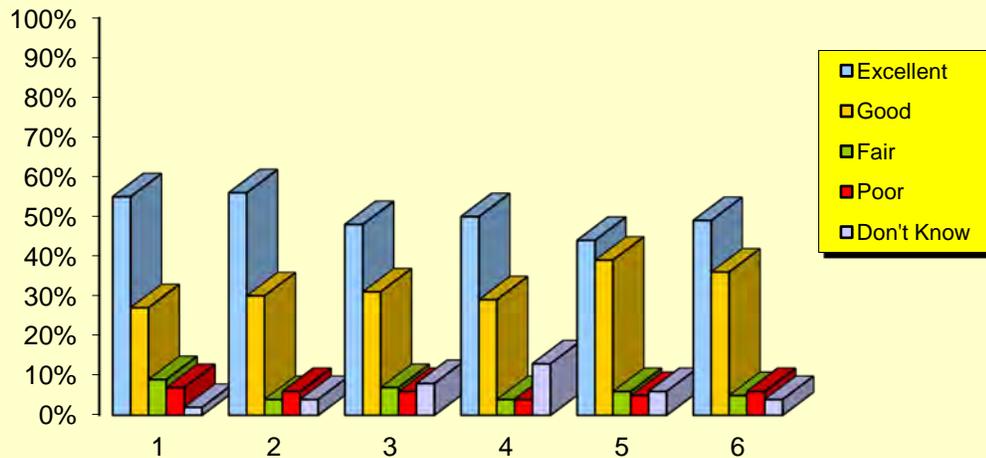
<u>Budget</u> <u>Obj</u>	<u>Budget Obj Title</u>	<u>Monthly Activity</u>	<u>Biennium to Date</u> <u>Activity</u>	<u>Financial Plan</u>	<u>Unobligated Plan</u>	<u>Monthly Avg to</u> <u>Date</u>	<u>Monthly Avg to</u> <u>Spend</u>
6443	DIST TO OREGON HEALTH AUTHORITY	89,897.00	89,897.00	230,216.00	140,319.00	8,989.70	10,022.79
		89,897.00	89,897.00	230,216.00	140,319.00	8,989.70	10,022.79

SUMMARY TOTALS

3400
BOARD OF DENTISTRY

		<u>Month Activity</u>	<u>Biennium Activity</u>
REVENUES	REVENUE	-32,101.21	1,234,410.69
	Total	-32,101.21	1,234,410.69
EXPENDITURES	PERSONAL SERVICES	61,860.47	578,282.92
	SERVICES AND SUPPLIES	38,350.06	427,116.12
	Total	100,210.53	1,005,399.04
TRANSFER OUT	TRANSFER OUT	97,532.50	100,277.50
	Total	97,532.50	100,277.50
SPECIAL PAYMENTS	SPECIAL PAYMENTS	89,897.00	89,897.00
	Total	89,897.00	89,897.00

Oregon Board of Dentistry Customer Service Survey July 1, 2013 - May 31, 2014



- 1 How do you rate the timeliness of the services provided by the OBD?
E= 55% G= 27% F= 9% P= 7% DK= 2%
- 2 How do you rate the ability of the OBD to provide services correctly the first time?
E= 56% G= 30% F= 4% P= 6% DK= 4%
- 3 How do you rate the helpfulness of the OBD?
E= 48% G= 31% F= 7% P= 6% DK= 8%
- 4 How do you rate the knowledge and expertise of the OBD?
E= 50% G= 29% F= 4% P= 4% DK= 13%
- 5 How do you rate the availability of information at the OBD?
E= 44% G= 39% F= 6% P= 5% DK= 6%
- 6 How do you rate the overall quality of services provided by the OBD?
E= 49% G= 36% F= 5% P= 6% DK= 4%

This Page

Left Blank

RECEIVED

MAY 05 2014

Oregon Board
of Dentistry



Mr. Patrick Braatz
Dr. Paul Kleinstub
1600 SW 4th Ave., Suite 770
Portland, OR 97201

Dear Patrick and Dr. Kleinstub,

Thank you for sharing your wisdom at the 2014 Oregon Dental Conference. It was a pleasure to work with you throughout the planning stages, as well as at the ODC. Your participation contributed greatly to the success of the conference.

You will find a summary of your course evaluation, which gives you an average of the scores. Also included is a sheet of any additional comments collected with the survey.

Thank you again,

A handwritten signature in black ink, appearing to read "Lauren Malone", with a long horizontal flourish extending to the right.

Lauren Malone
Managing Director
Meetings & Membership



2014 Oregon
Dental Conference™
April 5-6
Oregon Convention Center
Portland



Attendee Evaluation - Course Survey

4104: Record Keeping from the Board's Perspective
Patrick Braatz & Paul Kleinstub, DDS

QUESTIONS		5	4	3	2	1	MEAN	TOTAL
1 The content of the course was useful	Count	53	43	9	0	0	4.42	105
	Percent	50.48	41.0	8.6	0.0	0.0		
2 Course met stated learning objectives	Count	45	50	9	1	0	4.32	105
	Percent	42.86	47.6	8.6	1.0	0.0		
3 The course material was commercially unbiased	Count	49	44	12	0	0	4.35	105
	Percent	46.67	41.9	11.4	0.0	0.0		
4 Instructor was effective presenting material	Count	48	46	8	3	0	4.32	105
	Percent	45.71	43.8	7.6	2.9	0.0		
5 I would recommend this course to other attendees	Count	45	48	12	0	0	4.31	105
	Percent	42.86	45.7	11.4	0.0	0.0		

Key:
5 = Strongly Agree
4 = Agree
3 = Neutral
2 = Disagree
1 = Strongly Disagree

OVERALL MEAN 4.35



2014 Oregon
Dental Conference®
April 3-5
Oregon Convention Center
Portland



Attendee Evaluation - Course Survey

4105: How to Stay Out of Trouble with the Oregon Board of
Dentistry

Patrick Braatz & Paul Kleinstub, DDS

QUESTIONS		5	4	3	2	1	MEAN	TOTAL
1 The content of the course was useful	Count	46	42	15	0	0	4.30	103
	Percent	44.66	40.8	14.6	0.0	0.0		
2 Course met stated learning objectives	Count	48	40	14	1	0	4.31	103
	Percent	46.60	38.8	13.6	1.0	0.0		
3 The course material was commercially unbiased	Count	52	41	10	0	0	4.41	103
	Percent	50.49	39.8	9.7	0.0	0.0		
4 Instructor was effective presenting material	Count	40	44	15	4	0	4.17	103
	Percent	38.83	42.7	14.6	3.9	0.0		
5 I would recommend this course to other attendees	Count	43	42	15	3	0	4.21	103
	Percent	41.75	40.8	14.6	2.9	0.0		

Key:
5 = Strongly Agree
4 = Agree
3 = Neutral
2 = Disagree
1 = Strongly Disagree

OVERALL MEAN 4.28

Additional Comments Course 4104:

- Once again, organized and very informative. Thank you Mr. Braatz and Dr. Kleinstub
- Very helpful information. This course should be done yearly.
- I'm not a fan of the attitude that the board has towards dentistry. As a dentist we hope to improve ourselves and work with the board to find out requirements. I would prefer to avoid talking to them for fear that I would be singled out and they would make life difficult.
- Nice BIG RDH chart for the office rules and reg's board.
- I discovered some things I could be doing better. Very helpful!
- My only area of discontent was that I thought there would be more examples of actual record keeping. It was only within the last 15 minutes that they showed record keeping examples.
- Important information given in clear and easy to understand
- Dr. Kleinstub left a lot of gray area open for interpretation. There wasn't really a clear cut yes or no when questions were asked.
- I take this course every year and find something new and useful each time. Thank you for providing this course.

Additional Comments Course 4105:

- Loved the review the Dental Practice Act with a highlighter. What a good take-home. Thank you for the Dental Practice Act and the highlighters. Thank you Mr. Baartz and Dr. Kleinstub.
- This is another course that should be presented yearly.
- Went very fast...should have been more than a one hour class
- Scared me a bit, but I learned a lot!
- I thought highlighting areas were ridiculous. I think better explanation could have been given.
- EXCELLENT, SUGGEST REQUIRED 1 HOUR ON LINE CREDIT COURSE
- More details and examples would have been good.
- Nice way to share important information. Good to be able to take back to office to point out areas that need to be looked after. Easy to follow and nice handouts
- Great way to share information that needs to be included in the next staff meeting and to show those unaware of the correct manor to hold business and what is important to be looked after in each dental office
- I think that this may have been geared more towards dentists than dental hygienists however was able to get some information for RDH anyway.

UNFINISHED
BUSINESS
&
RULES

This Page

Left Blank

**DIVISION 1
PROCEDURES**

818-001-0087

Fees

(1) The Board adopts the following fees:

(a) Biennial License Fees:

(A) Dental — \$315;

(B) Dental — retired — \$0;

(C) Dental Faculty — \$260;

(D) Volunteer Dentist — \$0;

(E) Dental Hygiene — \$155;

(F) Dental Hygiene — retired — \$0;

(G) Volunteer Dental Hygienist — \$0.

(b) Biennial Permits, Endorsements or Certificates:

(A) Nitrous Oxide Permit — \$40;

(B) Minimal Sedation Permit — \$75;

(C) Moderate Sedation Permit — \$75;

(D) Deep Sedation Permit — \$75;

(E) General Anesthesia Permit — \$140;

(F) Radiology — \$75;

(G) Expanded Function Dental Assistant — \$50;

(H) Expanded Function Orthodontic Assistant — \$50;

(I) Instructor Permits — \$40;

(J) Dental Hygiene Restorative Functions Endorsement — \$50;

(K) Restorative Functions Dental Assistant — \$50;

(L) Anesthesia Dental Assistant — \$50;

(M) Dental Hygiene, Expanded Practice Permit — \$75

(N) Non-Resident Dental Permit - \$100.00

(c) Applications for Licensure:

(A) Dental — General and Specialty — \$345;

(B) Dental Faculty — \$305;

(C) Dental Hygiene — \$180;

(D) Licensure Without Further Examination — Dental and Dental Hygiene — \$790.

(d) Examinations:

- 35 (A) Jurisprudence — \$0;
- 36 (B) Dental Specialty:
- 37 (i) If only one candidate applies for the exam, a fee of \$2,000.00 will be required at the time of
- 38 application; and
- 39 (ii) If two candidates apply for the exam, a fee of \$1,000.00 will be required at the time of
- 40 application; and
- 41 (iii) If three or more candidates apply for the exam, a fee of \$750.00 will be required at the time
- 42 of application.

43 (e) Duplicate Wall Certificates — \$50.

44 (2) Fees must be paid at the time of application and are not refundable.

45 (3) The Board shall not refund moneys under \$5.01 received in excess of amounts due or to

46 which the Board has no legal interest unless the person who made the payment or the person's

47 legal representative requests a refund in writing within one year of payment to the Board.

48

49 Stat. Auth.: ORS 679 & 680

50 Stats. Implemented: ORS 293.445, 679.060, 679.115, 679.120, 679.250, 680.050, 680.075,

51 680.200 & 680.205

52 Hist.: DE 6-1985(Temp), f. & ef. 9-20-85; DE 3-1986, f. & ef. 3-31-86; DE 1-1987, f. & ef. 10-7-

53 87; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89, corrected by DE 1-1989, f. 1-27-89, cert. ef. 2-1-89;

54 Renumbered from 818-001-0085; DE 2-1989(Temp), f. & cert. ef. 11-30-89; DE 1-1990, f. 3-19-

55 90, cert. ef. 4-2-90; DE 1-1991(Temp), f. 8-5-91, cert. ef. 8-15-91; DE 2-1991, f. & cert. ef. 12-

56 31-91; DE 1-1992(Temp), f. & cert. ef. 6-24-92; DE 2-1993, f. & cert. ef. 7-13-93; OBD 1-1998, f.

57 & cert. ef. 6-8-98; OBD 3-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction, 8-2-99;

58 OBD 5-2000, f. 6-22-00, cert. ef. 7-1-00; OBD 8-2001, f. & cert. ef. 1-8-01; OBD 2-2005, f. 1-31-

59 05, cert. ef. 2-1-05; OBD 2-2007, f. 4-26-07, cert. ef. 5-1-07; OBD 3-2007, f. & cert. ef. 11-30-07;

60 OBD 1-2009(Temp), f. 6-11-09, cert. e. 7-1-09 thru 11-1-09; OBD 2-2009, f. 10-21-09, cert. ef.

61 11-1-09; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 3-2011(Temp), f. 6-30-11, cert. ef. 7-1-

62 11 thru 12-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2012, f. & cert. ef. 1-27-12; OBD

63 1-2013, f. 5-15-13, cert. ef. 7-1-13

64

DIVISION 12
STANDARDS OF PRACTICE

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) Lip augmentation;
- (k) Hair transplantation, not as an isolated procedure for male pattern baldness; and
- (l) 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), and

(b) Has successfully completed a clinical fellowship, of at least one continuous year in duration, in esthetic (cosmetic) surgery recognized by the American Association of Oral and Maxillofacial Surgeons or by the American Dental Association Commission on Dental Accreditation, or

(c) 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 ~~American Association for Ambulatory Health Care (AAAHC);~~ [Accreditation Association for Ambulatory Health Care \(AAHC\)](#).

(3) A dentist may utilize Botulinum Toxin Type A to treat a condition that is within the scope of the practice of dentistry after completing a minimum of 16 hours in a hands on clinical course(s) in which the provider is approved by the Academy of General Dentistry Program Approval for

35 Continuing Education (AGD PACE) or by the American Dental Association Continuing
36 Education Recognition Program (ADA CERP).
37 Stat. Auth.: ORS 679 & 680
38 Stats. Implemented: ORS 679.010(2), 679.140(1)(c), 679.140(2), 679.170(6) & 680.100
39 Hist.: OBD 6-2001, f. & cert. ef. 1-8-01; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 3-2013, f.
40 10-24-13, cert. ef. 1-1-1

DRAFT

DIVISION 12
STANDARDS OF PRACTICE

818-012-0030

Unprofessional Conduct

The Board finds that in addition to the conduct set forth in ORS 679.140(2), a licensee engages in unprofessional conduct if the licensee does or permits any person to:

(1) Attempt to obtain a fee by fraud or misrepresentation.

(2) Obtaining a fee by fraud or misrepresentation.

(a) A licensee obtains a fee by fraud if the licensee obtains a fee by knowingly making or permitting 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 payors 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

35 (B) Duplicates of study models and radiographs, photographs or legible copies thereof if the
36 radiographs, photographs or study models have been paid for.

37 (b) The dentist may require the patient or guardian to pay in advance a fee reasonably
38 calculated to cover the costs of making the copies or duplicates. The dentist may charge a fee
39 not to exceed \$30 for copying 10 or fewer pages of written material and no more than \$0.50 per
40 page for pages 11 through 50 and no more than \$0.25 for each additional page (including
41 records copied from microfilm), plus any postage costs to mail copies requested and actual
42 costs of preparing an explanation or summary of information, if requested. The actual cost of
43 duplicating x-rays may also be charged to the patient. Patient records or summaries may not be
44 withheld from the patient because of any prior unpaid bills, except as provided in (9)(a)(B) of this
45 rule.

46 (10) Fail to identify to a patient, patient's guardian, or the Board the name of an employee,
47 employer, contractor, or agent who renders services.

48 (11) Use prescription forms pre-printed with any Drug Enforcement Administration number,
49 name of controlled substances, or facsimile of a signature.

50 (12) Use a rubber stamp or like device to reproduce a signature on a prescription form or sign a
51 blank prescription form.

52 (13) Order drugs listed on Schedule II of the Drug Abuse Prevention and Control Act, 21 U.S.C.
53 Sec. 812, for office use on a prescription form.

54 (14) Violate any Federal or State law regarding controlled substances.

55 (15) Becomes addicted to, or dependent upon, or abuses alcohol, illegal or controlled drugs, or
56 mind altering substances.

57 (16) Practice dentistry or dental hygiene in a dental office or clinic not owned by an Oregon
58 licensed dentist(s), except for an entity described under ORS 679.020(3) and dental hygienists
59 practicing pursuant to ORS 680.205(1)(2).

60 (17) Make an agreement with a patient or person, or any person or entity representing patients
61 or persons, or provide any form of consideration that would prohibit, restrict, discourage or
62 otherwise limit a person's ability to file a complaint with the Oregon Board of Dentistry; to
63 truthfully and fully answer any questions posed by an agent or representative of the Board; or to
64 participate as a witness in a Board proceeding.

65 **(18) Fail to maintain at a minimum a current Health Care Provider Basic Life Support**
66 **(BLS)/Cardio Pulmonary Resuscitation (CPR) training or its equivalent. (Effective January**
67 **1, 2015)**

68

69 [Publications: Publications referenced are available from the agency.]
70 Stat. Auth.: ORS 679 & 680
71 Stats. Implemented: ORS 679.140(1)(c), 679.140(2), 679.170(6) & 680.100
72 Hist.: DE 6, f. 8-9-63, ef. 9-11-63; DE 14, f. 1-20-72, ef. 2-10-72; DE 5-1980, f. & ef. 12-26-80;
73 DE 2-1982, f. & ef. 3-19-82; DE 5-1982, f. & ef. 5-26-82; DE 9-1984, f. & ef. 5-17-84;
74 Renumbered from 818-010-0080; DE 3-1986, f. & ef. 3-31-86; DE 1-1988, f. 12-28-88, cert. ef.
75 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-011-0020; DE 1-1990, f.
76 3-19-90, cert. ef. 4-2-90; DE 2-1997, f. & cert. ef. 2-20-97; OBD 3-1999, f. 6-25-99, cert. ef. 7-1-
77 99; OBD 1-2006, f. 3-17-06, cert. ef. 4-1-06; OBD 1-2007, f. & cert. ef. 3-1-07; OBD 3-2007, f. &
78 cert. ef. 11-30-07; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 2-2009, f. 10-21-09, cert. ef.
79 11-1-09
80

This Page

Left Blank

DIVISION 12
STANDARDS OF PRACTICE

818-012-0040

Infection Control Guidelines

In determining what constitutes unacceptable patient care with respect to infection control, the Board may consider current infection control guidelines such as those of the Centers for Disease Control and Prevention and the American Dental Association. Additionally, licensees must comply with the following requirements:

(1) Disposable gloves shall be worn whenever placing fingers into the mouth of a patient or when handling blood or saliva contaminated instruments or equipment. Appropriate hand hygiene shall be performed prior to gloving.

(2) Masks and protective eyewear or chin-length shields shall be worn by licensees and other dental care workers when spattering of blood or other body fluids is likely.

(3) Between each patient use, instruments or other equipment that come in contact with body fluids shall be sterilized.

(4) Heat sterilizing devices shall be tested for proper function ~~[on a weekly basis]~~ by means of a biological monitoring system that indicates micro-organisms kill each calendar week in which scheduled patients are treated. Testing results shall be retained by the licensee for the current calendar year and the two preceding calendar years.

(5) Environmental surfaces that are contaminated by blood or saliva shall be disinfected with a chemical germicide which is mycobactericidal at use.

(6) Impervious backed paper, aluminum foil, or plastic wrap may be used to cover surfaces that may be contaminated by blood or saliva and are difficult or impossible to disinfect. The cover shall be replaced between patients.

(7) All contaminated wastes and sharps shall be disposed of according to any governmental requirements.

Stat. Auth.: ORS 679.120, 679.250(7), 680.075 & 680.150

Stats. Implemented: ORS 679.140, 679.140(4) & 680.100

Hist.: DE 1-1988, f. 12-28-88, cert. ef. 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; DE 2-1992, f. & cert. ef. 6-24-92; OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 3-2013, f. 10-24-13, cert. ef. 1-1-14

DIVISION 21
EXAMINATION AND LICENSING

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, study clubs, 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) 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.

35 **(6) At least 2 hours of continuing education must be related to infection control.**
36 **(Effective January 1, 2015)**

37

38 Stat. Auth.: ORS 679

39 Stats. Implemented: ORS 679.250(9)

40 Hist.: DE 3-1987, f. & ef. 10-15-87; DE 4-1987(Temp), f. & ef. 11-25-87; DE 1-1988, f. 12-28-88,
41 cert. ef. 2-1-89; DE 1-1989, f. 1-27-89, cert. ef. 2-1-89; Renumbered from 818-020-0072; DE 1-
42 1990, f. 3-19-90, cert. ef. 4-2-90; OBD 9-2000, f. & cert. ef. 7-28-00; OBD 16-2001, f. 12-7-01,
43 cert. ef. 4-1-02; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09;
44 OBD 3-2011(Temp), f. 6-30-11, cert. ef. 7-1-11 thru 12-27-11; OBD 4-2011, f. & cert. ef. 11-15-
45 11

46

DRAFT

This Page

Left Blank

1 **DIVISION 21**

2 **EXAMINATION AND LICENSING**

3 **818-021-0070**

4 **Continuing Education — Dental Hygienists**

5 (1) Each dental hygienist must complete 24 hours of continuing education every two years. An
6 Expanded Practice Permit Dental Hygienist shall complete a total of 36 hours of continuing
7 education every two years. Continuing education (C.E.) must be directly related to clinical
8 patient care or the practice of dental public health.

9 (2) Dental hygienists must maintain records of successful completion of continuing education for
10 at least four licensure years consistent with the licensee's licensure cycle. (A licensure year for
11 dental hygienists is October 1 through September 30.) The licensee, upon request by the Board,
12 shall provide proof of successful completion of continuing education courses.

13 (3) Continuing education includes:

14 (a) Attendance at lectures, study clubs, college post-graduate courses, or scientific sessions at
15 conventions.

16 (b) Research, graduate study, teaching or preparation and presentation of scientific sessions.
17 No more than six hours may be in teaching or scientific sessions. (Scientific sessions are
18 defined as scientific presentations, table clinics, poster sessions and lectures.)

19 (c) Correspondence courses, videotapes, distance learning courses or similar self-study course,
20 provided that the course includes an examination and the dental hygienist passes the
21 examination.

22 (d) Continuing education credit can be given for volunteer pro bono dental hygiene services
23 provided in the state of Oregon; community oral health instruction at a public health facility
24 located in the state of Oregon; authorship of a publication, book, chapter of a book, article or
25 paper published in a professional journal; participation on a state dental board, peer review, or
26 quality of care review procedures; successful completion of the National Board Dental Hygiene
27 Examination, taken after initial licensure; or test development for clinical dental hygiene
28 examinations. No more than 6 hours of credit may be in these areas.

29 (4) At least three hours of continuing education must be related to medical emergencies in a
30 dental office. No more than two hours of Practice Management and Patient Relations may be
31 counted toward the C.E. requirement in any renewal period.

32 (5) Dental hygienists who hold a Nitrous Oxide Permit must meet the requirements contained in
33 OAR 818-026-0040(9) for renewal of the Nitrous Oxide Permit.

34 **(6) At least 2 hours of continuing education must be related to infection control.**
35 **(Effective January 1, 2015)**

36

37 Stat. Auth.: ORS 679

38 Stats. Implemented: ORS 679.250(9)

39 Hist.: DE 3-1987, f. & ef. 10-15-87; DE 1-1988, f. 12-28-88, cert. ef. 2-1-89; DE 1-1989, f. 1-27-
40 89, cert. ef. 2-1-89; Renumbered from 818-020-0073; DE 1-1990, f. 3-19-90, cert. ef. 4-2-90;

41 OBD 9-2000, f. & cert. ef. 7-28-00; OBD 2-2002, f. 7-31-02, cert. ef. 10-1-02; OBD 2-2004, f. 7-

42 12-04, cert. ef. 7-15-04; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 2-2009, f. 10-21-09, cert. ef.

43 11-1-09; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 3-2011(Temp), f. 6-30-11, cert. ef. 7-1-

44 11 thru 12-27-11; OBD 4-2011, f. & cert. ef. 11-15-11

45

DRAFT

DIVISION 26
ANESTHESIA

818-026-0050

Minimal Sedation Permit

Minimal sedation and nitrous oxide sedation.

(1) The Board shall issue a Minimal Sedation Permit to an applicant who:

(a) Is a licensed dentist in Oregon;

(b) Holds a valid and current Health Care Provider BLS/CPR level certificate, or its equivalent;
and

(c) Completion of a comprehensive training program consisting of at least 16 hours of training and satisfies the requirements of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (2007)* at the time training was commenced or postgraduate instruction was completed, or the equivalent of that required in graduate training programs, in sedation, recognition and management of complications and emergency care; or

(d) In lieu of these requirements, the Board may accept equivalent training or experience in minimal sedation anesthesia.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full facemask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

- 35 (g) Sphygmomanometer, stethoscope, pulse oximeter, and/or automatic blood pressure cuff;
36 and
- 37 (h) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the
38 drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives
39 and anticonvulsants.
- 40 (3) Before inducing minimal sedation, a dentist who induces minimal sedation shall:
- 41 (a) Evaluate the patient;
- 42 (b) Give written preoperative and postoperative instructions to the patient or, when appropriate
43 due to age or psychological status of the patient, the patient's guardian;
- 44 (c) Certify that the patient is an appropriate candidate for minimal sedation; and
- 45 (d) Obtain written informed consent from the patient or patient's guardian for the anesthesia.
46 The obtaining of the informed consent shall be documented in the patient's record.
- 47 (4) No permit holder shall have more than one person under minimal sedation at the same time.
- 48 (5) While the patient is being treated under minimal sedation, an anesthesia monitor shall be
49 present in the room in addition to the treatment provider. The anesthesia monitor may be the
50 **[chairside] dental** assistant.
- 51 **(a) After training, a dental assistant, when directed by a dentist, may administer oral**
52 **sedative agents or anxiolysis agents calculated and dispensed by a dentist under the**
53 **direct supervision of a dentist.**
- 54 (6) A patient under minimal sedation shall be visually monitored at all times, including recovery
55 phase. The dentist or anesthesia monitor shall monitor and record the patient's condition.
- 56 (7) The patient shall be monitored as follows:
- 57 (a) Patients must have continuous monitoring using pulse oximetry. The patient's blood
58 pressure, heart rate, and respiration shall be taken if they can reasonably be obtained. If the
59 information cannot be obtained, the reasons shall be documented in the patient's record. The
60 record must also include documentation of all medications administered with dosages, time
61 intervals and route of administration.
- 62 (b) A discharge entry shall be made by the dentist in the patient's record indicating the patient's
63 condition upon discharge and the name of the responsible party to whom the patient was
64 discharged.
- 65 (8) The dentist shall assess the patient's responsiveness using preoperative values as normal
66 guidelines and discharge the patient only when the following criteria are met:
- 67 (a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

68 (b) The patient is alert and oriented to person, place and time as appropriate to age and
69 preoperative psychological status;
70 (c) The patient can talk and respond coherently to verbal questioning;
71 (d) The patient can sit up unaided;
72 (e) The patient can ambulate with minimal assistance; and
73 (f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
74 (g) A dentist shall not release a patient who has undergone minimal sedation except to the care
75 of a responsible third party.
76 (9) Permit renewal. In order to renew a Minimal Sedation Permit, the permit holder must provide
77 documentation of having a current Health Care Provider BLS/CPR level certificate, or its
78 equivalent. In addition, Minimal Sedation Permit holders must also complete four (4) hours of
79 continuing education in one or more of the following areas every two years: sedation, physical
80 evaluation, medical emergencies, monitoring and the use of monitoring equipment, or
81 pharmacology of drugs and agents used in sedation. Training taken to maintain current Health
82 Care Provider BLS/CPR level certification, or its equivalent, may not be counted toward this
83 requirement. Continuing education hours may be counted toward fulfilling the continuing
84 education requirement set forth in OAR 818-021-0060.

85
86 Stat. Auth.: ORS 679

87 Stats. Implemented: ORS 679.250(7) & 679.250(10)

88 Hist.: OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction 8-12-99; OBD 3-2003, f.
89 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 2-2005, f. 1-31-05, cert.
90 ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10

This Page

Left Blank

DIVISION 26
ANESTHESIA

818-026-0055

Dental Hygiene and Dental Assistant Procedures Performed Under Nitrous Oxide or Minimal Sedation

(1) Under indirect supervision, dental hygiene procedures may be performed for a patient who is under nitrous oxide or minimal sedation under the following conditions:

(a) A licensee holding a Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;

~~[(b) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with 818-026-0050(7) and (8); and~~

~~(c) An anesthesia monitor, in addition to the dental hygienist performing the authorized procedures, is present with the patient at all times.]~~

(b) The permit holder, or an anesthesia monitor, monitors the patient; or

(c) if a dental hygienist with a nitrous oxide permit administers nitrous oxide sedation to a patient and then performs authorized procedures on the patient, an anesthesia monitor is not required to be present during the time the patient is sedated unless the permit holder leaves the patient.

(d) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with 818-026-0050(7) and (8).

(2) Under direct supervision, a dental assistant may perform those procedures for which the dental assistant holds the appropriate certification for a patient who is under nitrous oxide or minimal sedation under the following conditions:

(a) A licensee holding the Nitrous Oxide, Minimal, Moderate, Deep Sedation or General Anesthesia Permit administers the sedative agents;

(b) The permit holder, or an anesthesia monitor, monitors the patient; and

(c) The permit holder performs the appropriate pre- and post-operative evaluation and discharges the patient in accordance with 818-026-0050(7) and (8).

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.250(7) & 679.250(10)

Hist.: OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12

This Page

Left Blank

1 **DIVISION 26**
2 **ANESTHESIA**

3 **818-026-0060**

4 **Moderate Sedation Permit**

5 Moderate sedation, minimal sedation, and nitrous oxide sedation.

6 (1) The Board shall issue or renew a Moderate Sedation Permit to an applicant who:

7 (a) Is a licensed dentist in Oregon;

8 (b) Either holds a current Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life
9 Support (PALS) certificate, whichever is appropriate for the patient being sedated, or
10 successfully completes the American Dental Association's course "*Recognition and*
11 *Management of Complications during Minimal and Moderate Sedation*" at least every two years;
12 and

13 (c) Satisfies one of the following criteria:

14 (A) Completion of a comprehensive training program in enteral and/or parenteral sedation that
15 satisfies the requirements described in Part V of the *ADA Guidelines for Teaching Pain Control*
16 *and Sedation to Dentists and Dental Students (2007)* at the time training was commenced.

17 (i) Enteral Moderate Sedation requires a minimum of 24 hours of instruction plus management
18 of at least 10 dental patient experiences by the enteral and/or enteral-nitrous oxide/oxygen
19 route.

20 (ii) Parenteral Moderate Sedation requires a minimum of 60 hours of instruction plus
21 management of at least 20 dental patients by the intravenous route.

22 (B) Completion of an ADA accredited postdoctoral training program (e.g., general practice
23 residency) which affords comprehensive and appropriate training necessary to administer and
24 manage parenteral sedation, commensurate with these Guidelines.

25 (C) In lieu of these requirements, the Board may accept equivalent training or experience in
26 moderate sedation anesthesia.

27 (2) The following facilities, equipment and drugs shall be on site and available for immediate use
28 during the procedures and during recovery:

29 (a) An operating room large enough to adequately accommodate the patient on an operating
30 table or in an operating chair and to allow an operating team of at least two individuals to freely
31 move about the patient;

32 (b) An operating table or chair which permits the patient to be positioned so the operating team
33 can maintain the patient's airway, quickly alter the patient's position in an emergency, and
34 provide a firm platform for the administration of basic life support;

- 35 (c) A lighting system which permits evaluation of the patient's skin and mucosal color and a
36 backup lighting system of sufficient intensity to permit completion of any operation underway in
37 the event of a general power failure;
- 38 (d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a
39 backup suction device which will function in the event of a general power failure;
- 40 (e) An oxygen delivery system with adequate full face mask and appropriate connectors that is
41 capable of delivering high flow oxygen to the patient under positive pressure, together with an
42 adequate backup system;
- 43 (f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate
44 continuous oxygen delivery and a scavenger system;
- 45 (g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets.
46 The recovery area can be the operating room;
- 47 (h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, oral
48 and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration
49 equipment, automated external defibrillator (AED); and
- 50 (i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the
51 drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives
52 and anticonvulsants.
- 53 (3) No permit holder shall have more than one person under moderate sedation, minimal
54 sedation, or nitrous oxide sedation at the same time.
- 55 (4) During the administration of moderate sedation, and at all times while the patient is under
56 moderate sedation, an anesthesia monitor, and one other person holding a Health Care
57 Provider BLS/CPR level certificate or its equivalent, shall be present in the operatory, in addition
58 to the dentist performing the dental procedures.
- 59 (5) Before inducing moderate sedation, a dentist who induces moderate sedation shall:
- 60 (a) Evaluate the patient and document, using the American Society of Anesthesiologists *Patient*
61 *Physical Status Classifications*, that the patient is an appropriate candidate for moderate
62 sedation;
- 63 (b) Give written preoperative and postoperative instructions to the patient or, when appropriate
64 due to age or psychological status of the patient, the patient's guardian; and
- 65 (c) Obtain written informed consent from the patient or patient's guardian for the anesthesia.
- 66 (6) A patient under moderate sedation shall be visually monitored at all times, including the
67 recovery phase. The dentist or anesthesia monitor shall monitor and record the patient's
68 condition.

69 (7) The patient shall be monitored as follows:

70 (a) Patients must have continuous monitoring using pulse oximetry and End-tidal CO2 monitors.

71 The patient's blood pressure, heart rate, and respiration shall be recorded at regular intervals

72 but at least every 15 minutes, and these recordings shall be documented in the patient record.

73 The record must also include documentation of preoperative and postoperative vital signs, all

74 medications administered with dosages, time intervals and route of administration. If this

75 information cannot be obtained, the reasons shall be documented in the patient's record. A

76 patient under moderate sedation shall be continuously monitored;

77 (b) During the recovery phase, the patient must be monitored by an individual trained to monitor

78 patients recovering from moderate sedation.

79 (8) A dentist shall not release a patient who has undergone moderate sedation except to the

80 care of a responsible third party.

81 (9) The dentist shall assess the patient's responsiveness using preoperative values as normal

82 guidelines and discharge the patient only when the following criteria are met:

83 (a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

84 (b) The patient is alert and oriented to person, place and time as appropriate to age and

85 preoperative psychological status;

86 (c) The patient can talk and respond coherently to verbal questioning;

87 (d) The patient can sit up unaided;

88 (e) The patient can ambulate with minimal assistance; and

89 (f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.

90 (10) A discharge entry shall be made by the dentist in the patient's record indicating the patient's

91 condition upon discharge and the name of the responsible party to whom the patient was

92 discharged.

93 (11) After adequate training, an assistant, when directed by a dentist, may dispense oral

94 medications that have been prepared by the dentist permit holder for oral administration

95 to a patient under direct supervision or introduce additional anesthetic agents in to an

96 infusion line under the direct visual supervision of a dentist.

97 (12) Permit renewal. In order to renew a Moderate Sedation Permit, the permit holder must

98 provide documentation of having current ACLS or PALS certification or current certification of

99 successful completion of the American Dental Association's course "*Recognition and*

100 *Management of Complications during Minimal and Moderate Sedation*" and must complete 14

101 hours of continuing education in one or more of the following areas every two years: sedation,

102 physical evaluation, medical emergencies, monitoring and the use of monitoring equipment, or

103 pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS or
104 PALS certification or successful completion of the American Dental Association’s course
105 “*Recognition and Management of Complications during Minimal and Moderate Sedation*” may
106 be counted toward this requirement. Continuing education hours may be counted toward
107 fulfilling the continuing education requirement set forth in OAR 818-021-0060.

108

109 [Publications: Publications referenced are available from the agency.]

110 Stat. Auth.: ORS 679

111 Stats. Implemented: ORS 679.250(7) & 679.250(10)

112 Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 1-1999, f. 2-26-99, cert. ef. 3-1-99; OBD 6-
113 1999, f. 6-25-99, cert. ef. 7-1-99; Administrative correction 8-12-99; OBD 2-2000(Temp), f. 5-22-
114 00, cert. ef. 5-22-00 thru 11-18-00; OBD 2-2001, f. & cert. ef. 1-8-01; OBD 3-2003, f. 9-15-03,
115 cert. ef. 10-1-03; OBD 1-2005, f. 1-28-05, cert. ef. 2-1-05; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-
116 05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2011(Temp), f. 5-9-11, cert. ef. 6-1-11 thru
117 1-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13; OBD 3-
118 2013, f. 10-24-13, cert. ef. 1-1-14

119

DIVISION 26
ANESTHESIA

818-026-0065

Deep Sedation

Deep sedation, moderate sedation, minimal sedation, and nitrous oxide sedation.

(1) The Board shall issue a Deep Sedation Permit to a licensee who holds a Class 3 Permit on or before July 1, 2010 who:

(a) Is a licensed dentist in Oregon; and

(b) Holds a current Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) certificate, whichever is appropriate for the patient being sedated.

(2) The following facilities, equipment and drugs shall be on site and available for immediate use during the procedures and during recovery:

(a) An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

(b) An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

(c) A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

(d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

(e) An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

(f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

(g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets.

The recovery area can be the operating room;

(h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter, electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment;

and

35 (i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the
36 drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives
37 and anticonvulsants.

38 (3) No permit holder shall have more than one person under deep sedation, moderate sedation,
39 minimal sedation, or nitrous oxide sedation at the same time.

40 (4) During the administration of deep sedation, and at all times while the patient is under deep
41 sedation, an anesthesia monitor, and one other person holding a Health Care Provider
42 BLS/CPR level certificate or its equivalent, shall be present in the operatory, in addition to the
43 dentist performing the dental procedures.

44 (5) Before inducing deep sedation, a dentist who induces deep sedation shall:

45 (a) Evaluate the patient and document, using the American Society of Anesthesiologists Patient
46 Physical Status Classifications, that the patient is an appropriate candidate for deep sedation;

47 (b) Give written preoperative and postoperative instructions to the patient or, when appropriate
48 due to age or psychological status of the patient, the patient's guardian; and

49 (c) Obtain written informed consent from the patient or patient's guardian for the anesthesia.

50 (6) A patient under deep sedation shall be visually monitored at all times, including the recovery
51 phase. The dentist or anesthesia monitor shall monitor and record the patient's condition.

52 (7) The patient shall be monitored as follows:

53 (a) Patients must have continuous monitoring using pulse oximetry, electrocardiograph monitors
54 (ECG) and End-tidal CO₂ monitors. The patient's heart rhythm shall be continuously monitored
55 and the patient's blood pressure, heart rate, and respiration shall be recorded at regular
56 intervals but at least every 5 minutes, and these recordings shall be documented in the patient
57 record. The record must also include documentation of preoperative and postoperative vital
58 signs, all medications administered with dosages, time intervals and route of administration. If
59 this information cannot be obtained, the reasons shall be documented in the patient's record. A
60 patient under deep sedation shall be continuously monitored;

61 **(b) Once sedated, a patient shall remain in the operatory for the duration of treatment**
62 **until criteria for transportation to recovery have been met.**

63 ~~(b)~~ (c) During the recovery phase, the patient must be monitored by an individual trained to
64 monitor patients recovering from deep sedation.

65 (8) A dentist shall not release a patient who has undergone deep sedation except to the care of
66 a responsible third party.

67 (9) The dentist shall assess the patient's responsiveness using preoperative values as normal
68 guidelines and discharge the patient only when the following criteria are met:

69 (a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;
70 (b) The patient is alert and oriented to person, place and time as appropriate to age and
71 preoperative psychological status;
72 (c) The patient can talk and respond coherently to verbal questioning;
73 (d) The patient can sit up unaided;
74 (e) The patient can ambulate with minimal assistance; and
75 (f) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness.
76 (10) A discharge entry shall be made by the dentist in the patient's record indicating the patient's
77 condition upon discharge and the name of the responsible party to whom the patient was
78 discharged.
79 (11) After adequate training, an assistant, when directed by a dentist, may administer oral
80 sedative agents calculated by a dentist or introduce additional anesthetic agents in to an
81 infusion line under the direct visual supervision of a dentist.
82 (12) Permit renewal. In order to renew a Deep Sedation Permit, the permit holder must provide
83 documentation of having current ACLS or PALS certification and must complete 14 hours of
84 continuing education in one or more of the following areas every two years: sedation, physical
85 evaluation, medical emergencies, monitoring and the use of monitoring equipment, or
86 pharmacology of drugs and agents used in sedation. Training taken to maintain current ACLS or
87 PALS certification may be counted toward this requirement. Continuing education hours may be
88 counted toward fulfilling the continuing education requirement set forth in OAR 818-021-0060.
89
90 [Publications: Publications referenced are available from the agency.]
91 Stat. Auth.: ORS 679
92 Stats. Implemented: ORS 679.250(7) & 679.250(10)
93 Hist. : OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2011(Temp), f. 5-9-11, cert. ef. 6-1-11
94 thru 1-27-11; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 1-2013, f. 5-15-13, cert. ef. 7-1-13
95

This Page

Left Blank

2 **GENERAL ANESTHESIA PERMIT**

3 General anesthesia, deep sedation, moderate sedation, minimal sedation and nitrous oxide
4 sedation.

5 (1) The Board shall issue a General Anesthesia Permit to an applicant who:

6 (a) Is a licensed dentist in Oregon;

7 (b) Holds a current Advanced Cardiac Life Support (ACLS) Certificate or Pediatric Advanced
8 Life Support (PALS) Certificate, whichever is appropriate for the patient being sedated; and

9 (c) Satisfies one of the following criteria:

10 (A) Completion of an advanced training program in anesthesia and related subjects beyond the
11 undergraduate dental curriculum that satisfies the requirements described in the ADA
12 Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students (2007)
13 consisting of a minimum of 2 years of a postgraduate anesthesia residency at the time training
14 was commenced.

15 (B) Completion of any ADA accredited postdoctoral training program, including but not limited to
16 Oral and Maxillofacial Surgery, which affords comprehensive and appropriate training necessary
17 to administer and manage general anesthesia, commensurate with these Guidelines.

18 (C) In lieu of these requirements, the Board may accept equivalent training or experience in
19 general anesthesia.

20 (2) The following facilities, equipment and drugs shall be on site and available for immediate use
21 during the procedure and during recovery:

22 (a) An operating room large enough to adequately accommodate the patient on an operating
23 table or in an operating chair and to allow an operating team of at least three individuals to
24 freely move about the patient;

25 (b) An operating table or chair which permits the patient to be positioned so the operating team
26 can maintain the patient's airway, quickly alter the patient's position in an emergency, and
27 provide a firm platform for the administration of basic life support;

28 (c) A lighting system which permits evaluation of the patient's skin and mucosal color and a
29 backup lighting system of sufficient intensity to permit completion of any operation underway in
30 the event of a general power failure;

31 (d) Suction equipment which permits aspiration of the oral and pharyngeal cavities and a
32 backup suction device which will function in the event of a general power failure;

- 33 (e) An oxygen delivery system with adequate full face mask and appropriate connectors that is
34 capable of delivering high flow oxygen to the patient under positive pressure, together with an
35 adequate backup system;
- 36 (f) A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate
37 continuous oxygen delivery and a scavenger system;
- 38 (g) A recovery area that has available oxygen, adequate lighting, suction and electrical outlets.
39 The recovery area can be the operating room;
- 40 (h) Sphygmomanometer, precordial/pretracheal stethoscope, capnograph, pulse oximeter,
41 electrocardiograph monitor (ECG), automated external defibrillator (AED), oral and
42 nasopharyngeal airways, laryngeal mask airways, intravenous fluid administration equipment;
43 and
- 44 (i) Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the
45 drugs used, vasopressors, corticosteroids, bronchodilators, intravenous medications for
46 treatment of cardiac arrest, narcotic antagonist, antihistaminic, antiarrhythmics,
47 antihypertensives and anticonvulsants.
- 48 (3) No permit holder shall have more than one person under general anesthesia, deep sedation,
49 moderate sedation, minimal sedation or nitrous oxide sedation at the same time.
- 50 (4) During the administration of deep sedation or general anesthesia, and at all times while the
51 patient is under deep sedation or general anesthesia, an anesthesia monitor and one other
52 person holding a Health Care Provider BLS/CPR level certificate, or its equivalent, shall be
53 present in the operatory in addition to the dentist performing the dental procedures.
- 54 (5) Before inducing deep sedation or general anesthesia the dentist who induces deep sedation
55 or general anesthesia shall:
- 56 (a) Evaluate the patient and document, using the American Society of Anesthesiologists Patient
57 Physical Status Classifications, that the patient is an appropriate candidate for general
58 anesthesia or deep sedation;
- 59 (b) Give written preoperative and postoperative instructions to the patient or, when appropriate
60 due to age or psychological status of the patient, the patient's guardian; and
- 61 (c) Obtain written informed consent from the patient or patient's guardian for the anesthesia.
- 62 (6) A patient under deep sedation or general anesthesia shall be visually monitored at all times,
63 including recovery phase. A dentist who induces deep sedation or general anesthesia or
64 anesthesia monitor trained in monitoring patients under deep sedation or general anesthesia
65 shall monitor and record the patient's condition on a contemporaneous record.
- 66 (7) The patient shall be monitored as follows:

67 (a) Patients must have continuous monitoring of their heart rate, heart rhythm, oxygen
68 saturation levels and respiration using pulse oximetry, electrocardiograph monitors (ECG) and
69 End-tidal CO2 monitors. The patient's blood pressure, heart rate and oxygen saturation shall be
70 assessed every five minutes, and shall be contemporaneously documented in the patient
71 record. The record must also include documentation of preoperative and postoperative vital
72 signs, all medications administered with dosages, time intervals and route of administration. The
73 person administering the anesthesia and the person monitoring the patient may not leave the
74 patient while the patient is under deep sedation or general anesthesia;

75 **(b) Once sedated, a patient shall remain in the operatory for the duration of treatment**
76 **until criteria for transportation to recovery have been met.**

77 ~~((b))~~ (c) During the recovery phase, the patient must be monitored, including the use of pulse
78 oximetry, by an individual trained to monitor patients recovering from general anesthesia.

79 (8) A dentist shall not release a patient who has undergone deep sedation or general
80 anesthesia except to the care of a responsible third party.

81 (9) The dentist shall assess the patient's responsiveness using preoperative values as normal
82 guidelines and discharge the patient only when the following criteria are met:

83 (a) Vital signs including blood pressure, pulse rate and respiratory rate are stable;

84 (b) The patient is alert and oriented to person, place and time as appropriate to age and
85 preoperative psychological status;

86 (c) The patient can talk and respond coherently to verbal questioning;

87 (d) The patient can sit up unaided;

88 (e) The patient can ambulate with minimal assistance; and

89 (f) The patient does not have nausea or vomiting and has minimal dizziness.

90 (10) A discharge entry shall be made in the patient's record by the dentist indicating the patient's
91 condition upon discharge and the name of the responsible party to whom the patient was
92 discharged.

93 (11) After adequate training, an assistant, when directed by a dentist, may introduce additional
94 anesthetic agents to an infusion line under the direct visual supervision of a dentist.

95 (12) Permit renewal. In order to renew a General Anesthesia Permit, the permit holder must
96 provide documentation of having current ACLS or PALS certification and complete 14 hours of
97 continuing education in one or more of the following areas every two years: deep sedation
98 and/or general anesthesia, physical evaluation, medical emergencies, monitoring and the use of
99 monitoring equipment, pharmacology of drugs and agents used in anesthesia. Training taken to
100 maintain current ACLS or PALS certification may be counted toward this requirement.

101 Continuing education hours may be counted toward fulfilling the continuing education
102 requirement set forth in OAR 818-021-0060.

103

104 [Publications: Publications referenced are available from the agency.]

105 Stat. Auth.: ORS 679

106 Stats. Implemented: ORS 679.250(7) & 679.250(10)

107 Hist.: OBD 2-1998, f. 7-13-98, cert. ef. 10-1-98; OBD 6-1999, f. 6-25-99, cert. ef. 7-1-99;

108 Administrative correction 8-12-99; OBD 2-2000(Temp), f. 5-22-00, cert. ef. 5-22-00 thru 11-18-

109 00; Administrative correction 6-21-01; OBD 3-2003, f. 9-15-03, cert. ef. 10-1-03; OBD 1-2005, f.

110 1-28-05, cert. ef. 2-1-05; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 2-2011 (Temp), f. 5-9-

111 11, cert. ef. 6-1-11 thru 11-27-11; OBD 4-2011, f & cert. ef 11-15-11; OBD 1-2013, f. 5-15-13,

112 cert. ef. 7-1-13

113

DRAFT

DIVISION 35
DENTAL HYGIENE

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

818-035-0025

Prohibitions

A dental hygienist may not:

- (1) Diagnose and treatment plan other than for dental hygiene services;
- (2) Cut hard or soft tissue with the exception of root planing;
- (3) Extract any tooth;
- (4) Fit or adjust any correctional or prosthetic appliance except as provided by OAR 818-035-0030(1)(h);
- (5) ~~Prescribe~~ Administer or dispense any drugs except as provided by OAR 818-035-0030, 818-035-0040, 818-026-0060(11) and 818-026-0070(11);
- (6) Place, condense, carve or cement permanent restorations except as provided in OAR 818-035-0072, or operatively prepare teeth;
- (7) Irrigate or medicate canals; try in cones, or ream, file or fill canals;
- (8) Use the behavior management techniques of Hand Over Mouth (HOM) or Hand Over Mouth Airway Restriction (HOMAR) on any patient.
- (9) Place or remove healing caps or healing abutments, except under direct supervision.
- (10) Place implant impression copings, except under direct supervision.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.020(1)

Hist.: DE 2-1992, f. & cert. ef. 6-24-92; DE 2-1997, f. & cert. ef. 2-20-97; OBD 7-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 2-2000(Temp), f. 5-22-00, cert. ef. 5-22-00 thru 11-18-00; OBD 2-2001, f. & cert. ef. 1-8-01; OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 2-2007, f. 4-26-07, cert. ef. 5-1-07; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 4-2011, f. & cert. ef. 11-15-11

This Page

Left Blank

DIVISION 35
DENTAL HYGIENE

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.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.025(2)(j)

Hist.: DE 5-1984, f. & ef. 5-17-84; DE 3-1986, f. & ef. 3-31-86; DE 2-1992, f. & cert. ef. 6-24-92; OBD 7-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 1-2001, f. & cert. ef. 1-8-01; OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02; OBD 1-2004, f. 5-27-04, cert. ef. 6-1-04; OBD 2-2005, f. 1-31-05, cert. ef. 2-1-05; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08; OBD 2-2009, f. 10-21-09, cert. ef. 11-1-09

DIVISION 35
DENTAL HYGIENE

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.

Stat. Auth.: ORS 679 & 680

Stats. Implemented: ORS 679.025(2)(j) & 679.250(7)

Hist.: DE 5-1984, f. & ef. 5-17-84; DE 3-1986, f. & ef. 3-31-86; DE 2-1992, f. & cert. ef. 6-24-92; OBD 3-1998, f. & cert. ef. 7-13-98; OBD 7-1999, f. 6-25-99, cert. ef. 7-1-99; OBD 8-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02; OBD 2-2007, f. 4-26-07, cert. ef. 5-1-07; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 1-2008, f. 11-10-08, cert. ef. 12-1-08

DIVISION 42
DENTAL ASSISTING

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 (818-042-0070 and 818-042-0090) or Expanded Orthodontic Function duty (818-042-0100) 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 or dispense any drug except fluoride, topical anesthetic, desensitizing agents [over the counter medications per package instructions](#) or drugs administered pursuant to [OAR 818-026-0030\(6\), OAR 818-026-0050\(5\)\(a\)](#), 818-026-0060(11), 818-026-0065(11), 818-026-0070(11) and as provided in 818-042-0070 and 818-042-0115.
- (7) Prescribe any drug.
- (8) Place periodontal packs.
- (9) Start nitrous oxide.
- (10) Remove stains or deposits except 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.
- (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 prosthetic or orthodontic appliance including bands, brackets, retainers, tooth moving devices, or orthopedic appliances except as provided in 818-042-0100.
- (17) Condense and carve permanent restorative material except as provided in OAR 818-042-0095.
- (18) Place any type of cord subgingivally.

- 33 (19) Take jaw registrations or oral impressions for supplying artificial teeth as substitutes for
34 natural teeth, except diagnostic or opposing models or for the fabrication of temporary or
35 provisional restorations or appliances.
- 36 (20) Apply denture relines except as provided in OAR 818-042-0090(2).
- 37 (21) Expose radiographs without holding a current Certificate of Radiologic Proficiency issued
38 by the Board (818-042-0050 and 818-042-0060) except while taking a course of instruction
39 approved by the Oregon Health Authority, Oregon Public Health Division, Office of
40 Environmental Public Health, Radiation Protection Services, or the Oregon Board of Dentistry.
- 41 (22) Use the behavior management techniques known as Hand Over Mouth (HOM) or Hand
42 Over Mouth Airway Restriction (HOMAR) on any patient.
- 43 (23) Perform periodontal probing.
- 44 (24) Place or remove healing caps or healing abutments, except under direct supervision.
- 45 (25) Place implant impression copings, except under direct supervision.
- 46 (26) Any act in violation of Board statute or rules.

47

48 Stat. Auth.: ORS 679 & 680

49 Stats. Implemented: ORS 679.020, 679.025 & 679.250

50 Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2000(Temp), f. 5-22-00, cert. ef. 5-22-00
51 thru 11-18-00; OBD 1-2001, f. & cert. ef. 1-8-01; OBD 15-2001, f. 12-7-01, cert. ef. 1-1-02; OBD
52 3-2OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10005, f. 10-26-05, cert. ef. 11-1-05; OBD 3-2007, f. &
53 cert. ef. 11-30-07; OBD 1-2010, f. 6-22-10, cert. ef. 7-1-10; OBD 4-2011, f. & cert. ef. 11-15-11;
54 OBD 2-2012, f. 6-14-12, cert. ef. 7-1-12

55

1 **DIVISION 42**
2 **DENTAL ASSISTING**

3 **818-042-0050**

4 **Taking of X-Rays — Exposing of Radiographs**

5 (1) A dentist may authorize the following persons to place films, adjust equipment preparatory to
6 exposing films, and expose the films under general supervision:

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

8 (b) A radiologic technologist licensed by the Oregon Board of Medical Imaging and certified by
9 the Oregon Board of Dentistry (OBD) who has completed ten (10) clock hours in a Board
10 approved dental radiology course and submitted a satisfactory full mouth series of radiographs
11 to the OBD.

12 ~~(2) [A dentist may authorize students in approved instructional programs to take dental x-rays
13 under the conditions established by the Oregon Health Authority, Oregon Public Health Division,
14 Office of Environmental Public Health, Radiation Protection Services, in OAR 333 division 106.]~~

15 **A dentist may authorize a dental assistant who has completed a course of instruction**
16 **approved by the Oregon Board of Dentistry, and who has passed the written Dental**
17 **Radiation Health and Safety Examination administered by the Dental Assisting National**
18 **Board, or comparable exam administered by any other testing entity authorized by the**
19 **Board, or other comparable requirements approved by the Oregon Board of Dentistry to**
20 **place films, adjust equipment preparatory to exposing films, and expose the films under**
21 **the indirect supervision of a dentist, dental hygienist, or dental assistant who holds an**
22 **Oregon Radiologic Proficiency Certificate. The dental assistant must successfully**
23 **complete the clinical examination within six months of the dentist authorizing the**
24 **assistant to take radiographs.**

25
26 Stat. Auth.: ORS 679

27 Stats. Implemented: ORS 679.025(2)(j) & 679.250(7)

28 Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2003, f. 7-14-03 cert. ef. 7-18-03; OBD 4-
29 2004, f. 11-23-04 cert. ef. 12-1-04; OBD 4-2011, f. & cert. ef. 11-15-11

30

This Page

Left Blank

**DIVISION 42
DENTAL ASSISTING**

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 ~~[in a program] approved by [the Oregon Health Authority, Oregon Public Health Division, Office of Environmental Public Health, Radiation Protection Services, or]~~ the Oregon Board of Dentistry, in accordance with OAR 333-106-0055 or submits

evidence that the Oregon Health Authority, Center for Health Protection, [RPS] 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) Passes a clinical examination approved by the Board and graded by the Dental Assisting National Board, Inc. (DANB), or any other testing entity authorized by the Board, consisting of exposing, developing and mounting a full mouth series of radiographs or by exposing and mounting a digital full mouth series of radiographic images (14 to 18 periapical and 4 bitewing radiographic images) within one hour and under the supervision of a person permitted to take radiographs in Oregon. No portion of the clinical examination may be completed in advance; a maximum of three retakes is permitted (i.e., three individual radiographic exposures, not three full mouth series); only the applicant may determine the necessity of retakes. The radiographic images should be acquired on an adult patient with at least 24 fully erupted teeth. The full mouth series must be submitted for grading within six months after it is taken.

Stat. Auth.: ORS 679

Stats. Implemented: ORS 679.020, 679.025 & 679.250

Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2003, f. 7-14-03 cert. ef. 7-18-03; OBD 4-2004, f. 11-23-04 cert. ef. 12-1-04; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 3-2007, f. & cert. ef. 11-30-07; OBD 4-2011, f. & cert. ef. 11-15-11; OBD 3-2013, f. 10-24-13, cert. ef. 1-1-14

This Page

Left Blank

1 **DIVISION 42**
2 **DENTAL ASSISTING**

3 **818-042-0090**

4 **Additional Functions of EFDAs**

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

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

14 (2) Apply temporary soft relines to ~~[full]~~ complete dentures for the purpose of tissue
15 conditioning.

16
17 Stat. Auth.: ORS 679

18 Stats. Implemented: ORS 679.025(2)(j) & 679.250(7)

19 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-
20 2013, f. 5-15-13, cert. ef. 7-1-13

21

This Page

Left Blank

1 **DIVISION 42**
2 **DENTAL ASSISTING**

3 **818-042-0120**

4 **Certification by Credential**

5 (1) Dental Assistants who wish to be certified by the Board in Radiologic Proficiency or as
6 Expanded Function Dental Assistants, or as Expanded Function Orthodontic Dental Assistants
7 shall:

8 (a) Be certified by another state in the functions for which application is made. The training and
9 certification requirements of the state in which the dental assistant is certified must be
10 substantially similar to Oregon's requirements; or

11 (b) Have worked for at least 1,000 hours in the past two years in a dental office where such
12 employment involved to a significant extent the functions for which certification is sought; and

13 (c) Shall be evaluated by a licensed dentist, using a Board approved checklist, to assure that
14 the assistant is competent in the expanded functions.

15 (2) Applicants applying for certification by credential in Radiologic Proficiency must obtain
16 certification from the Oregon Health Authority, ~~{Oregon Public Health Division,}~~ [Center for](#)
17 [Health Protection](#) ~~{Office of Environmental Public Health}~~, Radiation Protection Services, of
18 having successfully completed training equivalent to that required by OAR 333-106-0055 or
19 approved by the Oregon Board of Dentistry.

20
21 Stat. Auth.: ORS 679

22 Stats. Implemented: ORS 679.020, 679.025 & 679.250

23 Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2003, f. 7-14-03 cert ef. 7-18-03; OBD 4-
24 2004, f. 11-23-04 cert. ef. 12-1-04; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 4-2011, f. &
25 cert. ef. 11-15-11
26

This Page

Left Blank

1 **DIVISION 42**
2 **DENTAL ASSISTING**

3 **818-042-0130**

4 **Application for Certification by Credential**

5 An applicant for certification by credential shall submit to the Board:

- 6 (1) An application form approved by the Board, with the appropriate fee;
- 7 (2) Proof of certification by another state and any other recognized certifications (such as CDA
8 or COA certification) and a description of the examination and training required by the state in
9 which the assistant is certified submitted from the state directly to the Board; or
- 10 (3) Certification that the assistant has been employed for at least 1,000 hours in the past two
11 years as a dental assistant performing the functions for which certification is being sought.
- 12 (4) If applying for certification by credential as an EFDA or EFODA, certification by a licensed
13 dentist that the applicant is competent to perform the functions for which certification is sought;
14 and
- 15 (5) If applying for certification by credential in Radiologic Proficiency, certification from the
16 Oregon Health Authority, ~~[Oregon Public Health Division]~~ [Center for Health Protection](#) ~~[Office~~
17 ~~of Environmental Public Health]~~, Radiation Protection Services, or the Oregon Board of
18 Dentistry, that the applicant has met that agency's training requirements for x-ray machine
19 operators, or other comparable requirements approved by the Oregon Board of Dentistry.

20
21 Stat. Auth.: ORS 679

22 Stats. Implemented: ORS 679.020, 679.025 & 679.250

23 Hist.: OBD 9-1999, f. 8-10-99, cert. ef. 1-1-00; OBD 2-2003, f. 7-14-03 cert. ef. 7-18-03; OBD 4-
24 2004, f. 11-23-04 cert. ef. 12-1-04; OBD 3-2005, f. 10-26-05, cert. ef. 11-1-05; OBD 4-2011, f. &
25 cert. ef. 11-15-11

26

This Page

Left Blank

CORRESPONDENCE

Nothing to report under this tab

OTHER ISSUES

This Page

Left Blank

Board Approved: _____

OREGON BOARD OF DENTISTRY
1500 SW 1ST AVENUE, SUITE 770
PORTLAND, OR 97201
(971) 673-3200

RECEIVED

MAY 01 2014

**Dental Hygiene
Request for Approval of Restorative Curriculum**

Dental Hygiene Program Dental Hygiene CE Course

Name of Institution/Program:	Seattle Central Community College <i>(previously known as)</i> Oregon Board of Dentistry <i>now Seattle Central College</i>		
Name of Program Director:	Ona Canfield		
Address:	1701 Broadway		
City:	Seattle	State:	WA Zip code:
			98122 Telephone:
			(206) 934-3184
Date Institution/Program adopted/revised current Curriculum:	2008 see below for respective courses		

Any changes to the course curriculum must have prior approval from the Board. Please provide the Board with adequate notice so that approval can be obtained before any changes to the curriculum are implemented.

Emailed Curriculum :

- DHY 112 (2006)
- DHY 114 (2006)
- DHY 236 (2006)
- DHY 119 (2008)
- DHY 233 (2005)
- DHY 234 (2005)
- DHY 235 (2005)

We are currently revising our curriculum and we will send it to you upon approval by the State of Washington.

Thank you,

Program Director's Signature: Ona U. Canfield

Date: 4/23/14



Seattle Central
Community College
1701 Broadway
Seattle, WA 98122
(206) 587-3800
www.seattlecentral.edu

April 23, 2014

Oregon Board of Dentistry
1500 SW 1st Avenue, Suite 770
Portland, OR 97201

To the Oregon Board of Dentistry:

Seattle Central College (previously Seattle Central Community College Dental Hygiene Program is accredited by the Commission on Dental Accreditation.

We exceed the bulleted items listed on page 1 of the adopted list of requirements for the RDH Restorative Course Curriculum. We have in our curriculum:

- 66 hours of didactic education incorporating the objectives listed.
- 88 hours of laboratory skill practice on typodonts incorporating the objectives listed.
- 144 hours of restorative practice on patients in a clinical setting where the student places both amalgam and composite restorations in CODA accredited school location sites).

I have included course outlines of our curriculum of our associate degree dental hygiene program. In addition, I have attached to the PDF, our clinic Restorative Handbook.

Please feel free to contact me with any questions.

Sincerely,

A handwritten signature in cursive script that reads "Ona U. Canfield".

Ona U. Canfield, RDH, MEd
Director, Dental Hygiene Program
Seattle Central Community College
1701 Broadway, BE 3210
Seattle, WA 98122

206-934-3184 phone
206-934-6337 fax
ona.canfield@seattlecolleges.edu

PROGRAM SEQUENCE
SEATTLE CENTRAL COMMUNITY COLLEGE
Dental Hygiene Program Scope and Sequence
REQUIREMENTS FOR THE
Associate of Applied Science-Transfer Degree - A.A.S.-T. DEGREE

<u>PREREQUISITE COURSES</u>		<u>CREDITS</u>
BIOL& 241	Human Anatomy & Physiology I	5
BIOL& 242	Human Anatomy & Physiology II	5
BIOL& 260	Microbiology	5
CHEM& 121	Intro to Chemistry	5
CHEM& 122	Intro to Organic Chemistry	5
MATH& 107	Math in Society	5
PSYC& 100	General Psychology	5
ENGL& 101	Composition I	5
ENGL& 102	Composition II	5
HUM 105	Intercultural Communication	5
SOC& 101	Intro to Sociology OR ANTH& 206 Cult Anth	5/5
NTR 150	Human Nutrition	5
Total Prerequisite Credits:		60

<u>FIRST YEAR COURSES</u>		<u>CREDITS</u>
<i>Quarter 1</i>	Fall	
DHY 100	Fundamentals of Dental Hygiene I	4
DHY 101	Clinical Dental Hygiene I (6 hrs lab)	3
DHY 102	Health Promotion (2 hrs didactic)	2
DHY 103	Dental Radiology I (2 didactic, 4 hrs lab)	4
DHY 110	Head and Neck Anatomy	2
DHY 112	Dental Anatomy and Morphology (2 hrs didactic, 2 hr lab)	3
DHY 117	Emergency Management (1 hr didactic)	1
		19
<i>Quarter 2</i>	Winter	
DHY 104	Preventive Dentistry (2 didactic)	2
DHY 105	Oral Biology (2 hrs Online)	2
DHY 108	Periodontology I (1 hr didactic, 2 hrs lab)	2
DHY 109	Human Pathophysiology (3 hrs Online)	3
DHY 113	Dental Radiology II (2hrs lecture, 2 hrs lab/clinic)	3
DHY 114	Restorative Practice and Materials I (2 hrs didactic, 2 hrs lab)	3
DHY 120	Fundamentals of Dental Hygiene II (2 hours didactic)	2
DHY 121	Clinical Dental Hygiene II (8 hours lab)	4
		21

Quarter 3	Spring	
DHY 107	Pharmacology (3 hrs Online)	3
DHY 118	Pain Control Anesthesia (2hr didactic, 4 hr lab)	4
DHY 119	Restorative Practice and Materials II (2hrs didactic, 2hrs lab)	3
DHY 122	Oral Pathology (2 hours Online)	2
DHY 130	Fundamentals of Dental Hygiene III (2 hours didactic)	2
DHY 131	Clinical Dental Hygiene III (8 hours lab/clinic)	4
		18

SECOND YEAR COURSE DESCRIPTIONS

Quarter 4	Summer	
DHY 200	Fundamentals of Dental Hygiene IV (2 hours didactic)	2
DHY 201	Clinical Dental Hygiene IV (16 hours lab/clinic)	8
DHY 222	Community Health I (1 hour didactic)	1
DHY 233	Restorative Practice and Materials III (4 hours in lab/clinic)	2
		13

Quarter 5	Fall	
DHY 203	Ethics and Jurisprudence (2 hours online)	2
DHY 208	Periodontology II (2 hrs didactic)	2
DHY 220	Fundamentals of Dental Hygiene V (3 hrs didactic)	3
DHY 221	Clinical Dental Hygiene V (16 hours in clinic)	8
DHY 223	Community Health II	2
DHY 234	Restorative Practice and Materials IV, (4 hours in lab/clinic)	2
		17

Quarter 6	Winter	
DHY 215	Selective Populations (One hour didactic; one credit clinic)	2
DHY 224	Community Health III	2
DHY 230	Fundamentals of Dental Hygiene VI	3
DHY 231	Clinical Dental Hygiene VI (16 hours clinic)	8
DHY 235	Restorative Practice and Materials V (4 hours in clinic)	2
		17

Quarter 7	Spring	
DHY 217	Community Clinical Rotation	2
DHY 236	Restorative Practice and Materials VI (4 hours in clinic)	2
DHY 238	Professional Issues	1
DHY 240	Fundamentals of Dental Hygiene VII	2
DHY 241	Clinical Dental Hygiene VII (16 hours clinic)	8
		17

TOTAL PROGRAM CREDITS:	122
TOTAL PROGRAM CREDITS INCLUDING PREREQUISITES:	182

PROGRAM SCOPE
SEATTLE CENTRAL COMMUNITY COLLEGE
Dental Hygiene Program Scope and Sequence
REQUIREMENTS FOR THE
Associate of Applied Science-Transfer Degree - A.A.S.-T. DEGREE

<u>PREREQUISITE COURSES</u>		<u>CREDITS</u>
BIOL& 241	Human Anatomy & Physiology I	5
BIOL& 242	Human Anatomy & Physiology II	5
BIOL& 260	Microbiology	5
CHEM& 121	Intro to Chemistry	5
CHEM& 122	Intro to Organic Chemistry	5
MATH& 107	Math in Society	5
PSYC& 100	General Psychology	5
ENGL& 101	Composition I	5
ENGL& 102	Composition II	5
HUM 105	Intercultural Communication	5
SOC& 101	Intro to Sociology OR ANTH& 206 Cult Anth	5/5
NTR 150	Human Nutrition	5
Total Prerequisite Credits: 60		

<u>DENTAL HYGIENE PROGRAM COURSES</u>		<u>CREDITS</u>
DHY 100	Fundamentals of Dental Hygiene I	4
DHY 101	Clinical Dental Hygiene I (6 hrs lab)	3
DHY 102	Health Promotion (2 hrs didactic)	2
DHY 103	Dental Radiology I (2 didactic, 4 hrs lab)	4
DHY 104	Preventive Dentistry (2 didactic)	2
DHY 105	Oral Biology (2 hrs Online)	2
DHY 107	Pharmacology (3 hrs Online)	3
DHY 108	Periodontology I (1 hr didactic, 2 hrs lab)	2
DHY 109	Human Pathophysiology (3 hrs Online)	3
DHY 110	Head and Neck Anatomy	2
DHY 112	Dental Anatomy and Morphology (2 hrs didactic, 2 hr lab)	3
DHY 113	Dental Radiology II (2hrs lecture, 2 hrs lab/clinic)	3
DHY 114	Restorative Practice and Materials I (2 hrs didactic, 2 hrs lab)	3
DHY 117	Emergency Management (1 hr didactic)	1
DHY 118	Pain Control Anesthesia (2hr didactic, 4 hr lab)	4
DHY 119	Restorative Practice and Materials II (2hrs didactic, 2hrs lab)	3
DHY 120	Fundamentals of Dental Hygiene II (2 hours didactic)	2
DHY 121	Clinical Dental Hygiene II (8 hours lab)	4
DHY 122	Oral Pathology (2 hours Online)	2
DHY 130	Fundamentals of Dental Hygiene III (2 hours didactic)	2
DHY 131	Clinical Dental Hygiene III (8 hours lab/clinic)	4
DHY 200	Fundamentals of Dental Hygiene IV (2 hours didactic)	2
DHY 201	Clinical Dental Hygiene IV (16 hours lab/clinic)	8
DHY 203	Ethics and Jurisprudence (2 hours online)	2

DHY 208	Periodontology II (2 hrs didactic)	2
DHY 215	Selective Populations (One hour didactic; one credit clinic)	2
DHY 217	Community Clinical Rotation	2
DHY 220	Fundamentals of Dental Hygiene V (3 hrs didactic)	3
DHY 221	Clinical Dental Hygiene V (16 hours in clinic)	8
DHY 222	Community Health I (1 hour didactic)	1
DHY 223	Community Health II	2
DHY 224	Community Health III	2
DHY 230	Fundamentals of Dental Hygiene VI	3
DHY 231	Clinical Dental Hygiene VI (16 hours clinic)	8
DHY 233	Restorative Practice and Materials III (4 hours in lab/clinic)	2
DHY 234	Restorative Practice and Materials IV, (4 hours in lab/clinic)	2
DHY 235	Restorative Practice and Materials V (4 hours in clinic)	2
DHY 236	Restorative Practice and Materials VI (4 hours in clinic)	2
DHY 238	Professional Issues	1
DHY 240	Fundamentals of Dental Hygiene VII	2
DHY 241	Clinical Dental Hygiene VII (16 hours clinic)	8
TOTAL PROGRAM CREDITS:		122
TOTAL PROGRAM CREDITS INCLUDING PREREQUISITES:		182

Course Outline

Division: Health and Human Services

Curriculum: Dental Hygiene

Title: Dental Anatomy & Morphology

Course Number: DHY 112

COURSE TYPE: Workforce Education/Preparatory Course

Quarter-Hour Credits: 3

Approximate Clock Hours per Quarter for: 44

Lecture & Lab – Lecture 2/Lab 1 (two hours each credit for lab)

Type of Course: Workforce Education

Course Description: Lectures and discussions on nomenclature, anatomy, morphology and function of the primary and permanent dentitions, with an emphasis on the application of dental anatomy and morphology to clinic procedures. Laboratory exercises include tooth carving and identification of and instrumentation on model teeth.

Course Outcomes: By the end of the course, the competent student will be able to:

1. Describe the human dental formula for the deciduous and permanent dentition.
2. Describe the anatomy and morphology of the primary and permanent dentition.
3. Describe Universal, International and Palmer numbering systems for the primary and permanent dentition.
4. Describe the relationship of the form and function of the primary and permanent dentition.
5. Identify the development and eruption patterns of deciduous and permanent dentitions.
6. Identify the primary and permanent dentition on teeth models.
7. Carve the required permanent tooth wax ups and composite placement.
8. Evaluate the required permanent tooth wax ups and composite placement.

Length of Course: 11 weeks Class Size (maximum): 18

Prerequisite(s): Admission to the Dental Hygiene Program and successful completion of all prerequisite coursework with a 2.8 grade or higher or instructor permission

Distribution Areas for the A.A. Degree (if applicable):

- Visual, Literary & Performing Arts (Arts and Humanities)
- Natural World (Math, Natural & Physical Sciences)
- Individuals, Cultures and Societies (Social Sciences)

A.A. Degree Designations (if applicable):

- “QSR” (Mathematics/Quantitative Reasoning)
- “IS” (Integrated Studies)
- “C” (Communication)
- “GS” (Global Studies)
- “US” (United States Cultures)

Topical Outline and Major Divisions:

- Identify specific anatomical and morphological characteristics of permanent and primary teeth from drawings, 3-dimensional models, photographs, or extracted teeth.
- Apply wax and composite carving concepts, techniques and instrumentation to the process of restoring anterior and posterior teeth crown anatomy and morphology.
- Apply knowledge of permanent and primary anatomical and morphological characteristics that affect successful debridement of crown and root surfaces and appropriate selection of periodontal scaling instruments.
- Identify carving technique competency levels by self-evaluating permanent teeth wax carving build-ups and composite placement.
- Improve spatial and psychomotor skills and meet carving competency levels by using correct carving techniques.
- Identify nomenclature used in descriptive tooth anatomy and morphology.
- Describe dental formulas for the permanent and primary dentitions.
- List tooth identification systems for permanent and primary dentitions.
- Identify permanent and primary teeth from drawings, 3-dimensional models, photographs.
- List trait categories describing permanent and primary tooth similarities and differences.
- Describe anatomic and morphologic characteristics of permanent and primary dentitions.
- Functions of permanent and primary teeth
- Describe alignment of teeth.
- Describe dental anomalies.
- Apply methods of carving permanent teeth wax carvings.
- Self-evaluate permanent teeth wax carvings.

Outline Developed by: Ona U. Canfield

Date: 10/30/06

COURSE OUTLINE

DIVISION: Health & Human Services

CURRICULUM: Dental Hygiene

COURSE TITLE: Restorative Practice and Materials I

COURSE NUMBER: DHY 114

TYPE OF COURSE: Workforce Education/Preparatory CREDITS: 3

COURSE DESCRIPTION: This is the first of a six course sequence in clinical restorative dentistry focusing on the chemical, physical and mechanical properties of dental materials commonly used by dental hygienists and their manipulation. Students learn laboratory and clinical applications including the placement of restorations into prepared cavities.

STUDENT OUTCOMES: Upon completion of this course, the competent student will be able to apply critical thinking skills to the following:

1. Demonstrate effective placement and condensing technique in placing amalgam restorations in the laboratory setting.
2. Demonstrate amalgam carving technique that fully restores the functional anatomical structure of maxillary and mandibular posterior teeth restored in a laboratory setting.
3. Demonstrate amalgam polishing techniques on any restorations completed in the laboratory.
4. Select and place appropriate cement base, intermediate base, liner and varnish for any appropriate restoration.
5. Demonstrate effective communication skills by discussing restorative treatment plans with dental clients.
6. Discuss and document the procedures involved in restorative emergency treatment of patients who present in the clinic and are assigned to your care.
7. Discuss and/or explain endodontic procedures used in dentistry.
8. Apply environmental protection and safety protocols in working with mercury and other potentially harmful dental materials in the laboratory and clinic settings.
9. Describe the physical and chemical properties, and characteristics of direct and indirect materials used in dentistry and their relationship to the oral environment.
10. Describe properties and types of matrix bands and rubber dams; successfully manipulate and secure them to teeth in any area of the dentition.

11. Analyze the clinical behavior of a properly triturated amalgam and reject improperly triturated amalgams for placement.
12. Analyze the clinical behavior of an amalgam that has been properly manipulated and is being used for placement in a prepared tooth.
13. Manage time adequately to place and manipulate amalgam restorations within the setting time that allows for optimal handling.

LENGTH OF COURSE: One quarter

CLASS SIZE: 18 students

PREREQUISITES: Admission to the Dental Hygiene program and successful completion of all prerequisite coursework with a 2.8 or higher.

TOPICAL OUTLINE:

CLOCK HOURS: 44

- Week 1: Course expectations, safety procedures, laboratory set-up.
- Week 2: Rubber dam manipulation, matrix and wedge placement on dentoforms and in the mouth working on each other.
- Week 3: History and characteristics of amalgam, use of mercury in the mouth and mercury toxicity, tirturation, initial procedures in proper condensing, characteristics of amalgam during the condensing phase of placement. Practice on placing posterior occlusal restorations.
- Week 4: Review of anatomy of and carving technique for the marginal ridges, oblique ridges, fossae, central and secondary grooves. Practice on occlusals and Class II mandibular restorations.
- Week 5: Video presentation of fully carved amalgam, timed practice on selected Class II fillings.
- Week 6: Polishing completed amalgam restorations, techniques; continued practice in placing Class II amalgams on maxillary posterior teeth.
- Week 7: WREB evaluation criteria, self-evaluation of work using WREB standards; continued practice in placing and polishing amalgams.
- Week 8: Self-timed placement of all restorations, polishing.
- Week 9: Formal timing and mock WREB evaluation of 2 Class II molar preparations, one maxillary and one mandibular.
- Week 10: Self-timed placement of restorations and polishing.
- Week 11: Formal timing and mock WREB evaluation of 2 Class II molar preparations for students not passing in week 9. Regular practice for students who have passed WREB exercises.

METHODS OF INSTRUCTION:

1. Individual clinical practice on mannequins focusing on one- to- one supervision, individual review of procedure and evaluative suggestions for changes in technique or corrections in methods.

2. Small group workshops with instructors to discuss, demonstrate and review safety procedures and to handle mercury and mercury disposal correctly.
3. Small group problem solving situations related to the practice of dental hygiene and client care some using observation of patients or role plays.
4. Viewing live and canned videotapes of most teeth that will be carved. Video on the placement of temporaries, cements etc.
5. Mock board simulations using regional standards criteria.

METHODS OF TESTING/EVALUATION:

1. Minimum passing grade depends on:

- a. Completion of all lab requirements by last lab session
- b. Completion of 4 class 2 amalgam restorations meeting *minimum* WREB passing grade based on their criteria
- c. Attendance in the lab
- d. Acceptable polish of 75% of all amalgams (whether or not they met WREB criteria)

2. Grade above passing depends on:

- 50% 4 class 2 amalgam restorations above the minimum requirement for passing
- 50% Final timed carvings of Mock Board in Week 9 using WREB criteria and grading method. Students passing the first timed carving in week 9 may improve their score in week 11, but will not be penalized for a lower score.

OC 10/30/06

Application to Establish or Revise a Course

Please read [Instructions](#)

Course number: DHY 119	Course title: Restorative Practice and Materials II
Submission date: 06/02/08	Next Course Establishment meeting date:
<input type="checkbox"/> New Course <input type="checkbox"/> Significant Course Revision* <input checked="" type="checkbox"/> Minor Modification (e.g., title or number change)* <input type="checkbox"/> Mode of Delivery addition or change	Proposal description: <i>Rearrangement of Contact Hours.</i>
*Submit existing course outline with this proposal.	
Designations Requested: <input type="checkbox"/> QSR <input type="checkbox"/> IS <input type="checkbox"/> C <input type="checkbox"/> GS <input type="checkbox"/> US <input type="checkbox"/> None	
Additional comments:	
Faculty Contact(s): Candida Garcia Division: Health & Human Services Mail stop: BE3210 Email: cgarcia@sccd.ctc.edu Phone: 206-909-3230 Health & Human Services Division: BE 3210 Mail stop: BE 3210 Email: omchin@sccd.ctc.edu Phone: 206-587-4186	
<input type="checkbox"/> Provisional Approval Request Please state reason for provisional request: _____ The course may be offered before without complete committee review if <i>all CE documentation is provided—see instructions</i> . Requests will receive a response within 2 weeks (except summer). Provisionally approved courses must be reviewed and revised as needed for full approval within two quarters. CRC use: Provisional approval valid through: _____. Full approval must be obtained by: _____	

Routing & Signatures

NOTE: Signatures indicate approval of the course outline and details as proposed in this document.

Proposing Faculty	Date
Dean and/or Executive Dean for Workforce Education	Date
Curriculum Review Chair <i>Course will be routed to Diane Gherman after CRC approval</i>	Date
Manager of Instructional Information	
Vice President for Instruction	Date

Upon approval copies to: Siegal Center, Proposing Faculty, Division Office, Advising, Library

Course Outline

Course Prefix & No.: DHY 119	Title: Restorative Practice and Materials II	Credits: 3
Division: Health & Human Services	Program/Department: Dental Hygiene	
Maximum Class Size: 18	Course length: 11 weeks	Prerequisite(s): Admission to the program, Oral Anatomy and Tooth Morphology (DHYG 110,112, Restorative Practice & Materials I (DHYG 114)
Total Contact Hours: 44 Lecture: 22 (11 h. = 1 cr.) Lab: 22 (supervised; 22 hrs.=1 cr.) Clinical: _____ Other: _____ (unsupervised; 33 hrs. = 1 cr.)	Mode(s) of Delivery: <input checked="" type="checkbox"/> On campus self-contained <input type="checkbox"/> Correspondence <input type="checkbox"/> Telecourse <input type="checkbox"/> Online instruction <input checked="" type="checkbox"/> Hybrid (e.g., online and on campus) <input type="checkbox"/> Other (please describe): _____	
Course Description	This is the second of six course sequence in clinical restorative dentistry focusing in didactic and laboratory application on : Dental dam application, matrix and wedge application, amalgam and composite placement, carving, finishing and polishing, overhang removal using both hand and rotary instruments.	
Course Goals	<ul style="list-style-type: none"> *Identify restorative armamentarium and their proper use *Demonstrate knowledge of the laboratory procedure associated with acceptable mercury hygiene in handling , properly trituration and placement of amalgam alloy *Demonstrate knowledge of laboratory procedure associated with acceptable composite resin handling, placement, finishing and polishing *Demonstrate knowledge of the laboratory procedure regarding techniques associated with dental dam placement *Demonstrate proper placement of matrix and wedge * Demonstrate proper overhang removal using hand and rotary instruments without damaging surrounding tooth structure and tooth integrity *Summarize principles and indications for restoring teeth and possible post operative complications *Identify clinical detection and radiographic appearance of existing restorations *Distinguish acceptable occlusal relationship after restorative a procedure *Acquire technical skills and proficiency needed for future course work in clinical restorative practice 	
Learning Outcomes	<p>As a result of taking this course, students will be able to:</p> <ul style="list-style-type: none"> ▪ Perform correct techniques learned in dental materials in proper handling of restorative materials ▪ Perform correct instrument selection for specific procedures ▪ Place, finish and polish amalgam and composite resin restorations on typodonts ▪ Safely remove amalgam and composite overhangs ▪ Safely place and remove dental dam, matrix and wedge ▪ Perform patient education and management 	
Program/AA/AS Outcomes	<p>This course addresses the following program or degree outcomes:</p> <ul style="list-style-type: none"> ▪ Correctly apply concepts and performance skills learned in previous classes for specific laboratory situation (tooth morphology and dental materials) 	

	<ul style="list-style-type: none"> ▪ Explain composition and use of dental materials related to restorative dentistry ▪ Demonstrate and evaluate laboratory competency in all procedures for placing and finishing amalgam and composite restoration ▪ Recognize and describe indications and rationale for placement of amalgam and composite restoration ▪ Demonstrate acceptable performance of knowledge with proper handling of biohazardous and hazardous restorative waste materials ▪ Apply critical thinking skills to evaluate use and application of dental materials to specific situations ▪ Apply knowledge gained from previous classes for patient education and management ▪ Demonstrate professional behavior
Topical Outline and/or Major Divisions	<ul style="list-style-type: none"> * Principles of Cavity Preparation, Indications for Restoring Teeth * Matrix Systems, Dental Rotary Instruments * Polishing Materials: Abrasives * Post-operative Complications, Clinical Detection of Restorative Materials * Radiographic Appearance of Dental Materials * Oral Appliances (Materials and Fabrication) * Specialty Materials (Orthodontic, Endodontic, Oral Surgery, Pedodontics, Periodontics) * Oral Prosthetics (Classification, Materials and Fabrication) * Acrylic Resins * Dental Ceramics (Classification, Materials and Fabrication) * Dental Implants (Classification, Materials, Fabrication and Placement)
Distribution Area	Select One
Additional Information	
CRC Use Only Special Designation (s)	<input type="checkbox"/> QSR <input type="checkbox"/> IS <input type="checkbox"/> C <input type="checkbox"/> GS <input type="checkbox"/> US <input type="checkbox"/> None
Outline Prepared by: Candida Garcia Date: 06/02/08	

Additional Information

All new courses and major revisions:

Review the Seattle Central Community College Mission and Values and Learning Outcomes (see left menu bar at <http://seattlecentral.edu/sccc/>) and respond briefly (150-300 words each) to the following:

Mission and Values: How does the course support the college's Mission and Values?

Assessment: Briefly explain how you will know students have achieved the course specific and college wide or program outcomes you have identified for the course.

Mode Statement (required for all modes other than face-to-face):

Explain how the course outcomes will be met in the proposed mode(s):

Required if special designations are requested:

For *each* designation requested explain how the course will meet the designation criteria found at <http://seattlecentral.edu/users/crc/page.php?page=409>.

Designation Requested: Select designation (optional)

Statement:

Designation Requested: Select designation (optional)

Statement:

COURSE OUTLINE

CURRICULUM:	DENTAL HYGIENE
COURSE TITLES:	RESTORATIVE PRACTICE & MATERIALS III
COURSE NUMBERS:	DHY 233
COURSE TYPE:	Workforce Education
COURSE CREDITS:	2
INSTRUCTOR:	TBA
QUARTER:	SUMMER
DAYS/TIMES:	TBA

COURSE DESCRIPTION:

This is the third laboratory course in restorative dental practice and materials focusing on correct placement of dental restorations in the laboratory on mannequins and in the clinic on patients. Students practice and develop manipulative and carving skills in the placement of amalgam and composite restorations as allowed by Washington State law.

LENGTH OF COURSE: ONE QUARTER CLASS SIZE: 18 STUDENTS

PREREQUISITES: Admission to the Dental Hygiene program and successful completion of DHY 114 and 119 and completion of all prerequisite coursework with a 2.8 or higher or permission of the instructor.

STUDENT OUTCOMES :

1. Demonstrate novice level speed and judgement in the effective placement, carving, polishing, and evaluation of amalgam restorations in clinic and laboratory settings averaging 2.0 points total completed per session.
2. Demonstrate novice level speed and judgement in the effective placement, finishing, and evaluation of composite restorations in clinic and laboratory settings averaging 2.0 points total completed per session.
3. Select and place appropriate cement base, intermediate base, liner and varnish for all restorations with no time restrictions.

4. Analyze the clinical behavior of a properly manipulated amalgam or composite restoration
5. Respond to medical emergencies and describe methods of preventing emergencies.
6. Demonstrate effective placement, carving, polishing and evaluation of 75% of amalgam restorations and 75 % of composite restorations in clinic.

TOPICAL OUTLINE:

CLOCK HOURS: 44

- Week 1: Placement of rubber dam and matrix bands; supervised practice on manikins
Week 2: Review of amalgam restorative procedures; supervised practice on manikins
Week 3: Review of amalgam restorative procedures; supervised practice on manikins
Week 4: Review of composite procedures; anterior teeth; clinical practice on patients or manikins
Week 5: Review of composite procedures; posterior teeth; clinical practice on patients or manikins
Week 6: Supervised clinical practice with patients
Week 7: Supervised clinical practice with patients
Week 8: Polishing procedures; supervised clinical practice with patients
Week 9: Timed preparations and mock board testing
Week 10: Supervised clinical practice with patients
Week 11: Evaluation of mock boards and repeat testing opportunity

METHODS OF INSTRUCTION:

- Individual one to one instruction at the dental chair using manikins and supervised instruction on patients
Small group demonstrations
Observations
Use of the intra-oral camera to demonstrate procedures

METHODS OF TESTING/EVALUATION:

Each student must complete the following minimum requirements. Failure to complete each of The following requirements will result in a grade deduction or incomplete.

1. For minimum competency in DHY 233, the student must receive a minimum **clinical average of 2.0 points per restorative session**
2. Complete three (3) Class II amalgam or composites restorations.
3. Complete one Class III or IV composite restoration.
4. Accurately document course work and restorative tally form. Attend all clinic and laboratory sessions.

SEATTLE COMMUNITY COLLEGE DISTRICT COURSE CODING APPROVAL FORM

College: NSCC SCCC SSCC SVI
Date: 8/8/05 Submitted by: Jan West Phone #: 344-4349

Please check all boxes that are appropriate for this request:

- Add to inventory effective (Year/Quarter): Fall 2005
- Delete from inventory effective (Year/Quarter):
- Change to another CIP code:
- Change course title to:
- Change or Add to the AA Degree distribution table (See #4 & #5 below):
- Other (specify): 5th quarter course in new Dental Hygiene program.

Dept: Allied Health, Business, Languages & Cultures Course #: DHY 234 CIP Code: 51.0602 Institutional Intent: 21

Course Title: Restorative Practice and Materials IV

Fund Source: State Grant/Contract Student/Self Support

(1) Is this course a requirement for a Workforce Education Program? (Intent 21)

Yes Program Code: 308
No

(2) Is this course designed for Limited English Proficiency? Yes No

Academic Disadvantaged? Yes No

(3) Does this course contain a workplace training component? Yes No

(4) Which, if any, AA Degree requirement will this course satisfy?

- Q/SR – Quantitative Symbolic Reasoning Communication
- Visual, Literary and Performing Arts Individuals, Cultures and Societies
- Natural World Global Studies United States Cultures

(5) Which, if any, former AA Degree requirement will this course satisfy?

- Language/Communication Literature/History of Ideas Music, Art, Drama
- The Physical Universe The Living World Science, Tech and Environment

Credits: 2.0 Variable Credit: Yes No List Course Contact Hours:

Lecture (1:1) Lab (2:1) 44 Clinical/Work Site (3:1) Other (5:1)

Total Contact Hours: 44

Is this course shared across the District? Yes No

If yes, have you received concurrence from the other colleges?

Yes Contact Name(s):
No

Signatures:

Curriculum Committee Chair Date

Janet West / *9-15-05* / *Marilyn Mitchell*

Originating Dean Date Originating Dean of Workforce Education or

COURSE OUTLINE

CURRICULUM: Dental Hygiene
COURSE TITLES: Restorative Practice & Materials IV
COURSE NUMBERS: DHY 234
COURSE TYPE: Workforce Education
COURSE CREDITS: 2

COURSE DESCRIPTION: This is the fourth laboratory course in restorative dental practice and materials focusing on correct placement of dental restorations in the laboratory on mannequins and in the clinic on patients. Students practice and develop manipulative and carving skills in the placement of amalgam and composite restorations as allowed by Washington State law.

STUDENT OUTCOMES: Upon completion of this course, the competent student will be able to apply critical thinking skills to the following:

1. Demonstrate effective placement, carving, polishing, and evaluation of amalgam restorations in clinic and laboratory settings to specific standard per session.
2. Demonstrate effective placement, finishing, and evaluation of composite restorations in clinic and laboratory settings to a specific standard per session.
3. Demonstrate effective communication skills by discussing restorative treatment plans with dental clients
4. Select and place appropriate cement base, intermediate base, liner and varnish for all restorations.
5. Analyze improper triturated amalgam restorations and formulate possible solutions to correct the trituration technique
6. Analyze the clinical behavior of a properly manipulated amalgam or composite restoration
7. Recognize the indications and rationale for crown and bridge and other prosthodontics, demonstrating effective communication to a patient during presentation of the treatment plan.
8. Demonstrate effective placement, carving, polishing and evaluation of 80% of amalgam restorations and 80 % of composite restorations in clinic.

LENGTH OF COURSE: ONE QUARTER

CLASS SIZE: 18 STUDENTS

PREREQUISITES : Admission to the Dental Hygiene Program and completion of Restorative Materials and Practice I, II and III, or waiver by the instructor.

TOPICAL OUTLINE:

CLOCK HOURS: 44

- Week 1: Patient procedures and selection
- Week 2: Clinically supervised placement of amalgam restorations
- Week 3: Clinically supervised placement of amalgam restorations
- Week 4: Effective patient communication
- Week 5: Manipulation of dental materials
- Week 6: Evaluation of polishing techniques
- Week 7: Clinically supervised placement of composite restorations
- Week 8: Clinically supervised placement of composite restorations
- Week 9: Carving and finishing of composite restorations
- Week 10: Laboratory development of skills for the WREB
- Week 11: Laboratory development of skills for the WREB

METHODS OF INSTRUCTION:

Individual one on one instruction at the dental chair, small group demonstrations, use of the intra-oral camera to demonstrate procedures, laboratory practice using manikins.

METHODS OF TESTING/EVALUATION:

Productivity per restorative session; quantity and quality of amalgam and composite restorations; documentation of restorative tally.

All written work is required to meet standards outlined by the Dental Hygiene program with completion of each required course at 2.8 or higher.

Rev 0/05

SEATTLE CENTRAL COMMUNITY COLLEGE
DENTAL HYGIENE PROGRAM
DIVISION OF HEALTH AND HUMAN SERVICES

COURSE OUTLINE

CURRICULUM: DENTAL HYGIENE
COURSE TITLES: RESTORATIVE PRACTICE & MATERIALS IV
COURSE NUMBERS: DHY 235
COURSE TYPE: Workforce Education
COURSE CREDITS: 2
INSTRUCTOR: TBA
QUARTER: FALL
DAYS/TIMES: TBA

COURSE DESCRIPTION:

This is the fifth laboratory course in restorative dental practice and materials focusing on correct placement of dental restorations in the laboratory on mannequins and in the clinic on patients. Students practice and develop manipulative and carving skills in the placement of amalgam and composite restorations as allowed by Washington State law.

LENGTH OF COURSE: ONE QUARTER CLASS SIZE: 18 STUDENTS

PREREQUISITES: Admission to the Dental Hygiene Program and completion of DHY 234, Restorative Materials and Practice III, or waiver by the instructor

TEXTBOOKS: As assigned by instructor

STUDENT OUTCOMES: At the completion of this course, the competent student will apply critical thinking skills to the following:

1. Demonstrate effective placement, carving, polishing, and evaluation of amalgam restorations in clinic and laboratory settings averaging 3.0 points total completed per session.
2. Demonstrate effective placement, finishing, and evaluation of composite restorations in clinic and laboratory settings averaging 3.0 points total completed per session.

3. Demonstrate effective communication skills by discussing restorative treatment plans with dental clients
4. Select and place appropriate cement base, intermediate base, liner and varnish for all restorations.
5. Discuss and document the procedures involved in restorative emergency treatment of a patient.
6. Discuss and/or explain endodontic procedures used in dentistry.
7. Demonstrate intermediate to advanced level of skill in overhang removal.
8. Demonstrate effective placement, carving, polishing and evaluation of 80% of amalgam restorations and 80% of composite restorations in clinic.
9. Demonstrate effective communication skills by discussing restorative treatment plans with dental clients
10. Recognize the indications and rationale for posterior composites and sealants, demonstrating effective placement and technique in the clinical setting.
11. Analyze the clinical behavior of a properly manipulated amalgam or composite restoration.
12. Analyze improper triturated amalgam and formulate possible solutions to correct the problem.

TOPICAL OUTLINE:

CLOCK HOURS: 44

Week 1: Patient procedures and selection

Week 2: Clinically supervised placement of amalgam restorations

Week 3: Clinically supervised placement of amalgam restorations

Week 4: Effective communication of procedures and methods

Week 5: Manipulation of dental materials

Week 6: Carving and polishing techniques

Week 7: Clinically supervised placement of composite restorations

Week 8: Clinically supervised placement of composite restorations

Week 9: Carving and finishing of composite restorations

Week 10: Increasing speed in laboratory development of skills for the WREB

Week 11: Increasing speed in laboratory development of skills for the WREB

METHODS OF INSTRUCTION:

Individual one to one instruction at the dental chair

Small group demonstrations

Use of the intra-oral camera to demonstrate procedures

METHODS OF TESTING/EVALUATION:

Each student must complete the following minimum requirements. Failure to complete each of The following requirements will result in a grade deduction or incomplete.

1. For minimum competency the student must receive an established minimum clinical points per restorative session

2. Complete a set number of amalgam and/or composites restorations.
3. Accurately document course work and restorative tally form.
4. Attend all clinic and laboratory sessions and complete laboratory requirements by the end of the last lab session for the quarter.

SEATTLE CENTRAL COMMUNITY COLLEGE
DENTAL HYGIENE PROGRAM
HEALTH AND HUMAN SERVICES DIVISION

COURSE OUTLINE

CURRICULUM:	DENTAL HYGIENE
COURSE TITLES:	RESTORATIVE PRACTICE & MATERIALS VI
COURSE NUMBERS:	DHY 236
COURSE TYPE:	Workforce Education
COURSE CREDITS:	2
INSTRUCTOR:	TBA
QUARTER:	SPRING
DAYS/TIMES:	TBA

COURSE DESCRIPTION:

This is the final laboratory course in restorative dental practice and materials focusing on correct placement of dental restorations in the laboratory on mannequins and in the clinic on patients. Students practice and develop manipulative and carving skills in the placement of amalgam and composite restorations as allowed by Washington State law to the competence level needed to pass professional licensing exams.

LENGTH OF COURSE: ONE QUARTER CLASS SIZE: 18 STUDENTS

PREREQUISITES: Admission to the Dental Hygiene Program and completion of Restorative Materials and Practice V, or waiver by the instructor

TEXTBOOKS: As assigned by instructor

CLOCK HOURS: 44

STUDENT OUTCOMES: At the completion of this course, the competent student will apply critical thinking skills to:

1. Demonstrate effective placement, carving, polishing, and evaluation of amalgam restorations in clinic and laboratory settings averaging 3.2 points total completed per session.
2. Demonstrate effective placement, finishing, and evaluation of composite restorations in clinic and laboratory settings averaging 3.2 points total completed per session.
3. Recognize, discuss, and/or refer a patient for any problem encountered in patient assessment.
4. Demonstrate effective communication skills by discussing restorative treatment plans on all restorative materials with dental clients
4. Demonstrate effective restorative treatment for special needs patients including pedodontic patients, medically compromised, disabled, mentally and behaviorally challenged patients that are treated in clinic,
5. Explain the indications and rationale for all prosthodontics and alternative options in a way that assists patient decision-making.
7. Demonstrate advanced level of skill in overhang removal.
8. Demonstrate effective placement, carving, polishing and evaluation of 80% of amalgam restorations and 80 % of composite restorations in clinic.

TOPICAL OUTLINE BY WEEKS:

1. Supervised clinical experiences with patients and/or manikin practice
2. Supervised clinical experiences with patients and/or manikin practice
3. Supervised clinical experiences with patients and/or manikin practice
4. Supervised clinical experiences with patients and/or manikin practice
5. Supervised clinical experiences with patients
6. Supervised clinical experiences with patients
7. Supervised clinical experiences with patients
8. Mock Board Timed procedures; Supervised clinical experiences with patients
9. Mock Board Timed procedures; Supervised clinical experiences with patients
10. Mock Board Timed procedures; Supervised clinical experiences with patients
11. Mock Board Timed procedures; Supervised clinical experiences with patients

METHODS OF INSTRUCTION:

Individual one to one instruction at the dental chair
 Small group demonstrations
 Observation
 Use of the intra-oral camera to demonstrate procedures

METHODS OF TESTING/EVALUATION:

1. Clinical average of points per restorative session
2. Completion of required quality on amalgam and/or composite restorations.
3. Accurate documentation of course work and restorative tally form.
4. Attendance at all clinic and laboratory sessions.

**SEATTLE CENTRAL COMMUNITY
COLLEGE**

**RESTORATIVE
LAB/CLINIC MANUAL**



TABLE OF CONTENTS

LAB

Section 1 Lab Policies

Section 2 Lab Activities

NOTEBOOK

Section 3 Notebook Guidelines and Organization

CLINIC

Section 4 Materials Theory and Technique

Section 5 Dental Dams

Section 6 Burs and Hand Cutting Instruments

Section 7 Amalgam Restorations

Section 8 Composite Restorations

Section 9 Patient Management

Section 10 Clinic Management and Operatory Organization

Section 11 Clinic Policies

Section 12 Case Management

Section 13 Clinic Flow and Procedural Timing

Section 14 Evaluation

LAB

SECTION 1 - LAB POLICIES

PPE

Appropriate PPE must be worn at all times! It is not necessary to wear a lab coat in lab. Mask, glasses and gloves are always mandatory. Restorative lab involves the handling of some toxic materials and many items that can and do become projectiles, thus risking serious personal injury.

Sanitation

The medium tray cover plastic bags are carefully placed under typodonts during lab sessions when working on amalgam restorations. These amalgam scraps must be carefully collected and correctly disposed.

Amalgam capsules are placed in a large container and not thrown in the trash. Amalgam debris are placed in a smaller jar with water to prevent off-gassing. Lids on the left-over capsule container, amalgam disposal jar and new amalgam container must be kept on and tight at all times. This is to minimize amalgam vapors.

DO NOT use air/water tips to blast loose amalgam off restorations-in-progress as this scatters and aerosolizes toxic mercury. Loose amalgam should only be suctioned or gently wiped off.

Safety

Curing lights need to be carefully managed as the blue light emitted is damaging to direct vision. The operator may be conscientiously looking away, but instructors are often walking around, checking in on activities and are more at risk of looking at uncovered lights. Please cover them appropriately with an orange cover or by hand.

Chair Positioning

Due to movability of unit chairs and the necessity of having adequate operator maneuverability around the headrest, students need to monitor chair position. The chair should be only a few inches away from the electrical box secured underneath. Any chair slid too far away will promote exposure to connecting cords and hamper student ability to move around the headrest properly. Please, let instructors know at beginning of lab and they will move it for you.

Clinic Management

Before, during and after restorative lab sessions, clinic equipment and supplies must be properly utilized, cleaned up and put away as specified in this manual and verbally by instructors.

Supply Drawers: Students are not in need of any supplies from these drawers/cupboards during lab sessions except for the amalgam triturators and capsules.

Operatory Bi-fold Cupboards: As above, all supplies contained within are for clinic use on patients and are not be used for lab activities. The only exception is curing lights.

Curing Lights: Curing lights that are stowed in the bi-fold cupboards need to be wiped down with sterilization wipes before being put away as they may be used for clinic the next session. **Never** remove the curing lights screwed onto operatory unit swing arms.

Unit Maintenance: Please follow regular clinic policies for putting operatory in order at the end of clinic sessions. Miscellaneous debris must be picked up off the floor.

Sterilization Area: Keeping the sterilization area clean and orderly applies to restorative lab sessions as during all other program sections. Assigned (CA) clinic assistants will be primarily responsible for this. However, after lab sessions, students may want to begin sterilizing certain supplies in preparation for clinical activities. Each student should at least *begin* the sterilization process for their own supplies to avoid excessive back-ups in the sterilization process and to prevent overworking assigned CAs.

Operatory Set-Up

Please set up unit as outlined in the appendix. We will try to replicate our *clinical* set-up to the degree reasonable for lab activities. However, in order to minimize wasting plastic bags and supplies, only one bag will be utilized to catch amalgam scraps.

After lab is finished and supplies are put away, please WIPE DOWN operatory so it is clean for following clinic sessions.

SECTION 2 - LAB ACTIVITIES AND GRADING

Restorative Lab Challenges

Lab activity opportunities are to be maximized for sufficient learning and board preparation. Restorative education has the unique challenge of maintaining concurrent skill sets throughout the program as follows.

The first skill set revolves around the placement/creation of restorations on typodonts. Since the (WREB) Western Regional Examining Board tests restorative students on typodonts, skills must be maintained in this area. This greatly impacts clinical activities, which would be the second skill set. The reality is that for the majority of students, time spent outside of scheduled lab activities will be necessary to reinforce and refine restorative skills for both typodont and patient activities.

Seattle Central has limited clinic space, which can make it a challenge for students to find sufficient extra-curricular practice time. At the beginning of each quarter, restorative instructors will create a schedule based on coordination with other program divisions and submit it to students.. It is *highly suggested* that students begin utilizing these times immediately. Quite often, it may be *necessary* for them to do so as grades will be partly based on specific restoration scores received. There may not be enough time during scheduled lab times for students to redo restorations to achieve better or passing grades.

Restoration Grading Guidelines

Students are required to complete a series of restorations each quarter at certain minimum grade levels. However, since only a portion of the grade is based on the sum of these scores, it is possible that, should there be difficulties in other graded areas; final grades could be below minimum acceptable. Students have the option, AFTER they have completed all required restorations, of redoing any or all in an attempt to obtain a higher grade. The highest grade will always be used for final grading.

Most restorations will be timed. This allows students to develop ever greater speed with their skills preparing them for patients and the WREB. Students prepare themselves for specific restorations and write a start-time on their *completely* filled out restoration evaluation form. At this time students bring this to an instructor for initialing. This is repeated for the stop-time.

After completion, students spend a few minutes and *carefully* evaluate their own restoration making notations on the grade sheet. Lab activities get quite busy and a sign-up sheet is utilized for grading purposes. If a student has not self-evaluated their work when the instructor comes over, they are bumped to bottom of the list. The purpose of this is to develop evaluation skills, something

absolutely necessary for restorative education. So, instructors look first to student self-evaluation as they assess learning progress.

Extra-curricular practice is a great time for students to complete timed restorations and repeat certain ones for higher grades. Since restorative instructors may not be supervising, students must get their start/stop times from the PSR or Clinic Coordinator. Of course, it is not advisable for students to misuse this avenue by spending more than the allotted time for these activities. Ultimately, if their speed is not developed, success at WREB is undermined as the board is a *timed* examination with only 1.5 hours for 2 sizable class II restorations, start to finish.

After each tooth is graded, instructors drill a noticeable hole in the plastic tooth, marking it as graded. Students are given a bur to keep available for instructors to use for this purpose.

Half an hour prior to the end of lab, students fill out their daily lab evaluations, place them in the notebook and turn it in to instructors. They may then clean up.

RESTORATIVE NOTEBOOK (Starts Summer Qtr.)

SECTION 3 – NOTEBOOK GUIDELINES AND ORGANIZATION

Students are required to keep a restorative notebook of all lab and clinical exercises and activities. This notebook is kept up-to-date and organized as specified below.

Guidelines

Notebooks should always stay in clinic. Any removal constitutes a HIPAA violation since they contain confidential patient evaluation forms. Students need to have their notebook at their unit during all lab and clinic activities for reference by the student and instructors.

Lab

Prior to beginning of *lab* sessions, students place a lab evaluation form on the clipboard for instructor use. At the end of lab, self-evaluation forms are filled out by students, placed in the appropriate section of the notebook and turned in to instructors in location designated.

All restorations are recorded in a tracking sheet, for the specific material and by quarter. These grade forms and tracking sheets are used for reference and should be kept in the notebook.

Clinic

During clinical sessions, evaluation forms are also placed on the clipboard for instructor use. As in lab, when self-evaluation is complete with these forms, place them in designated sections and turn in notebook *with* completed patient chart.

Organization - By Tabs: Latest of any form is always on top for ease of use

Quarterly Requirements: Requirement sheets for both lab and clinic.

Tracking Sheets: For amalgam & composite, please keep these up to date during each lab session. Place the typodont grade sheets behind these tracking sheets with latest on top.

Lab Evaluations: Place latest on top.

Clinic Evaluations: Place latest on top.

Patient Restorations: Place latest on top.

CLINIC

SECTION 4 - MATERIALS THEORY

Restorative clinic involves the use of numerous materials. The clinician needs to understand not just the order and steps, but the science behind the use of all materials. The following chart can be photocopied for use by students, or used as a template to create their own.

Students must have a copy of this chart available or create their own personal restorative reference card prior to seeing their first patient.

RESTORATIVE REFERENCE CARD

STEP	MATERIAL	WHEN/WHERE TO USE IT	HOW TO USE IT	WHY TO USE IT
1	Dycal	<ul style="list-style-type: none"> - Pulp or near pulp exposure - Apply only where necessary, do not extend near cavosurface margins - DDS may apply in order to cover pulp exposure quickly. However, if student does so, make sure prep is clean and relatively matte-dry. 	<ul style="list-style-type: none"> - 1:1 ratio mix small amounts with the tip of the spatula in a stirring, not smashing motion - Immediately wipe off spatula as material will set - Apply with dycal instrument with gentle dabbing motions, do not scrub - No light cure needed - Allow to harden for several minutes 	<ul style="list-style-type: none"> - Helps build secondary dentin - Acts as a protective coating - Limited use as dycal doesn't bond with tooth structure or release fluoride
2	Glass Ionomer Base/Liner SCC Brands Fuji or Vitrebond	<ul style="list-style-type: none"> - Not on pulp exposure - Deep prep as base/liner - Over dycal as protective layer as dycal is very brittle - Never near cavosurface margins 	<ul style="list-style-type: none"> - 1:1 ratio mix in small amounts with the tip of the spatula in a stirring, not smashing motion - Immediately wipe off spatula as material will set - Apply with same instrument as dycal 	<ul style="list-style-type: none"> - To prevent post-op sensitivity by providing a protective base/liner - Prevents etching deep dentin - Releases fluoride - Glass ionomers <i>chemically</i> bond with tooth structure

			<ul style="list-style-type: none"> with gentle dabbing motions, do not scrub - Light cure for 30 seconds 	<ul style="list-style-type: none"> - Very common for deep preparations
3	Etchant 37% Phosphoric Acid	-Used on all composite restorations and sealants.	<ul style="list-style-type: none"> - Enamel - 30 seconds - Dentin - 15 seconds - Apply by first rimming enamel <i>then</i> filling remainder of prep - Trace tip around in prep to remove air bubbles - Rinse w/water only if possible for 20-30 seconds - Use high-vac to remove water from prep, limit use of air - DO NOT DESICCATE - Desiccation collapses protein fiber matrix responsible for majority of bond strength - Desiccation causes sensitivity 	<ul style="list-style-type: none"> - Removes contaminants and smear layer - Opens/ exposes crystalline enamel tags and dentinal tubules and exposes dentinal protein fiber matrix allowing for micro-mechanical bonding - Over etching collapses/dissolves crystalline irregularities and protein fiber matrix, thus inhibiting proper adhesion - Over etching results in trauma/tooth sensitivity
4	Dentin Desensitizers SCC Brands Gluma or Hurriseal	- Not necessary for superficial preps but can be used routinely when dentin is exposed	<ul style="list-style-type: none"> - Shake bottle to mix contents. - scrub into prep with micro-brush for 30 seconds-1 minute - Lightly air dry or blot dry with micro-brush to remove excess - Do not cure 	<ul style="list-style-type: none"> - Desensitizing agent - Seals dentinal tubules by recreating artificial smear layer compatible w/bond - Sealed tubules inhibit fluid movement and nerve stimulation - Inhibits the growth of bacteria
5	Single Bond SCC Brand Bond-1 Primer & Adhesive	- All composite restorations and sealants	<ul style="list-style-type: none"> - Shake bottle to mix contents, dispense not sooner than 30 seconds prior to use and re-cap immediately. All of above is due to separation of alcohol 	<ul style="list-style-type: none"> - Contains a “wetting” agent or primer, which allows resin to flow into crystal irregularities - Contains a light curing resin material with no filler

			solvent and adhesive and evaporation of solvent. - Brush on prep with micro-brush and dab excess - Air dry gently (clear air/water line of water first and keep clear) for 3-5 seconds - Do not blast air - Light cure 10secs	- Contains alcohol as a solvent - Micromechanically bonds to tooth structure - Gentle air prior to curing disperses excess bond and evaporates alcohol solvent
6	Flowable Composite	- Can be used against any matrix or hard to access prep areas	- Place along matrix bands and trace with explorer - Light cure for 20secs	- Low viscosity, flows in small areas easily - Creates micro-flashing with IP fillings which can then be finished rather than resultant micro-voids
7	Universal Composite	- All applications depending on type of composite	- Place in increments - Never connect wall-floor-wall with one increment - Light cure 20-30secs each time - Final cure after matrix removed buccal/lingual	- Aesthetically pleasing - Minimally invasive dentistry - Adhesive properties increase structural stability in tooth

****For Amalgam Restorations steps 1, 2, and 4 may be followed if necessary**

Further Considerations

Prevention of Tooth Sensitivity

Historically, composite dentistry has been marked by a great deal of post-op tooth sensitivity. As technology and technique have advanced, changes have been made to minimize this problem. While there are many causes of tooth sensitivity we will discuss a few concepts here as they apply to our clinic, some of which also apply to any restorative procedure be it amalgam, crown, composite, etc.

Traumatic Forces:

The prevailing theory related to dentinal hypersensitivity should be reviewed and applied to restorative procedures as dentin is almost universally exposed. Dentin contains numerous pores, or tubules, which connect the nerve chamber to the outside environment. These tubules are understood to contain fluid, which can be disturbed/ affected by outside stimuli. Should this happen, nerve endings residing inside the nerve chamber but with small extensions in the tubules are stimulated with resultant pain. A common example of this is root surface hypersensitivity, especially in regard to recession and/or abfraction.

During restorative procedures, once dentin and thus the dentinal tubules as well are exposed, ANY aggressive application of air, in particular, can lead to traumatized nerves and sensitivity. With this in mind, we will discuss desiccation and force.

Desiccation:

At any time throughout the restorative procedure, desiccation of the tooth can result in trauma to nerves. This is particularly the case after etching. Desiccation after etchant has been applied collapses the protein fiber matrix and crystalline irregularities that provide for ideal bonding. It is not sufficient to “re-wet” the prep if over-dried since the damage has already been done.

In order to prevent this, once etchant has been sufficiently rinsed, we want to avoid the typical blast of air most commonly taught. Rather, the high-vac suction held over the prep will remove most of the moisture. After rinsing is complete, simply stop rinsing, hold suction over prep briefly, proceed to dry the “field” around the tooth to prevent moisture contamination issues and the check to ensure prep does not contain excessive water. If so, *gentle* air with suction will be sufficient.

The ideal result is similar to the portion of sand on a beach between the dry sand and the water, moist but not pooling.

Force:

A powerful combination of air/water to rinse preparations is common in dentistry. This is the case during the removal of decay and after etching. We will attempt to *only use water* to rinse our preps at Seattle Central. Once again, aggressive outside stimuli can result in agitation of pulpal nerves and lead to sensitivity. Occasionally, especially when a glass ionomer has been applied, the etchant will cling to the inside of the prep. If this is the case, use of a micro-brush to remove the etchant followed by another rinse is an effective solution.

Over-Etching:

Similar to desiccation, over-etching a prep can collapse/dissolve the protein fiber matrix and crystalline irregularities that provide for micro-mechanical bonding. Additionally, etchant is very caustic and easily results in trauma to pulpal nerves.

Etchant is ideally applied to enamel first, especially the cavosurface margin, which typically is under-etched. Enamel requires at least 30 seconds whereas dentin only 15 seconds. We describe this process as “rimming” the enamel first, then proceeding into the prep to fill completely with etchant. At that point, count 15 seconds and begin rinsing.

Layering:

Due to composite shrinkage, which is minimized in newer composite generations, layering is important. It is also time-consuming and, therefore, not practiced as frequently as it should be. We never want to connect more than 2 surfaces of a prep with one increment, especially with the first couple increments and in larger preparations.

Hyperocclusion:

After the restoration is completed we need to check the occlusion to make sure that the patient’s bite is even, between the right and left sides and that the tooth we have just restored is not the only one hitting. If the tooth is left in hyperocclusion, within a day or two they will have a very sore and sensitive tooth. It is important to check the bite with articulating paper and adjust till the patient can feel both sides of their mouth and the occlusal markings are even and appear as when we checked them preoperatively.

Moisture Control

This aspect of composite technique cannot be over-emphasized! All it takes is to hold a mouth mirror in a patient’s open mouth and watch as if fogs up with each breath of the patient to realize the moisture potential in the oral cavity.

Due to this, dental dams are utilized at Seattle Central whenever possible. Adequate moisture control is necessary and must be maintained. If a dental dam is leaking, the addition of cotton rolls placed under the dam may suffice to stop leakage, or the dam will need to be re-done.

For cases where a dental dam is not possible, such as with class V restorations, the utmost care needs to be taken to prevent moisture contamination. This necessitates close cooperation between operator and assistant. Such techniques will be demonstrated.

Once again, it cannot be over-emphasized that any restoration, no matter how beautiful, done without proper moisture control, is at best simply beautiful. Ethically, professionally and morally, we strive to ensure quality in this aspect of restorative dental hygiene!

SECTION 5 – DENTAL DAMS

Dental dams, although in existence for over 100 years, are one of the most widely underused tools of infection and quality control and patient safety. We will briefly discuss these factors to provide a basis for Seattle Central's dental dam policy.

Infection Control

Guidelines for infection control published by the US Centers for Disease Control and Prevention, recommend the use of dental dams and high-velocity air evacuation as a means of minimizing the dissemination of contaminants and spatter, especially since most restorative procedures involve powerful air/water forces, which readily create aerosols.

Patient Safety

Restorative procedures are rife with opportunities for small items to be dropped into patients' mouths with possible serious repercussions. Apart from equipment and instruments, restorative materials such as mercury containing amalgam must be absolutely prevented from being swallowed.

Quality Control

Though amalgam restorations pose more risk to the patient should some be swallowed or inhaled, they are less technique sensitive than composite restorations. Any dental professional who has held a mouth mirror in a patient's mouth and observed it fog due to vapor in the patient's breath, can testify to the moisture ever-present in the oral cavity. Even such vapor will contaminate composite restorations and prevent proper bonding. Dental dams should ideally be used for every composite based restoration, even sealants. However, due to possible discomfort associated with dam clamps, it is not always possible without local anesthesia. One exception to dental dams is class V (gumline) restorations as the dental dam will actually cover and obstruct the working area. Excellent isolation is required for these.

It is Seattle Central Dental Hygiene Program policy to use dental dams in every possible situation. Alternatively in certain situations we have available in the center demonstration operatory the Isolite unit.

Dental Dam Clamps

The clamp is placed and removed from the most posterior tooth by being stretched wide and then released gently on or off the tooth with a dental dam

forceps. The dental dam clamp consists of four prongs and two jaws connected by a bow. Prongs may be straight or inverted. The jaws may be flat, apically curved, or serrated. The clamp is used to anchor the dam to the most posterior tooth isolated. Clamps are also used to retract gingival tissue. Many different sizes and shapes are available, with specific clamps designed for specific teeth and specific situations. There are so many clamps available that can be confusing and overwhelming. With experience, you will find a small selection of clamps that will work in most situations.

Facts and tidbits about clamps:

When properly positioned on a tooth, the clamp should contact the tooth in at least four areas: 2 facial and 2 lingual. This prevents rocking or tilting. The clamp should be centered on the tooth.

Prongs that are directed gingival can help secure the clamp to a partially erupted tooth, a tooth with irregular shape or when additional soft tissue retraction is needed.

Jaws of the clamp should not extend beyond the mesial and distal line angles of the tooth because this will interfere with matrix and wedge placement, also a complete seal will be difficult to achieve and tissue trauma is more likely.

Wings are designed to provide extra retraction of the dental dam from the operating field. ***They also provide for the placement of the dental dam as a pre-assembled unit. In this case, the winged clamps are best for easy securing to the dental dam before placement. It will be Seattle Central's policy for students to attempt this manner of placing a dental dam in most situations.***

Floss ligatures: clamps should always be tied with a long strand of dental floss before being placed in the mouth. Should the clamp become removed accidentally, it can be retrieved easily and prevented from being aspirated by the patient.

This is the general use for some of the clamps available:

- 4 Molar clamp: Very widely used clamp
- W4 Same as (4) but without wings.
- 8A Molar clamp, root clamp, and primary 2nd molars, works especially well on upper molars
- 14 molar clamp, works well on lower molars
- 14A same purpose as 14 except it is for very large molars
- 12A UL and LR molars, works well on primary molars
- 13A UR and LL molars, works well on primary molars
- 2A premolar clamp with flat jaws, may work on primary molars
- 00 anterior clamp, especially small lower anterior

SECTION 6 – BURS AND HAND-CUTTING INSTRUMENTS

ROTARY INSTRUMENTS **BURS**

General description

Made of tungsten carbide

Parts of the bur

1. head
2. shank – friction grip, latch-type, straight
3. shaft

Types of Burs

Cutting burs

1. Used to cut and shape tooth structure for various types of restorations, and for removal of old restorations.
2. Named according to shape of bur head and angle of cutting blades.
3. Numbered according to size (smaller number, smaller size).
4. Generally six to eight blades
5. Shapes
 - (a) Round
 - (b) Inverted cone
 - (c) Straight fissure
 - (d) Straight fissure crosscut
 - (e) Tapered fissure
 - (f) Tapered fissure crosscut
 - (g) Pear
 - (h) Special bur for amalgam preparation

Basic Bur Shapes Used In Operative Dentistry

Type/Shape

Numerical Category

Inverted Cone	33 1/2, 34, 35, 37, 38, 39
Round	1/4, 1/2, 1, 2, 4, 6, 8
Plain Fissure	55, 56, 57, 58
Tapered Fissure	169, 170, 171
Crosscut Plain Fissure	556, 557, 558
Crosscut Tapered Fissure	669, 700, 701

Diamonds

1. Vary in size, shape, length, and function
2. Have excellent abrasive or cutting action, as they have thousands of cutting edges (vs. the six to eight blades of a carbide bur)
3. Uses (depending on size, shape and grit)
 - (a) gross reduction of tooth structure (e.g. crown preparation)
 - (b) cutting and shaping tooth preparation
 - (c) finishing and polishing restorations

Finishing Burs

1. Made of carbon steel
2. 10+ blades, therefore produces smoother cutting action and smoother surface
3. Named according to shape

Surgical Burs

1. made of carbon steel or tungsten carbide
2. various size, shapes, shank lengths
3. used to cut through bone or to split crown or roots for tooth during an extraction

Acrylic or denture burs

1. Used for removal of excess acrylic, or occlusal adjustments of dentures or partial dentures, or other acrylic appliances (e.g. night guards, orthodontic appliances)
2. Names according to shape

Cleaning and Sterilization of Burs

DO NOT USE COLD STERIZING SOLUTIONS for carbide burs-chemicals will dull and weaken the burs.

MOUNTED STONES

Green stones

1. silicon carbide abrasive
2. produces moderately rough surface
3. used to initiate bulk removal of restoration material during finishing of amalgam and gold restorations; occlusal adjustments

White stones

1. dense aluminum oxide abrasive
2. produces a smooth surface
3. used to smooth restorative materials during final finishing

DISCS

Physical characteristics

1. group of abrasive-coated rotary instruments
2. variety of abrasive coatings; synthetic or natural; silicon carbide, sand, garnet or quartz
3. variety of grits
4. sizes from 1/4 inch to 7/8 inch diameter
5. mounted on snap-on or screw-on mandrel

Uses- for refining cavity preparations, and finishing and polishing restoration; proximal surfaces, buccal and lingual contours of teeth or restorations, or incisal edges.

Wheels-molded abrasive rotary instruments primarily used in laboratory procedures; for finishing and polishing

Mandrels

1. Designs to hold (mount) stones, discs, and wheels
2. Bur-type shank; i.e. friction-grip, latch, or straight
3. May be snap-on or screw-on head

HAND CUTTING INSTRUMENTS

General Description

Use

1. designed to refine the walls, margins and angles of cavity preparations
2. not used much anymore, as current research shows sharp line angles in a preparation tend to weaken the tooth; better to prepare the tooth with curved line angles (e.g. #245 or #330 bur)

Parts

1. blade or nib-the functional end
2. shank-"connector" between handle and blade
3. handle or shaft-portion of instrument held by operator; may be serrated, knurled, or smooth

Single-ended or double-ended

1. double-ended may be referred to as right and left (e.g., spoon excavator or enamel hatchet) or classified according to use on mesial or distal surfaces (e.g., gingival margin trimmer or bi-angle chisel)

Formula Numbers-three or four numbers (printed on handle) describing the size of the blade and the angle at which it is set to the shaft.

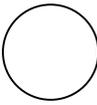
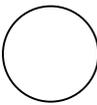
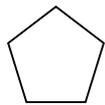
1. three-numbered formula
 - a. first number represents width of blade in tenths of millimeters
 - b. second number represents length of blade in millimeters
 - c. third number shows, in degrees, the angle that the blade forms with the shaft
2. four-numbered formula
 - a. first number represents width of blade in tenths of a millimeter
 - b. second number represents, in degrees, the angle that the cutting edge of the blade makes with the shaft
 - c. third number designates the length of the blade in millimeters
 - d. fourth number shows, in degrees, the angle that the blade forms with the shaft

Types of Instruments

Enamel hatchets, Hoes, Angel formers, Gingival margin trimmers, Spoon excavators and Chisels

Seattle Central's DDS Bur Block

Back

Latch Angle Round (slow speed) <div style="text-align: center;"></div> #2	Latch Angle Round <div style="text-align: center;"></div> #4	Latch Angle Round <div style="text-align: center;"></div> #6	Latch Angle Round <div style="text-align: center;"></div> #8	Diamond Flame <div style="text-align: center;"></div>
Friction Grip Round (high speed) <div style="text-align: center;"></div> Same sizes as the latch type	Friction Grip Round <div style="text-align: center;"></div>	Friction Grip Round <div style="text-align: center;"></div>	Friction Grip Round <div style="text-align: center;"></div>	Fissurotomy <div style="text-align: center;"></div>
Straight Fissure 57 <div style="text-align: center;"></div>	Tapered Fissure 168 <div style="text-align: center;"></div>	Pear <div style="text-align: center;"></div>	Inverted Cone 33 1/2 <div style="text-align: center;"></div>	Inverted Cone 34,35 <div style="text-align: center;"></div>

Front

DDS bur blocks must be kept fully stocked. It is the student's responsibility to inspect bur block prior to procedure to make sure all burs are present and in order. This is also necessary afterwards as burs may be lost, broken or need replacing. If such is the case, new burs should be taken from the stock containers with sterile cotton pliers and placed in bur block prior to sterilization.

Bur blocks must not be tipped sideways since certain burs may fall out and be lost. Blocks need to be kept upright and placed in the sonic bath

SECTION 7 - AMALGAM

AMALGAM CONDENSING & CARVING

Background Information

Amalgam is the most widely used restorative material. Amalgam is produced by mixing mercury with a silver-tin alloy; which usually contains a small amount of copper and zinc. Its characteristics (for example, its strength and setting time) are determined by the ratio of mercury to alloy. The mixing of the mercury and the alloy produces an amalgam that for a few minutes is moldable but then quickly sets and becomes hard.

GENERAL OUTLINE OF CREATING AMALGAM RESTORATIONS AT SEATTLE CENTRAL COMMUNITY COLLEGE RESTORATIVE CLINIC

Steps may be done and then be checked	Steps must be watched	Either: Determined by Instr.
---------------------------------------	-----------------------	------------------------------

ABC: Anatomy drawn effectively, significant facts noted (such as height of marg ridge)
Bite evaluated and noted thoroughly
Contacts evaluated for interproximal restorations

**INSTRUCTOR
CHECK:**

ABC: These three steps will require notation on the laminated tooth outline cards. Restorative is just that, an attempt to restore to previous form and function and improve if possible. To do so, one must evaluate the tooth prior to restoring.

A= Anatomy – evaluate the existing anatomy. Note depth of grooves, significant anatomy deviations, size of embrasures, location of contacts, tightness of contacts, height of marginal ridges and so on.

B= Bite/Occlusion – Mark the occlusion using articulating paper. Dry the patient's teeth thoroughly with air and then align the paper against the non-moving maxillary teeth. Have the patient firmly tap and chew. Note not just dispersion but intensity of hits and on surrounding teeth as well.

C= Contacts – In the case of interproximal restorations, evaluate the pre-existing contact with floss, determining its tightness, location and size. Also, check surrounding teeth for context.

DENTAL DAM

Properly punched, seated & tucked
Clamp properly selected & seated

INSTRUCTOR CHECK:

Isolation Stage: A dental dam will be used whenever possible.

We will typically attempt to do dental dams with winged clamps and the frame on for speed and ease of application.

MATRIX & WEDGE

Sketch of prep complete
Matrix & wedge properly selected and placed

INSTRUCTOR CHECK:

Sketch: After the DDS prepares the tooth, the student must utilize their laminated tooth outline card to draw the prep as a tool for finishing and understanding of the location of restoration margins

Matrix: Place as taught in lab and have instructor check.

Key principles with matrix placement:

Preserve the form/contour of matrix band.

Close off the interproximal box completely. This may require more than one wedge, carefully placed.

In so doing, ensure the wedges are not impinging on the matrix band thus creating a dent in the proximal box.

Wedge very, very, very firmly!

Know where to burnish; this can be critical for contact creation and embrasure form.

INSTRUCTOR OBSERVATION:

Base/Liner- properly mixed & placed Type:

Desensitizer process,
Gluma/HurriSeal

Moisture control established and maintained - CRITICAL AREA!!!

See Section IV – Materials Theory chart for more details

Moisture Control: Remember that without proper isolation throughout procedure, the most beautiful restoration is a bad one. In fact, it could be said that isolation is the foundation and must be maintained. This also applies to materials handling and instruments. If an explorer, for example, is contaminated prior, and then used to trace the flowable without being wiped off, contaminants have been introduced. This also goes for handling the tip of microbrushes with gloves, handling composite with gloves, wiping tips of instruments with wet 2x2s and so on. Think comprehensively!

POSSIBLE INSTRUCTOR OBSERVATION:

CONDENSATION OF AMALGAM

Condensed with sufficient speed/force

Condensed thoroughly and overfilled

Matrix removed safely

INSTRUCTOR CHECK (IF NOT OBSERVED):

Condensing Amalgam: Condensation is the process of inserting and compressing dental amalgam into a cavity preparation so that the cavity is completely filled with a unified mass of amalgam. Condensing amalgam promotes adaptation of the amalgam to the walls and margins of the cavity preparation. It also compresses the amalgam, eliminating voids, and reduces the amount of residual mercury. These conditions increase the strength of the amalgam restoration.

Even the smallest cavity preparation is restored with at least two increments of amalgam. Each increment should be small because small increments are easier to condense into the angles of the cavity preparation. Adaptation of the amalgam to the walls and margins of the preparation is thus maximized. Using small increments also reduces the possibility of voids occurring between the condensed increments. The voids and improper bonding of poorly condensed amalgam weaken the amalgam and prevent satisfactory polishing.

The amalgam must be condensed **immediately** after trituration. A mix of amalgam that has begun to set prevents adequate condensing. As the amalgam gets harder, voids cannot be eliminated and the increments of amalgam do not bond. A mix of amalgam that is difficult to manipulate must be discarded. This can occur about 3-5 minutes after trituration depending on type of alloy used.

Amalgams - Step by Step

Procedure for condensing amalgam into a preparation

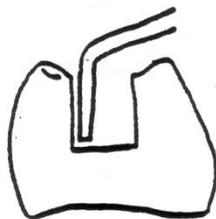
Visualize the size and shape of the cavity preparation. This image will be helpful during condensing and carving procedures when the outline is obscured by overfilling the cavity preparation. You can accomplish by drawing it on a piece of paper.

Condense the first increment of amalgam. Using the small end of the amalgam carrier, place the first increment of amalgam on the gingival floor of the cavity preparation.

Hold the condenser in a modified pen grasp; secure a finger rest on the adjacent teeth. A secure finger rest provides more leverage and enables you to condense with well controlled, begin with **FORCEFUL** strokes; then reducing pressure and condensing using multiple light and swift strokes. You will be using arm as well as finger pressure. Using the small end of the smaller condenser, apply light to moderate force to the mass of amalgam to spread and adapt the mass along the entire gingival floor. With a Class II preparation, please condense inside the proximal box area first. (Situating the amalgam with lighter pressure is important because it causes some “intermeshing” of the amalgam particles. This provides for a stable surface on which you can apply the force that is necessary for complete and thorough condensation. If the condensation is approached with too great of pressure during the first strokes, the amalgam will be forced out from under the condenser and adaptation to the cavity preparation will not occur. (You will force the amalgam out of the preparation as fast as you place it.)

Once amalgam is “situated” on the gingival floor as well as the proximal box, begin condensation moderately forcefully, using vertical strokes followed by oblique strokes to force and adapt amalgam into all the line angles and point angles.

Initial condensing angle



Subsequent condensing angles



Approximately, Six to eight quick strokes should be enough to force the amalgam to the bottom of the preparation, condense it, and adapt it to the walls of the preparation. Amalgam is sufficiently condensed when the end of the condenser no longer penetrates the mass.

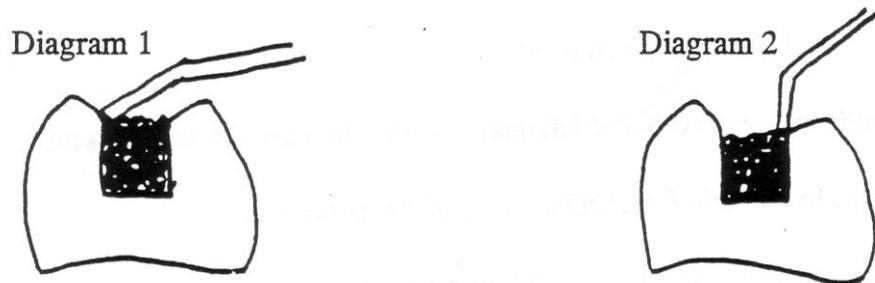
Place and condense a second increment of amalgam into the cavity.

- A second increment is now placed into the cavity.
- Once again, lightly spread the amalgam over the surface where you plan to condense -- increasing pressure may be applied as the amalgam begins to adhere to the underlying material.
- Now with the amalgam in place, apply considerable force and thoroughly adapt the new increment. (10 lbs. pressure at finger tips)
- Remember to condense **into** the cavity preparation as well as in the direction of matrix in order to establish interproximal contour.
- During condensation, soft, mercury-rich amalgam may work up around the head and shank of the condenser. Remove this amalgam excess by pushing it away and out of the preparation with the end of the condenser.
- Continue using the small end of the condenser until the preparation has been filled up to the level of the pulpal floor.

Place and condense subsequent increments of amalgam.

- Once the preparation has been filled to the level of the pulpal floor, begin utilizing the larger end of the condenser - continue condensing into the cavity preparation and toward the matrix board.
- Lightly spread the amalgam over the surface where you plan to condense.
- The area to be condensed is larger now and condensation becomes more efficient with the larger end of the instrument.
- Apply considerable force to the amalgam while working in an orderly sequence around the entire cavity preparation.
- Each stroke of the condenser should overlap the previous stroke forming a sequential pattern of overlapping circles over the entire surface.
- Continue to condense until the amalgam is firmly packed, then place another increment.

- When amalgam is condensed, mercury is pulled through the various layers or increments, thereby creating one solid dense homogenous mass.
- However, this creates a mercury rich layer on the top and this material must be removed with the head of the condenser before placing further increments.



At the occlusal cavosurface margin angle, the condenser should be position as illustrated in diagram 1. If the condenser is placed at the occlusal cavosurface margin, as illustrated in diagram 2, there is a hazard of chipping the margin. (Note: We will go over this in lab multiple times.)

Important Tip:

- When the entire preparation has been filled, the minimum of one more increment will be placed to provide for overfilling (be very careful to condense at an angle to the occlusal cavosurface margin -- vertical strokes may cause chipping of the margin of the preparation.)
- The preparation is overfilled for two reasons:
 - a) There is ample material with which to carve anatomy.
 - b) The mercury being pulled up through the mass does not end up at the cavosurface margin. Mercury-rich amalgam is weak and would jeopardize the strength of the restoration. Therefore, overfilling allows the mercury-rich final layer of amalgam to be removed.
- Remove the final mercury-rich excess layer with either the condenser or an explorer.
- Clear away any excess occlusal bulk at the same time as removing the mercury rich excess.

- This step is intended to help the practitioner “feel” for any imperfections at the cavosurface margins.
- Clear the amalgam bulk away from the matrix band. Place an explorer tip next to the matrix band in the proximal areas and clear away the excess bulk in the occlusal embrasure. Keep the tip of the explorer in contact with the matrix band and clear the bulk away slightly above the contact area. Do not let tip of explorer dip too low and remove excess marginal ridge bulk.

Note: Do not allow the tip of explorer to touch the interproximal walls or mesial and/or distal cavosurface margins to avoid creating deficiencies.

THIS IS AN APPROPRIATE PLACE TO NOTE THAT ONCE AMALGAM HAS BEGUN TO HARDEN, IT IS UNACCEPTABLE TO ATTEMPT TO ADD ADDITIONAL AMALGAM TO DEFICIENT AREAS!!! ADDED AMALGAM MAY STAY IN PLACE. HOWEVER, ITS COHESION WITH THE BULK OF THE RESTORATION IS MINIMAL – A BUILT IN WEAKNESS/DEFECT.

The matrix band is now ready to be removed and the following evaluation criteria must have been met:

1. The preparation was overfilled.
2. The mercury-rich layer was removed.
3. Occlusal bulk was removed and amalgam covers the cavosurface margins.
4. The amalgam mass feels firm under force of the condenser or your finger.
5. The matrix band has been cleared and bulk has been removed from the occlusal embrasure.

REMOVAL OF THE WEDGE, MATRIX AND RETAINER

Procedure

- Unscrew end knob on retainer.
- Hold the band firmly by placing index finger on top of matrix.

- Remove retainer.
- Remove the wedge with cotton pliers.
- Hold the marginal ridge with a large condenser head or finger.
- If only one proximal surface is being restored, remove the band from the non-restored side first while holding the marginal ridge of the restored surface.
- Next, while still holding the bulk of amalgam on the marginal ridge of the restored proximal, lift the matrix off.

AMALGAM CARVING

- **Steps 1 through 6**
- **Proximal carving and development of the marginal ridge.**

Step 1. Clear the gingival cavosurface margin.

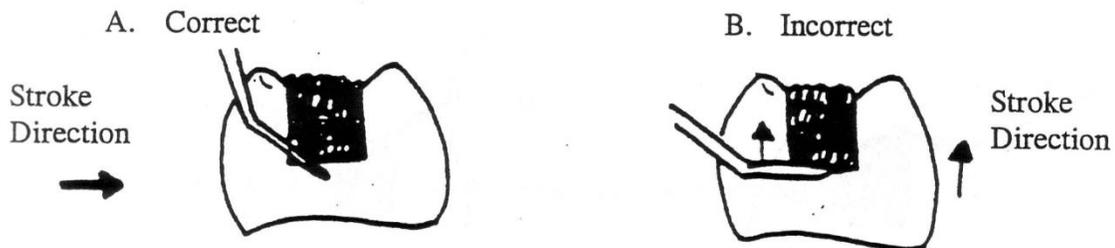
-
- Determine the correct side of the blade to be used. Place the Half Hollenbeck carver into the interproximal space. Adapt the blade in a vertical position with the cutting edge of the blade placed directly into the interproximal space.



Note: The “skinny side” of the blade slides interproximally and automatically guides you to select the correct blade adaptation for clearing the gingival area.

Adapt and engage the blade **oblique** to the gingival cavosurface margin with the tip of the instrument placed on enamel below the margin. This angulation and placement allows for a stroke that will: (1) reach slightly further than halfway across the gingival margin (2) Protect the gingival margin and not cause a deficiency or ditching, (3) Protect the interproximal contour from becoming flattened.

- Note:** A. If the blade is not oblique the mid-interproximal will not be reached.
- B. If the blade is placed parallel to the gingival floor and the stroke moved toward the occlusal, the instrument will ditch into the amalgam as it moves from enamel to amalgam and cause a marginal deficiency. This type of stroke also causes flattening of the interproximal contour.



Note: An interproximal carver can be employed in this step. This instrument will be demonstrated in lab.

Step 2. Clean the proximal buccal and lingual cavosurface margins.

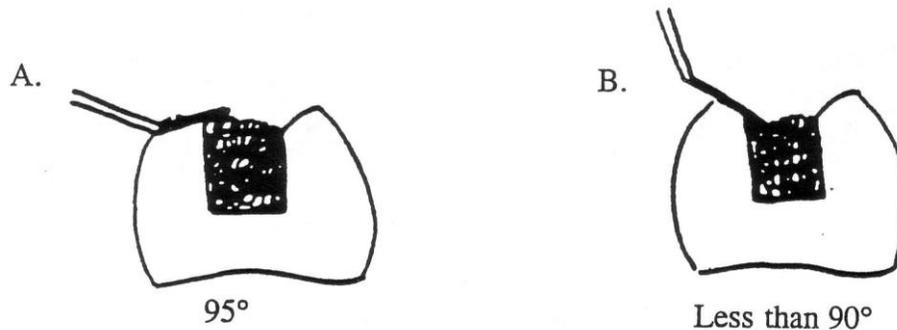
- Clear the restoration from gingival floor up to and over the marginal ridge. Strokes of this kind demand a steady hand and caution.
- Instrument placement:
 1. The blade is not placed at a right angle to the proximal margin.
 2. Only the terminal segment of the blade is in contact with amalgam.
 3. The blade is slightly open (an obtuse angle to the margin).
 4. The blade rests on enamel.



- A. Only the terminal 2-3 mm portion of the blade is used thereby only clearing the margin and leaving bulk interproximally to create rounded contours.

- B. If a large portion of the blade is used, not only will the margin be cleared **and** the interproximal contour will be flattened.

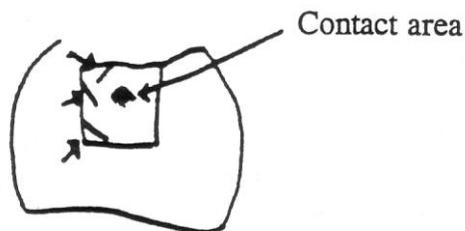
The stroke begins slightly above the gingival margin and proceeds up and over the marginal ridge. When approaching the marginal ridge be sure the blade is at least 90° to the cavosurface margin. To open the blade to 95° would be even safer. An angulation of much less than 90° will result in a deficiency of the cavosurface margin at the marginal ridge.



- A. Note bulk of amalgam left an area of marginal ridge.
- B. Note lack of bulk to be used for contouring marginal ridge.

Step 3. Develop the proximal contour: Carefully shape the buccal, lingual and gingival embrasures as well as contact area.

- In the previous two steps, the blade of the instrument was supported by enamel while also in contact with amalgam. While shaping the proximal contour there will not be enamel support for the instrument.
- Place the edge of the blade on the amalgam and with a free hand stroke, gently carve and shape until the interproximal anatomy has been reproduced:



The blade will be placed in many different angles and the strokes in many directions to adequately contour the buccal, lingual and gingival embrasures. Direct each stroke into the contact area so contouring has completely surrounded this area.

Step 4. Develop the height of the marginal ridge.

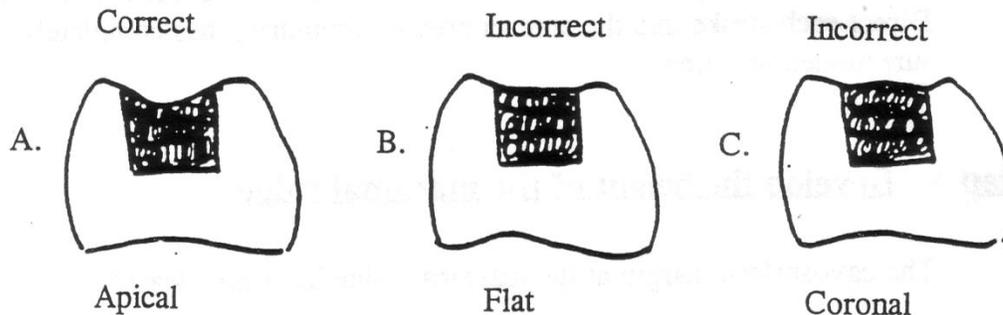
- The cavosurface margin at the marginal ridge has been cleared.
- Place the blade so it extends from enamel to half way across the Buccal-lingual dimension of the tooth. DO NOT ALLOW THE TIP OF THE CARVER TO CROSS THE CENTRAL GROOVE. IT WILL WIPE OUT THE RIDGES ON THE OTHER SIDE OF THE TOOTH (BUCCAL OR LINGUAL).
- Keep the blade slightly open and take several strokes back and forth over the marginal ridge.

Remember the existing enamel structure is completely guiding the stroke.

- Now with the majority of the bulk cleared away from the area of the marginal ridge, determine the height of the marginal ridge:
 - ⇒ If the teeth in the arch area in proper alignment the proper alignment the approximating marginal ridge may be used as a guide to determining the height.
 - ⇒ The proximal contour of the marginal ridge must be carefully visualized before beginning to carve.
 - Remember that marginal ridges curve apically. As the buccal and lingual cusp ridges slope apically on the mesial or distal, this ridge becomes the marginal ridge and continues to slope apically.
 - ⇒ With the correct contour in mind, use a free-hand stroke to remove bulk.
 - Begin the stroke a couple of millimeters in from the cavosurface margin and carve until you have attained the correct marginal ridge height.

At this point the goal is not to attain shape - only height. At this point the surface created will be flat and of the correct height that gently curves apically -- blending

downward from the buccal cusp ridge to marginal ridge and upward from mid-marginal ridge to lingual cusp ridge:



It is extremely important that you create apical contour to the marginal ridge. If the marginal ridge height is not correct, the height of ALL the rest of the occlusal anatomy will be incorrect.

Step 5. Shape the outside of the marginal ridge and develop the occlusal embrasure.

- There will be a bulk of amalgam in the area of the occlusal embrasure. Place the instrument at the height of the marginal ridge and take cutting stroke down into the contact area, shaping and rounding the proximal side of the marginal ridge.
- When the bulk has been removed from the occlusal embrasure, gently round the proximal side of the marginal ridge up to the height.

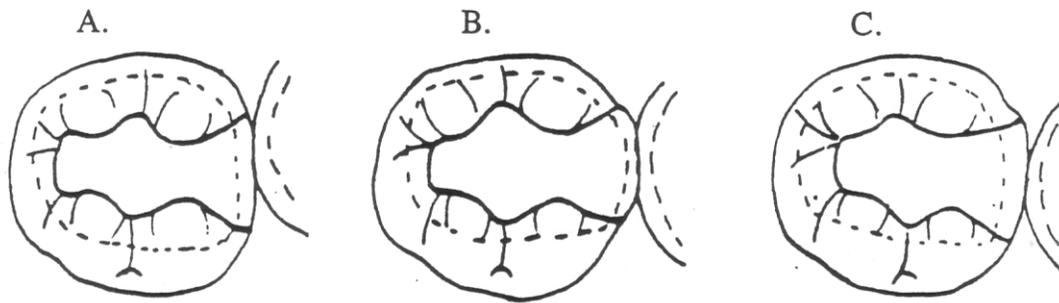
Note: Take a careful look at the contour. Be sure the contour of the amalgam is continuous with the contour of the tooth. There should be no dents, bulges or bumps.

To determine where the midpoint of the marginal ridge width is, look at the buccal and lingual cusp ridges. You should be able to follow and imaginary line gently curving from the height of the contour of the buccal cusp ridge, to the marginal ridge and then to the lingual cusp ridge.

Correct

Incorrect
Bulk needs to be removed from occl. embrasure

Incorrect
Bulk needs to be removed from lingual embrasure



- A. Presents a continuous contour
- B. Presents an occlusal table that is too wide mesially distally and closes the occlusal embrasure.
- C. Presents an altered occlusal table size as well as a small lingual embrasure. Both B & C will alter the patient's occlusion and cause trauma to the periodontal tissues.

Step 6. Check to see that all of the above steps are complete.

DO NOT GO ON UNLESS THEY ARE COMPLETE.

- Carefully check marginal ridge height. Make any necessary adjustments now. If a high marginal ridge is not discovered until the entire restoration has been carved, it could result in virtually recarving all the anatomy over again. i.e., If you lower the marginal ridge after all the anatomy has been carved:
 - a) the triangular fossa and pit will be too shallow
 - b) the entire occlusal table will have to be lowered
- Check the proximal contour - **LOOK** occlusally **AT THE SHAPE**. The contour should be continuous, not protruding.

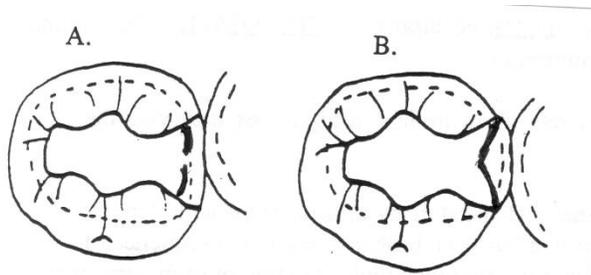
Make any necessary adjustments. You are now ready to begin carving the occlusal anatomy.

Note: As you gain experience and speed many of these steps will blend together. This procedure has been broken down into a sequence of separate steps to allow for a thorough understanding of each component of the task.

Now moving on to: Carving the occlusal anatomy –

Step 7. Locate and lightly place the buccal and lingual developmental grooves nearest to the restored marginal ridge.

- Remember grooves are curved not straight and they do **not** extend into the marginal ridge. DO NOT PLACE CARVER ON MARGINAL RIDGE OR IT WILL BREAK as in figure B.



Correct

Incorrect

- Carving these grooves lightly into the bulk of amalgam will serve as a visual “stop sign” during the clearing of the cavosurface margin.
- As you gain experience this step may be eliminated. For now it will serve as a visual cue not to continue the strokes used for clearing the cavosurface margin past these grooves. If the clearing stroke went past these grooves the marginal ridge could easily be destroyed.

Step 8. Clear the occlusal cavosurface margin COMPLETELY.

- Placement of the instrument is:
 - a) as close as possible to 90° to the cavosurface margin to provide for maximum bulk of material at margin.
 - b) Extend the blade of the Half Hollenbeck half way across the restoration so the tip is in the area of the central groove.
 - c) Keep the blade of the instrument in contact with enamel at all times.
 - d) Keep the blade perpendicular to the cavosurface margin AT ALL TIMES while clearing the margin. As the cavosurface margin curves, the blade must be constantly adapted to remain perpendicular. Otherwise the following could result:

- 1) Deficiency of the margin

2) Improper directional placement of developmental grooves (and thus also triangular ridges)

3) Improper directional placement of the central groove.

- **Stroke**

Clearing the margin means carving away excess amalgam until the amalgam is completely flush with the enamel. This is accomplished by beginning on one side (buccal or lingual) with the instrument placement just described.

- Begin clearing in the area of one triangular ridge.
- Take short repeated strokes only in this area
- Continue the strokes until **all** excess amalgam has been removed at the cavo-surface margin
- Now continue in this manner to clear area by area around the entire occlusal cavosurface margin
- When approaching a marginal ridge, stop the clearing stroke at the developmental groove placed to be the “stop sign.”

Step 9. Finishing the cavosurface margin.

Once the entire cavosurface margin has been cleared, go around the entire margin again using longer strokes to attain a satin smooth finish to the surface.

If the occlusal cavosurface margin has been thoroughly cleared, the following criteria will be observed:

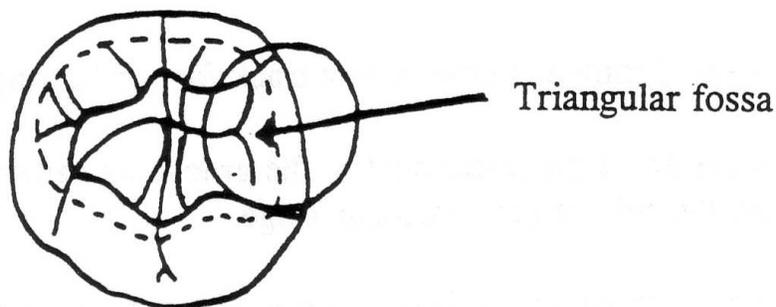
- a) Crisp, clean line where amalgam meets enamel
- b) The tactility will be a smooth transition between enamel and amalgam
- c) The developmental grooves will be clearly identified. (If part of a developmental groove exists in the remaining enamel at the cavosurface margin of the preparation, as the blade carves over that area it will automatically place the groove in the amalgam. This is one advantage to thoroughly clearing the margin. However,

since a groove will be made in the amalgam when you carve over a groove in the enamel, it is **CRITICAL** that the blade **always** be perpendicular to the margin. If the blade is at any other angle than perpendicular, the direction of the groove will be misplaced. If the groove is misplaced, so will the triangular ridge be misplaced and thus the entire occlusal anatomy will be incorrect.

- d) The central groove will be identified. This results from clearing the margin in the tip of the blade adapted into the area of the central groove.

There is now a smooth working surface, with the majority of the occlusal anatomy correctly identified. This becomes the “road map” the “guidelines” from which to contour the rest of the restoration. It is absolutely essential that the cavosurface margin be completely cleared. Do not continue on with the restoration until it is.

Step 10. Develop the triangular fossa.

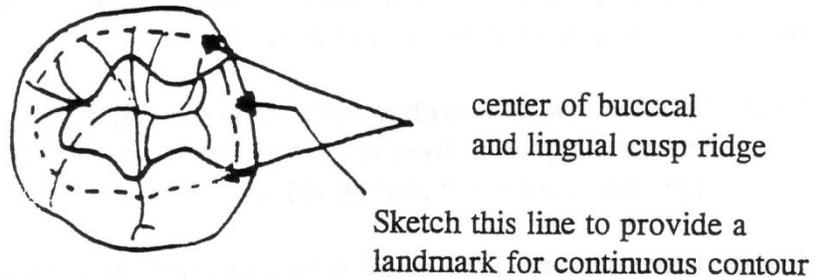


- Define the buccal and lingual developmental grooves (the ones that were originally the “stop signs”). Join them together to create a mesial (and/or distal) pit.
- Once defined, use the groove by placing the tip of the instrument in it and lay the side of the blade against the triangular ridge. Do not take over the cavosurface margin. Place instrument on amalgam, 1 mm. from margin and carry stroke down into the pit.
- Repeat this stroke several times to adequately remove the bulk from the triangular ridges. This will give contour to the triangular ridges and will accentuate the bulk of amalgam left between these grooves and the marginal ridge (this area is identified as a triangular fossa). The illusion of a triangle is created by the buccal and lingual developmental grooves meeting in the pit to form the apex and the marginal ridge being the base.

- To remove the bulk from the triangular fossa and not damage the marginal ridge, proceed as follows:

a)

Look at the center of the adjacent cusp ridges and lightly sketch a line from the center of the buccal cusp ridge -- across the center of the marginal ridge -- blending into the center of the lingual cusp ridge.



- b) Between the lines creating the three sides of the Δ , keep the tip directed somewhat into the pit and scoop out the bulk from the Δ fossa. The stroke should curve gently. Systematically work from one side to the other.

Step 11. Finish the fossa side of the marginal ridge.

- Gently shape and smooth the incline from the height of the marginal ridge down into the pit.

The development of the marginal ridge is now complete.

Step 12. Systematically shape each triangular ridge.

- Use a developmental groove as a track for the instrument.
- Place the tip of the instrument in the groove and adapt the side of the blade against the side of the triangular ridge at the highest point.
- Begin the stroke on amalgam -- do not take the stroke over the cavosurface margin.
- Repeat downward strokes into the central groove.

Note: The purpose is not to apply pressure with the tip and make the groove deeper -- It is to use the groove as a track and apply light pressure to the side of the blade and thus create contour to the triangular ridge by shaving off the excess.

- When excess bulk has been removed and contour achieved, connect the developmental groove with the central groove.

Note: In order to do this without destroying the height of the triangular ridge, the instrument will have to be "up righted" so that the side of the blade does not touch the triangular ridge.

- Sequentially shape each triangular ridge and carry the developmental groove into the central groove. Complete each triangular ridge before going onto the next.
- Check each triangular ridge for bulk or imperfections. Gently remove and smooth any excesses still existing on triangular ridges.

Step 13. Check all developmental grooves and central groove.

An instrument should be able to flow from one developmental groove into a central groove and then into another developmental groove with a smooth transition.

- Adapt the tip of the instrument into the developmental and central grooves and check for a smooth transition.
- If the instrument catches on excess amalgam in the groove, take several strokes to remove the excess until the groove is smooth.

Note: As experience and speed are acquired, it will be possible to check and remove excess from both the triangular ridges and grooves at the same time.

Step 14. Place mesial and/or distal occlusal spillways.

- Locate and mark where spillway will be placed.
 - a) Do not direct spillway into the contact area
 - b) Always place spillway at least 1 mm away from the lingual cavosurface margin. If placed any closer it could jeopardize the margin.
- Place the tip of the instrument in the identifying mark and use it as a track.
- Carve with the side of the blade directed to each side of the spillway.

Step 15. Check all margins for excess or deficiency.

- Using an explorer, direct the tip back and forth over all cavosurface margins checking for:
 - a) excess or plus margins
 - b) deficiency or minus margins
 - c) gingival overhang or deficiency
- Loupes are essential for this step.

Step 16. Check contact with floss.

- Adapt floss through contact applying pressure on adjacent tooth rather than fresh amalgam
- Check the contact for size
 - a) Is it narrow -- too high -- and thus slight and weak?
 - b) Is it too wide buccal lingually?
- Wrap the floss around the contact area -- Look at the size and shape.
- Make adjustments if necessary.

Step 17. Check occlusal contact.

- Remove dental dam
- Dry maxillary and mandibular teeth where occlusal contact is to be checked
- Hold articulating paper with cotton pliers and place over quadrant with restored tooth.
- Have patient “Very gently” tap teeth together 3 times using only a hinge movement.
- Look for high spots and remove
- Dry and place paper again and direct patient into lateral excursions
- Check for high spots and remove
- Evaluate the occlusion for:
 - a) centric holding points
 - b) freedom from balancing side interference’s
 - c) freedom from prematurity in centric relation

As a final note:

As you gain experience and speed many of these steps will blend together. This module is utilized best if read several times throughout your lab experiences.

SECTION 8 - COMPOSITE

COMPOSITE PLACEMENT & FINISHING

GENERAL OUTLINE OF PLACING A COMPOSITE AT SEATTLE CENTRAL COMMUNITY COLLEGE RESTORATIVE CLINIC

Steps may be done and then be checked	Steps must be watched	Either: Determined by Instr.
---------------------------------------	-----------------------	------------------------------

Color match properly before dental dam
Color:
Inspect surrounding teeth for causal factors – Class V damage, fractures, etc.

ABC: Anatomy drawn effectively, significant facts noted (such as height of marg ridge)
 Bite/occlusion evaluated and noted
 thoroughly
 Contacts evaluated for interproximal restorations

INSTRUCTOR CHECK:

Select color: Note that operatory lights should be color-corrected for sunlight, so it is not necessary to select shade with no light. However, full, direct op light can wash out subtleties in color selection. Do not stare at the shade guide and teeth too long. Looking around a couple times will allow the eyes to readjust.

Causal Factors: Always evaluate the reason why the restoration is being done. Often it is due to decay. Sometimes, however, there are traumatic forces involved such as bruxism and/or malocclusion. If such is the case, the patient needs to be educated about these factors. An example would be in the case of class V restorations due to abfraction. Evaluate the patient's occlusion, shifting, wear patterns and help them understand preventive measures as well as difficulties associated with class V composite retention.

ABC: These three steps will require notation on the laminated tooth outline cards. Restorative is just that, an attempt to restore to previous form and function and improve if possible. To do so, one must evaluate the tooth prior to restoring.

A= Anatomy – evaluate the existing anatomy. Note depth of grooves, significant anatomy deviations, size of embrasures, location of contacts, tightness of contacts, height of marginal ridges and so on.

B= Bite/Occlusion – Mark the occlusion using articulating paper. Dry the patient's teeth thoroughly with air and then align the paper against the non-

moving maxillary teeth. Have the patient firmly tap and chew. Note not just dispersion but intensity of hits and on surrounding teeth as well.

C= Contacts – In the case of interproximal restorations, evaluate the pre-existing contact with floss, determining its tightness, location and size. Also, check surrounding teeth for context.

DENTAL DAM

Properly punched, seated & tucked
Clamp properly selected & seated
Cord placed properly & tissue retraction effective

INSTRUCTOR CHECK:

Isolation Stage: A dental dam will be used whenever possible and retraction cord for Class V's

We will typically attempt to do dental dams with winged clamps and the frame on for speed and ease of application.

We will typically not use hemostatic agents with retraction cord as these agents can inhibit bonding of composite restorations.

MATRIX & WEDGE

Sketch of prep complete
Matrix & wedge properly selected and placed

INSTRUCTOR CHECK:

Sketch: After the DDS prepares the tooth, the student must utilize their laminated tooth outline card to draw the prep as a tool for finishing and understanding of the location of restoration margins

Matrix: Place as taught in lab and have instructor check.

Key principles with matrix placement:

Preserve form/contour of matrix band, especially so with composite sectional matrices.

Close off the interproximal box completely. This may require more than one wedge, carefully placed.

In so doing, ensure the wedges are not impinging on the matrix band thus creating a dent in the proximal box.

Wedge very, very, very firmly!

Know where to burnish; this can be critical for contact creation and embrasure form.

INSTRUCTOR OBSERVATION:

Base/Liner- properly mixed & placed Type:
Etchant process
Desensitizer process,
Gluma/Hurricaneal
Bond process
Moisture control established and maintained - CRITICAL AREA!!!

See Section IV – Materials Theory chart for most information

Bond Considerations

We are presently using a generation five of bonding agents that is a tubular penetration for the one step aqueous dentin primer (Bond 1). This is also called SINGLE BOND as it contains the primer and adhesive in one.

Single Bond contains ALCOHOL as a solvent for the adhesive. This alcohol evaporates quickly. The bottle must always be shaken prior to use, dispensed no more than 30seconds prior to use and recapped immediately.

Gently blowing air after bond application does 2 things. It disperses the bond to prevent pooling and it evaporates the alcohol solvent. The former is only necessary in certain situations, the latter, always. For this step, the air/water tip must be cleared of water and maintained clear with a GENTLE air stream as it is moved over the prep and held for 3-5seconds. Gentle air is the key since powerful blasts of air can ruin the environment by aerosolizing contaminants and traumatizing the tooth.

Single Bond is then cured for 10seconds. If a thorough coating is achieved the first application, no additional coats are necessary.

Moisture Control: Remember that without proper isolation throughout procedure, the most beautiful restoration is a bad one. In fact, it could be said that isolation is the foundation and must be maintained. This also applies to materials handling and instruments. If an explorer, for example, is contaminated prior, and then used to trace the flowable without being wiped off, contaminants have been introduced. This also goes for handling the tip of microbrushes with gloves, handling composite with gloves, wiping tips of instruments with wet 2x2s and so on. Think comprehensively!

POSSIBLE INSTRUCTOR OBSERVATION:

CONDENSATION/PLACEMENT OF RESIN

Flowable placed properly (mandatory on class II restorations)

Packable placed/condensed properly and cured incrementally & buccal/lingual after matrix removal

Safe handling of curing light

INSTRUCTOR CHECK (IF NOT OBSERVED):

Flowable: Seattle Central Community College Restorative Clinic places flowable composite in all Class II restorations to avoid deficiencies.

For a Class I restoration (if needed: if prep is open and doesn't contain hard to access corners or angles then none may be indicated), place a small, thin layer of flowable composite in designated areas. Run an explorer through the increment to break any bubbles. Cure for 30 seconds.

For a Class II restoration, place flowable composite at the cavosurface margins on the gingival floor and up the walls along the matrix band (any system of choice). Run an explorer through the increment to break any bubbles. Excess flow can be removed with the brush that you used to place the bond. Cure for 30 seconds. This could be likened to caulking tile, where the flowable is restricted to sealing the matrix junction.

Rationale: Flowable provides a seal in the proximal box. With this method, small flashings are created around the proximal box. Removing the small flashings with a goldknife, disking, and striping will create smooth cavosurface margins once the matrix system has been removed. Without, micro-voids are almost inevitable.

Packable: Ideal handling of composite means the complete prevention of contamination by handling with gloves. Place carefully and instructor will evaluate prior to finishing. Instructor must check before isolation is lost, even with difficult to isolate restorations such as class V's. Otherwise, if more composite needs to be added, all steps will have to be repeated.

Condensing (Placing) Composite

Condensation is the process of inserting and compressing dental composite into a cavity preparation so that the cavity is completely filled with a unified mass of composite. From this point on, the words condensing and placement will be interchangeable when referring to composite material. Proper placement of composite promotes adaptation of the composite to the walls and margins of the cavity preparation. The goal is to compress the composite to eliminate voids.

Composite material can easily envelope the condenser if pressed to hard and thus be pulled away from the intended area. Another difficulty encountered when placing the composite into line and point angles of the cavity preparation is the material sticks to the instrument and pulls away as you withdraw the instrument.

Even the smallest cavity preparation is restored with at least two increments of composite. Each increment should be small because of the need to cure the material all the way through. If the material is not completely cured, the material will often break, cause pain, promote marginal leakage, or cause recurrent decay. Either way, pain will result and failure of the restoration is inevitable. This can be compared to a jellybean that has a hard shell on the outside and a soft center. Adaptation of the composite to the walls and margins and corners of the preparation is thus maximized. Using small increments also reduces the possibility of allowing the material to touch both opposing walls on placement of the first increment. If this happens, the composite will shrink and cause resulting pain. Care must be taken when placing composite to deter voids and improper bonding of poorly placed composite.

Composite must be placed soon after dispensing. Even with UV light holders, ambient light cures the material quickly. It also can dry out and become mealy. Composite that has begun to set prevents adequate placement. As the composite gets harder, voids cannot be eliminated and the increments of composite do not bond. An increment of composite that is difficult to manipulate must be discarded. It is hard to say exactly how long this will take, but the handling of the increments will display difficulty in placement.

Composites – Step by Step

Procedure for placement composite into a preparation

Visualize the size and shape of the cavity preparation. This image will be helpful during placement procedures when the outline is inadvertently obscured by overfilling the cavity preparation. Sometimes it is helpful to draw the shape of the cavity preparation.

Condense the first increment of composite. Using the small end of the composite instrument (condensing side), place the first increment of composite on one side of the gingival floor and up along the cavity wall of the preparation or if Class II start in the proximal box. .

Hold the instrument in a modified pen grasp; secure a finger rest on the adjacent teeth. A secure finger rest provides a controlled technique. Using the small end of the anodized composite instrument (you may use the acorn condenser if you like), apply light force to the mass of composite to

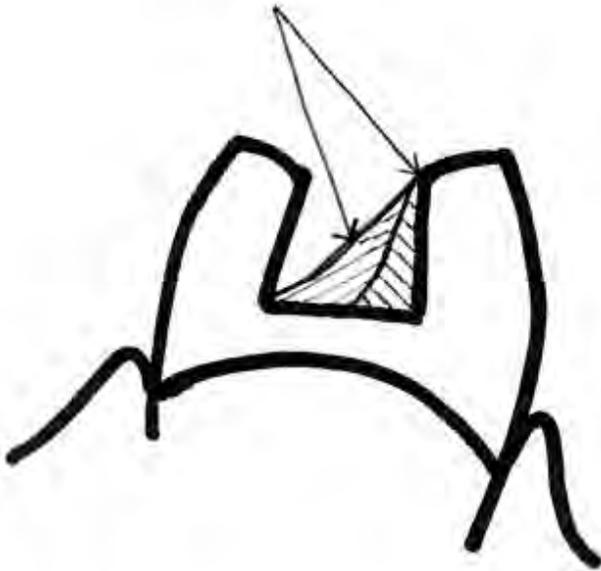
spread and adapt the mass along one side of the gingival floor pressing sideways up along the wall to the cavosurface margin. With a Class II preparation, please condense inside the proximal box area first. If the placement is approached with too great of pressure during the placement, the composite will be forced out from under the condenser and adaptation to the cavity preparation will not occur. (You will force the composite out and around the instrument as fast as you place it.)

First Incremental Placement of Composite



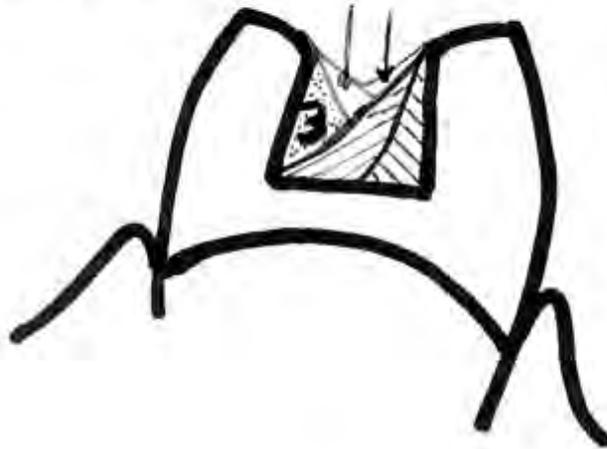
- Make sure the composite does not touch the opposing wall.
- Make sure the increment is or less than 2 to 2.5 mm in width depending on the color of composite (not height) to insure complete cure.
- Make sure not to allow the composite to flow above the occlusal cavosurface margins (see arrow). You do this by cutting off the excess with the instrument. Check that the material is not below the cavosurface margin. Magnification eyewear is a must to be completely accurate.
- Cure completely as directed by manufacturer.

Second Incremental Placement of Composite Material



- Place a second increment of composite on top of the first increment.
- Make sure this increment is 2.5 mm in width and it does not flow beyond the occlusal cavosurface margin.
- The composite material may now touch the opposing wall.
- Cure completely as directed by manufacturer. Follow with the third, fourth or as many needed to place the final increment.
- Placement must be carefully thought out. If you place the increments correctly, very little finishing is needed. The central groove is created by correctly placing the material to the intended depth. Using a bur is for correcting placement errors and not intended to be the instrument to create anatomy.

3rd, 4th & 5th Increments



- The incremental placement (layering) is done in this fashion to ensure complete curing of the material and for allowing shrinkage as to not pull the opposing walls together.
- This overlapping layering technique is used for Class I occlusal restorations as well as Class II restorations. Even Class V's can be sensitive if you do not layer and touch opposing walls. It is especially difficult with very narrowly cut Class I Occusal-Linguals. However, it is imperative to not allow shrinkage and thus, pulling the tooth inwards. This can be painful for the patient.
- These instructions are for optimum outcomes and are easier to read than to apply.

Considerations for Class II Restorations

- Remember to condense **into** the cavity preparation as well as in the direction of matrix in order to establish interproximal contour.
- Remove the wedge and matrix system. Cure interproximally from both buccal and lingual sides. Check that a contact is present and make sure the location is correct.

FINISHING OF THE INTERPROXIMAL CAVOSURFACE MARGINS & SHAPING THE EMBRASURES

Step 1. Clear the gingival cavosurface margin and the proximal buccal and lingual cavosurface margins (walls).

Proximal clearing & removal of overhangs:

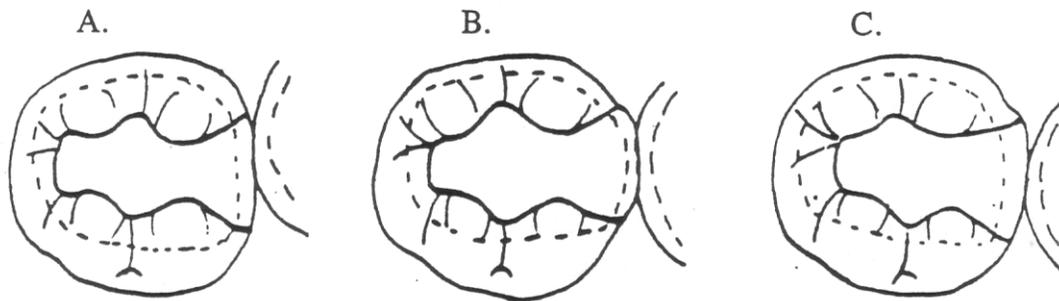
Ideally, minimal excess composite will be present interproximally if a proper matrix was placed. However, this must always be assessed as any overhanging margin can damage the periodontium.

- An (IPC) interproximal carver may be used to gently remove thin flash. This would be done similar to amalgam carving.
- Use a plastic strip. Use the coarsest side first and then finish with the fine side. When using a strip, remember that with only back and forth motions is may be possible to create an undesirable groove interproximally. To avoid this, the working motions should be up/down, back/forth and oblique.
- Some, very careful, direct interproximal work can be done with burs as handskills improve.

Step 2. Shape the proximal contour: Carefully shape the occlusal, buccal, lingual and gingival embrasures as well as contact area.

- Place a wedge between the interproximal area to be able to shape and clear the occlusal embrasure. You will also shape the buccal and lingual embrasure areas with the disc system. Be careful when using the most coarse disc (blue) as well as the (black). Take only a couple of passes and blow the debris from the area and evaluate before continuing.
- Start with a coarser disc and finish with the finest disc (grit).
- Use a plastic strip. Use the coarsest side first and then finish with the fine side. When using a strip, remember that with only back and forth motions is may be possible to create an undesirable groove interproximally. To avoid this, the working motions should be up/down, back/forth and oblique.
- Use interproximal finishing diamonds and burs to gently shape embrasures and line angles. Some, very careful, direct interproximal work can be done with burs as handskills improve.

Step 3. Develop the height of the marginal ridge with the disc system.



Correct	Incorrect	Incorrect
	Bulk needs to be removed from the occlusal & facial embrasures	Bulk needs to be removed from the lingual embrasure

- A. Presents a continuous contour
- B. Presents an occlusal table that is too wide mesially distally and closes the occlusal embrasure.
- C. Presents an altered occlusal table size as well as a small lingual embrasure. Both B & C will alter the patient's occlusion and cause trauma to the periodontal tissues.

Note: Take a careful look at the contour. Be sure the contour of the composite is continuous with the contour of the tooth. There should be no dents, bulges or bumps.

- The cavosurface margin at the marginal ridge has been shaped and all excess removed
- If the teeth in the arch area are in proper alignment, the approximating marginal ridge may be used as a guide to determining the height.

Once finished with the discs, prepare the highspeed handpiece with the finishing bur of choice.

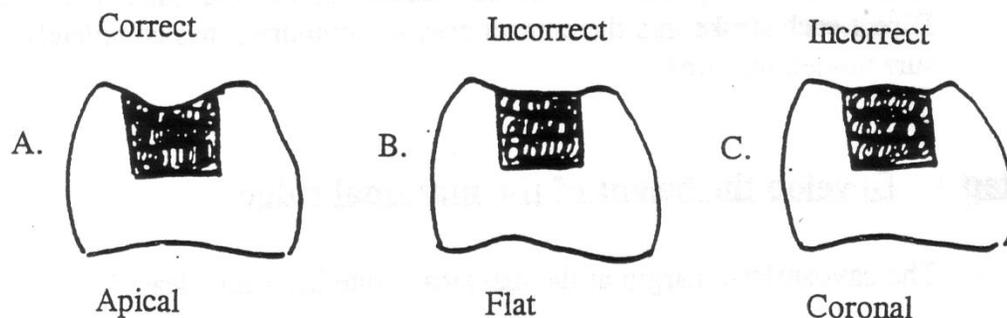
⇒ The proximal contour of the marginal ridge must be carefully visualized before beginning to bur.

- Remember that marginal ridges curve apically. As the buccal and lingual cusp ridges slope apically on the mesial or distal, this ridge becomes the marginal ridge and continues to slope apically.

⇒ With the correct contour in mind, use a finishing bur to shape.

- With a feather light pass of the bur, carefully guide the bur up and over the marginal ridge keeping the tip of the bur in the spillway to develop an apical contour. Pass over from the buccal and lingual until you have reached the correct marginal ridge height.

At this point the surface created will be rounded due to the discing and of the correct height that gently curves apically -- blending downward from the buccal cusp ridge to marginal ridge and upward from mid-marginal ridge to lingual cusp ridge:



It is extremely important that you create apical contour to the marginal ridge. If the marginal ridge height is not correct, the height of ALL the rest of the occlusal anatomy will be incorrect.

- When the bulk has been removed from the occlusal embrasure, gently round the proximal side of the marginal ridge up to the height.
- To determine where the midpoint of the marginal ridge width is, look at the buccal and lingual cusp ridges. You should be able to follow an imaginary line gently curving from the height of the contour of the buccal cusp ridge, to the marginal ridge and then to the lingual cusp ridge.

Step 5. Check to see that all of the above steps are complete.

DO NOT GO ON UNLESS THEY ARE COMPLETE.

- Carefully check marginal ridge height. Make any necessary adjustments now. If a high marginal ridge is not discovered until the entire restoration has been completed, it could result in virtually shaping all the anatomy over again. i.e., If you lower the marginal ridge after all the anatomy has been carved:
 - c) the triangular fossa and pit will be too shallow
 - d) the entire occlusal table will have to be lowered
- Check the proximal contour - **LOOK** occlusally **AT THE SHAPE**. The contour should be continuous, not protruding.

Make any necessary adjustments. You are now ready to begin finishing the occlusal anatomy.

FINISHING THE OCCLUSAL ANATOMY

Step 6. Locate and lightly place the buccal and lingual developmental grooves with the finishing bur nearest to the restored marginal ridge.

- **Feather touch with finishing bur**
Clearing the margin means shaving away excess composite until it is completely flush with the enamel. This is accomplished by beginning with the bur on one side (buccal or lingual) and be careful not damaging enamel.
- Smooth the entire occlusal surface.

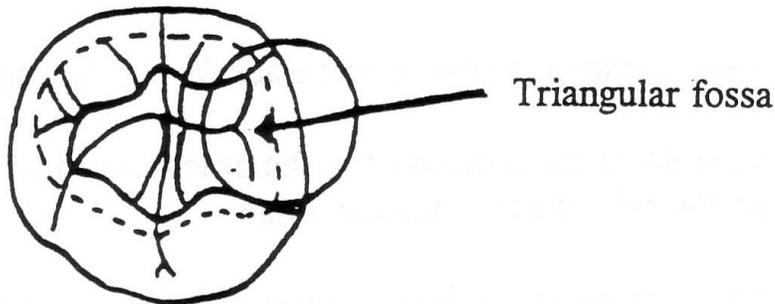
If the occlusal cavosurface margin has been thoroughly cleared, the following criteria will be observed:

Crisp, clean line where composite meets enamel

The tactility will be a smooth transition between enamel and composite

The central groove will be identified. This central groove results from shaving the occlusal surface with the tip of the bur adapted into the area of the central groove.

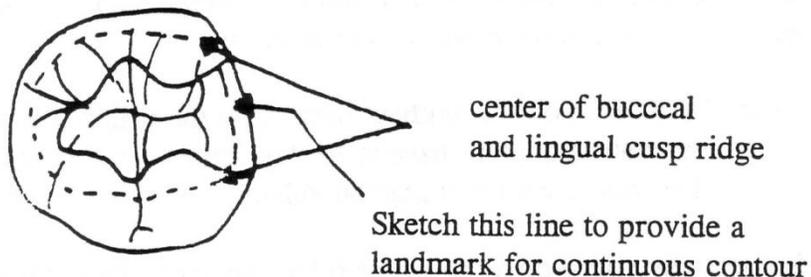
Things that should be considered while shaving the occlusal anatomy:



◆ Develop the triangular fossa.

- To remove the bulk from the triangular fossa and not damage the marginal ridge, proceed as follows:
 - a) Look at the center of the adjacent cusp ridges and lightly sketch a line from the center of the buccal cusp ridge -- across the center of the marginal ridge -- blending into the center of the lingual cusp ridge.
 - c) Between the lines creating the three sides of the Δ , keep the tip of the bur directed somewhat into the pit and shave out the bulk from the Δ fossa. The stroke should curve gently. Systematically work from one side to the other.

◆ Finish the fossa side of the marginal ridge.



- Gently shape and smooth the incline from the height of the marginal ridge down into the pit with the finish bur if needed.

THE DEVELOPMENT OF THE MARGINAL RIDGE IS NOW COMPLETE.

◆ Systematically shape each triangular ridge.

- Use a developmental groove as a track for the instrument.
- Place the tip of the bur in the groove and adapt the side of the bur against the side of the triangular ridge.
- Begin the shaving on the composite -- do not take the bur over the cavosurface margin.
- Repeat downward movements into the central groove.

Note: The purpose is not to apply pressure with the tip and make the groove deeper -- It is to use the groove as a track and apply light pressure to the side of the bur and thus create contour to the triangular ridge by shaving off the excess.

- When excess bulk has been removed and contour achieved, connect the developmental groove with the central groove.

Note: In order to do this without destroying the height of the triangular ridge, the instrument will have to be “up righted” so that the side of the blade does not touch the triangular ridge.

- Sequentially shape each triangular ridge and carry the developmental groove into the central groove. Complete each triangular ridge before going onto the next.
- Check each triangular ridge for bulk or imperfections. Gently remove and smooth any excesses still existing on triangular ridges.

◆ Check all developmental grooves and central groove.

An explorer should be able to flow from one developmental groove into a central groove and then into another developmental groove with a smooth transition.

- Adapt the tip of the explorer into the developmental and central grooves and check for a smooth transition.
- If the explorer catches on excess composite in the groove, take another pass with the bur to remove the excess until the groove is smooth.

Note: As experience and speed are acquired, it will be possible to check and remove excess from both the triangular ridges and grooves at the same time.

◆ **Place mesial and/or distal occlusal spillways.**

- Locate and mark where spillway will be placed.

Do not direct spillway into the contact area

Always place spillway at least 1 mm away from the lingual cavosurface margin. If placed any closer it could jeopardize the margin.

- Carve with the side of the blade directed to each side of the spillway.

NOW TO COMPLETE THE RESTORATION

Check all margins for excess or deficiency.

- Using an explorer, direct the tip back and forth over all cavosurface margins checking for:

excess or plus margins

deficiency or minus margins

gingival overhang or deficiency

NOTE: When using an explorer, BE CAREFUL not to create gray scratch lines in the composite, especially in aesthetic areas.

Check contact with floss.

- Adapt floss through contact
- Check the contact for size

Is it narrow -- too high -- and thus slight and weak?

Is it too wide buccal lingually?

- Wrap the floss around the contact area -- Look at the size and shape.
- Make adjustments if necessary.

Check occlusal contact.

- Remove dental dam
- Dry maxillary and mandibular teeth where occlusal contact is to be checked. This can be accomplished by having patient chew on a dry 2x2
- Hold articulating paper with cotton pliers and place over quadrant with restored tooth.
- Have patient “Very gently” tap teeth together 3 times using both hinge and excursion movements.
- Look for high spots and remove
- Check for high spots and remove
- Evaluate the occlusion for:
 - d) centric holding points
 - e) freedom from balancing side interference’s
 - f) freedom from prematurity in centric relation

Finish with polish system for a lustrous surface.

As a final note:

As you gain experience and speed many of these steps will blend together. This module is utilized best if read several times throughout your lab experiences. This module is not intended to replace lab experience, but used in conjunction with learning this skill.

SECTION 9 - PATIENT MANAGEMENT

Professionalism

An important aspect of being a professional health care provider is to maintain a professional demeanor before patients during all situations. This may be easier when things run smoothly and the student has become comfortable with the process of care and procedure. However, during the learning process, it is generally the case that students face uncomfortable situations where they are unsure of their skills and abilities. Additionally, even experienced clinicians face challenges their professionalism.

Inspire Confidence

Patients need to have confidence that they are in good hands and are having their needs met. Expressions and words or phrases that create impressions the student doesn't know what they are doing are inappropriate.

Though it may seem silly, it is far too common to hear exaggerated sighs, moans and other such sounds. Phraseology such as "I don't know what I'm doing", "I'm lost", "I can't do this", "this is all messed up", and so on, are also inappropriate. Rather, WHENEVER there is unsurity or difficulty, an excellent way to request help is to say, "I have concerns with this or that" or "would you please give me some advice as to how best to deal with this issue because...". In every way, we try to show the patient we are in control and will come up with the best result through mutual collaboration.

Additional phrases to avoid are, "this is the first time I've ever done this", and "I'm still new at this". Though a task is challenging to do correctly, patients appreciate the time taken to have it done right.

Explain/ Educate the Patient

Frankly, patients do not understand restorative procedures and the complexity and difficulty of quality patient care. Generally, patients want to understand what is involved in their care and respond positively to such education. Therefore, explain to patients that quality takes time. Explain key aspects of the procedure so they understand what is involved. An example might be regarding composite restorations, that they are very technique sensitive and thus take more time than placing amalgams. More specifically, we could discuss the incremental layering and curing to prevent sensitivity, which no patient would choose to experience. Beyond this, we can explain difficult situations, things that slow us down or create special challenges such as deep preparations, heme issues, access issues in far-posterior areas and so on.

Being forward about such things allows patients to understand how things are going and exercise patience with us and contributes toward developing their

appreciation of being well cared for. Nine times out of ten, patients, if given the choice, would spend the time and cooperate with us to receive quality care and restorations.

Be Honest

We do not need to necessarily hide mistakes from patients. We do not need to broadcast every little *less than ideal* factor of our restorative process, but critical issues that could result in sensitivity issues or require redoing the restoration need to be discussed in a tactful manner.

The basic premise in EVERY situation is that we have the patient's interests at the forefront and will deal with them in the IDEAL manner, in all matters. What that means is that if we make a mistake that needs to be addressed, we do so because we want to take care of the patient. We do not cover it over or blame the patient or even blame ourselves. Patients need to understand that restorative dentistry is VERY challenging and less than ideal outcomes are, unfortunately, possible. What is important is that we identify such, and take steps to correct them.

Example: if the bonding step is skipped in a restoration, let's explain to the patient what happened, that we did leave out this critical step, but will take whatever action is necessary to make sure the patient has a quality restoration. We do not say, "we messed up". Though we did, we emphasize how we will correct the situation. The patient may be upset, but at the very least, they will *trust* us and our honest approach.

Measure of Success

Often, even experienced clinicians wonder if they could have done better and think about things they would change if given the opportunity. We do our very best, strive to continually progress and also have realistic expectations of our work. A good measure for success is the application of the physician's code to *do no harm*. If, at the very least, we leave the patient as good as or better off than when they came to us, we have fulfilled this fundamental principle.

Appreciating that our duties as restorative clinicians are very challenging and that our results are very much impacted by the circumstances of each patient and their specific situation, will allow us to progress forward as clinicians, constantly seeking to improve in the care we provide, while not becoming discouraged by less than perfect results.

Various

1. Pay attention to their comfort
2. Use a neck-pillow
3. Properly position the headrest; support under the base of the head, not too far back.
4. Use a patient towel to allow you to keep them dry
5. Use lip moisturizer
6. Don't patronize them by being repetitive. Let them know to "breathe" during anesthesia and "assure" them, but not 50 times during one injection.
7. Never speak condescendingly
8. Never handle them roughly
9. Don't be too quick to apologize. Blame is not necessary. Things are usually a matter of difficulty in patient management, which we will be learning for the rest of our career.
10. Be ready with a bite-block
11. Have fun, use humor, patients need that

Introduce Instructors and Doctors

It is courteous to the patient and to instructors to be introduced. Please do so with a smile!

Local Anesthesia

Local anesthesia should be identical to that done in traditional clinic. The only difference may be with regard to the quantity of anesthesia given. Often, additional anesthetic is required to achieve sufficient pulpal anesthesia for the duration of restorative appointments

SECTION 10 - CLINIC MANAGEMENT & OPERATORY ORGANIZATION

Operatory Setup

It is important to be completely set up for a restorative procedure. This is especially the case when having to operate alone. Besides creating an unprofessional environment, lack of preparedness can jeopardize the quality of the restorative process, which relies on smooth and effective step by step procedures. Students are required to fill out the following form and present it to instructors at the pre-clinic meeting. (See next page for checklist.)

Seattle Central Community College
RESTORATIVE CLINIC
OPERATORY SET-UP CHECK OFF LIST

Student: _____

Date: _____

- _____ Xrays on view box
- _____ Anesthesia forms filled out completely for planned injections
- _____ Evaluation forms filled out completely: Both Case Management and Restoration Evaluation
- _____ Patient towel

- _____ Both water bottles full
- _____ Both power switches on
- _____ Both air/water handpieces have tips
- _____ Suction bags slid down and suction ready to use
- _____ Operator swing arm bagged loosely to prevent handpieces from falling out
- _____ Suction cords untangled
- _____ Garbage bag taped up to allow operator to keep work area as clean as possible

- _____ Clean tray readily accessible to OPERATOR with *extra* disposable supplies, anesthetic, clamps and restorative supplies such as discs, matrices, wedges, flowable (flow tip), dental dam, micro-brushes, mixing wells and so on
- _____ Clean cotton-tip pliers set by tray for obtaining clean items from tray
(two trays may even be used, one by the x-ray view-box and the other by the computer mouse)

- _____ Highspeed handpiece on green-taped cord
- _____ Place a 56,57 straight fissure bur in highspeed (33.5 for class Vs), check it for air/water flow and leave bur in handpiece
- _____ Slowspeed handpiece on black-taped cord
- _____ DDS bur block fully stocked
- _____ Spoon excavator available
- _____ Composite finishing and polishing items all available and organized

- _____ Curing light placed appropriately with cord untangled to allow ready use

All restorative supplies available and arranged neatly, in order of use. The following is not a comprehensive list, but simply a guide to setup.

(If some supplies are not expected to be used, they may be kept on the clean supplies tray)

dycal	mixing pad	finishing strips
glass ionomers	mixing well	discs
etch	micro-brushes pre-bent	wedges, plastic & wooden
Desensitizer	articulating paper	matrices: sectional and toffl.
single-bond		
flowable (with tip available but not on if not sure it will be used)		
composite gun (shade must be obtained before procedure commences)		

Dental dam supplies arranged neatly, including floss, clamp, punch, bite-block(if patient needs one)

Retraction cord (if necessary)

Anesthesia supplies ready along with extra carpule(s) and tip(s) on clean tray

Preparation for DDS

As noted in the check-off list above, the student must be ready for the DDS when he/she arrives to prepare the tooth. The doctor's time is extremely valuable and clinic sessions need to progress in a timely manner. Should a student be unprepared, the doctor may move on to the next student.

Additionally, we encourage an attitude of respect and consideration amongst the dental "team". Part of showing this respect is being prepared for the doctor's arrival.

Clinic Supplies

By Operatory

Each operatory contains a basic supply of restorative materials. These need to be used with care, kept organized and stocked. Each operator should ensure restocking at the end of the session, but the primary responsibility lies with assigned clinic assistants.

Some operatory supplies will go through sterilization and be returned to their appropriate operatory as described in more detail below.

Clinic Management

Before, during and after restorative lab sessions, clinic equipment and supplies must be properly utilized, cleaned up and put away as specified in this manual and verbally by instructors.

Supply Drawers: Students may need some supplies from these drawers/cupboards during clinic sessions. These areas need to be kept well organized and if items are running out, students need to write the item on the 'request for supplies clipboard' by the front desk.

Operatory Bi-fold Cupboards: As above, all supplies contained within are for clinic use on patients and should not be used for lab activities. The only exception is for curing lights.

Curing Lights: Never remove the curing lights screwed onto operatory unit swing arms.

Unit Maintenance: Please follow regular clinic policies for putting operatory in order at the end of clinic sessions. Miscellaneous debris must be picked up off the floor.

Sterilization Area: Keeping the sterilization area clean and orderly applies to restorative clinic sessions as during all other program sections. Assigned (CA) clinic assistants will be primarily responsible for this.

Operatory Cleanup

Once patients are dismissed and all chart/paperwork is done, clean up may commence. Despite being rushed many times, do not forget that it is EASY to throw away small restorative supplies.

First, separate small savable items:
Cavifill caps
Extra matrices, maybe contaminated by handling but not used
Sectional matrix ring
Burs and polishing items

Supplies that are not disposable and are wiped down need to be so thoroughly. Ideally, they should be sprayed down with a disinfecting spray and allowed to sit for a few minutes while clean up continues.

Operatory supplies:

- Etch and flowable: Wipe down well, break the metal tip off. This signals the need to change the tip prior to the next patient, removes IO contaminants and material left inside the tip will harden/cure while preserving inner contents. Place in specified manner with tip over 2x2 gauze.
- Shade Guide: Wipe down well!
- Composite Gun: Wipe down well!
- All Other Supplies: Wipe down well and put away according to pictures inside bi-fold cupboard doors

Sterilization

Restorative Supplies by Operatory

Each operatory contains a basic setup of restorative supplies/materials. Three of these items need to be sterilized and returned to the designated operatory. This must be done in a timely fashion as at least twice per week they will be utilized.

After sterilization, these items need to be either returned directly to appropriate operatory or placed on the top tray, left-hand corner of clean supplies counter in the sterilization area. If placed on this tray, please use a bib to cover bur blocks. Sterilization duties for ALL clinic assistants involve returning items on this tray to operatories.

Bur Block



Please, do not bag bur blocks. Do not tip bur blocks over. They must be placed carefully in the bath, rinsed and placed in either the statim or autoclave for sterilization. If placed in the statim, do not slam cassette into place as bur blocks will tip over.

Spoon Excavator & Retraction Cord Packer



Please, bag these instruments individually. Prior to doing so, look on handle for engraved operatory #, then write this on the bag for easy identification.

Clamps

Not pictured are dental dam clamps, to be restocked in designated containers. Dental dam clamps need to have the clamp number written on the bag as it is sometimes difficult to see the engraving on the clamp bow when it is bagged. There are a variety of restorative supplies that belong to the clinic, some of which are stocked in the surplus drawers in sterilization and can be used by students and others that only instructors will be using.

Other

Restorative supplies – taped black & red with **NO** labeling on the package need to be put away in the drawers.

Restorative (or other) supplies that have the designation **(CC)** written on the bag need to be put away in the far left-hand cupboard on the clean side of sterilization.

SECTION 11 - CLINIC POLICIES

Clinic Policies

Refer to Student Handbook and General Clinic Manual for information on clinic policies and procedures such as dress code, attendance, exposure control, handling of patient information & confidentiality, etc.

SECTION 12 - CASE MANAGEMENT

Patient Case Management

1. Check the health history to be sure the patient can be treated in restorative clinic. This involves evaluation of local anesthesia, ASA type, medications and patient demeanor and ability to handle long and possibly uncomfortable restorative procedures. Ensure that a medical consult is not required. Children are scheduled on a case by case basis due to stress from the length of appointments.

2. All restorations must be approved by a clinic dentist. Some restorations may be too large for a student to attempt, so if there is any doubt, please clear with instructors first. The following outline details what types of restorations students are expected to appoint based on the quarter and student skill level. Radiographs must be no older than 1 year.

Seattle Central Restoration Difficulty Classifications For Treatment Planning

These classifications are to be determined by the DDS according to specifications below and written in the left-hand column of the green treatment plan sheet during initial exams.

Restoration difficulty is associated with the quarter or skill level during which students may begin appointing such restorations.

A = Easy/ Summer Quarter

- Occlusal pits or very small class I restorations
- Buccal & lingual pits
- Sealants & (PRR) preventive resin restorations/prep seals
- Small supra-gingival class V restorations in easily accessible areas - no lingual or hard to access posterior areas

B = Moderate/ Fall Quarter

- Larger class I restorations – large occlusal or OB, OL, OLB
- All class V restorations except for large, subgingival and difficult to access such as lingual surfaces and 2nd molars
- Small, easily accessed class II restorations – 2 surfaces only MO, DO
- Small, supragingival class III restorations – 2 surfaces only
- Small class IV restorations and incisal chips

C = Difficult/ Winter Quarter

- Moderately sized class II restorations of all kinds – up to 3 surfaces but no MODs.
- Moderately sized class III & IV restorations
- Class V restorations – easily accessed lingual surfaces

D = Very Difficult/ Spring

- Larger class II restorations of 3 or more surfaces – MOD, MODB, MOBL
- Large class III restorations, gingivally located and 3 or more surfaces
- Large class IV restorations
- Large, subgingival & difficult to access class V restorations – all lingual surfaces and 2nd molars

R = Refer or Community Clinic

- Crowns
- All basic restorations very close to pulp cavities risking pulp exposure
- Basic restorations of sufficient size too difficult for students at a given time
 - large emergent 3-5 surface restorations diagnosed too far in advance of students ability to care for: Diagnosed summer for example
- Occlusal Guards
- Extractions - erupted, non-surgical & by CONSULT only

3. Check the tx plan in the chart with the dental charting and x-rays to confirm the correct tooth/restoration/surfaces/size is diagnosed.

4. Check the progress notes to make sure the restoration has not already been completed. All completed restorations MUST be highlighted and dated in tx plan but sometimes are not.

5. Verify with the patient that proposed restorations were not completed elsewhere.

6. Discuss with patient the restoration to be done, which material will be used, cost of procedure and payment policy and any other factors involved in patient understanding and compliance. Do not promise a certain number of restorations. Explain the time involvement necessary for the student restoration process.

7. In case of cancellations, have back-up patients available.

8. Patients may be shared. However, discuss this with instructors first.

Treatment Plan

It is a clinic policy to keep patient charts up-to-date. This is very important for restorative clinic in order to avoid mistakes in scheduling, or even in treatment.

As treatment is completed, it must be highlighted and dated.

If the DDS, on approving treatment, decides to modify ANY aspect of the treatment plan including sequencing, the adjustment(s) should be made and the DDS needs to date and sign for it. It is the student's responsibility to make sure this happens.

SECTION 13 - CLINIC FLOW & PROCEDURAL TIMING

Pre-Clinic

Operators:

Set up operatory according to specifications, review chart and be ready to meet on time.

Assistants:

Arrive ½ hour prior to meeting, arrange appropriate forms and help prepare clinic for patients.

- Help operators set up
- Sterilize supplies, ensure follow up after AM or previous session
- Evaluate operatory restorative supplies prior to and following procedure and stock accordingly.
- As already mentioned, if supplies are low, communicate such to Lead CA who will take stock throughout clinic and fill out the supply request form.

Lead Assistant:

- Put up DDS and Instructor sign-up sheet
- Fill out a clinic assistant duties sheet, attach to a clipboard and place on instructors' counter for reference throughout appointment. Assistant will come and refer to this sheet and check-off duties accomplished during the session. This same sheet will be utilized for the following session by that lead assistant, who will fill out additional items in a different color
- Take stock of restorative supplies and fill out supply request form *before* supplies run out!
- Pass around the pre-clinic meeting form for instructors and make sure all operators fill it out completely

Restorative Pre-Clinic Meetings

Meetings are held 15 minutes prior to patient seating. Everyone must be present. The units should be totally set up in advance according to picture examples provided in this manual. Anesthesia and restorative reference cards need to be readily available. Assistants **MUST** show up on time as well to help classmates setup and participate in the clinic meeting.

To Prepare

Review patient chart and note the following on the pre-clinic meeting form:

- Procedure - Tx plan sequencing, explain any deviations
- Tx plans not PRIORITIZED, SIGNED, & CLASSIFIED by DDS will cause delay in clinic and may interfere with scheduled procedure
- HHX concerns
- ASA code
- Contraindications to restorative tx
- Anesthetic to be used, needle type, dosage, specific injections
- Special questions for Dr. or RDH

During Appointment

1. The first few minutes after patient is seated are identical to traditional clinic where vitals are checked and a signature from an instructor is obtained.
2. The student will prepare the patient for evaluation. Have a clean mirror and explorer ready for the DDS, and sign up for confirmation of treatment.
3. Once confirmation has been obtained, the student may now proceed with the restorative process. If the DDS determines any changes to treatment, the student must notify the patient of such changes and discuss new cost and other considerations. **THIS IS NOT TO BE UNDERESTIMATED!**
4. The restorative process must follow specified procedural steps as outlined on the evaluation forms. It is the STUDENT'S responsibility to follow the steps and notify instructors as progress is made. To assist in this, students will be provided with a laminated copy of the restoration evaluation form to keep taped up and easily referenced during the appointment. This form should be wiped down and stowed after each session. Students can also make notes on this form to assist them prior to the procedure. The actual evaluation forms will be kept on the instructor clipboard and thus unavailable to students.

For more detailed information on specific steps, see the amalgam and composite sections of this manual where colored sections of the evaluation forms are depicted with comments.

Ideally, the student sign-up sheet will be utilized. However, due to the inadvisability of operators leaving chair-side during restorative procedures, good sense must be used, which may require assistants to help with signing up. In the case no one is available to sign up the operator, they may wish to verbally notify an instructor. Instructors will make every attempt to be fair with the order of student requests but reserve the right to deviate as they deem necessary.

If a student feels they are being treated unfairly, they are advised to discuss the matter with an instructor privately. Such dialogue is very welcome!

Paperwork

All forms including those for anesthesia must be filled out in advance and placed under restorative forms on the clipboard. Make sure the DDS signs the approval of treatment before continuing with appointment. Complete one restoration evaluation form for each restoration to be done. Place the restoration evaluation form on top of all forms in the clipboard.

End of Procedure

Patients ideally should be dismissed 1/2hour prior to end of clinic session. There are no assigned check-out times. However, instructors or DDS may be required to finish procedure to ensure timeliness.

End of Appointment

When the procedure is completed, fill out the super-bill, obtain signature from instructor and DDS and walk patient up and dismiss. Then complete all necessary paperwork and chart entries and give to instructors promptly. The unit may be cleaned up and wiped down afterward.

Chart Entries

It is important to fill out the progress notes as depicted below for several reasons. Ease of readings is one. More importantly, the “procedure” column is a tool for ready reference of patient work. It must be clear and not crowded with information. Conversely, if the tooth # is missing, the body of the text has to be searched to find it. By chance this is combined with an undated tx plan, students may be unaware the filling has already be completed and appoint again. Mistakes like this must be avoided.

Date	Treatment Code	Procedure	PD Date	Explanation
10/2		Exams		CC: Discomfort #3, heat sensitive
				EO/IO/GD review, NSF. DDS. eval #3
	####	#19		DO Comp – Shade A2
				Vitrebond, etch, gluma, single bond, flow, Z-250.
				Complications?? Decay very deep in mesial.
		LA		2 carps of 2% Lidocaine w/1:100,000 epi to L-IABL, no adv rxns.
		DD/Cord		DD 18-22. Cord packed. 1 piece, removed in whole.
		PE		Pt. instructed in the possibility of post-op sens, but to call if sens persist, especially if bite off.
		TXN		#4 MOD composite.
				Student
				Instructor
				DDS
				Extra notes that could be made
	####	X-rays		1 PA, to evaluate #3 due to lingering sens.
		Presc.		Pt given prescription for antibiotic due to advanced Apical radiolucency #3.
		Referral		Endodontist for RCT eval #3.

Unit Maintenance & Clean-up

Follow protocol for cleaning up units and disinfecting operatory. Record any needed repairs on repair request sheets by front office.

Attitude

One final note: PLEASE, above all things, it is imperative that you attempt to enjoy yourself. If you find it difficult to do so, immediately discuss this with your friendly instructors so they may help you to achieve excellence with a smile. Nobody wants a sour hygienist; it's already difficult enough to go to the dentist!

SECTION 14 - EVALUATION PROCESS & FORMS

Restorative operates by the AIS system.

This evaluation system is not a personal attack! It should be viewed as a way to help in the development of a true dental professional. In Restorative class, the AIS will be progressive. In other words, usually, an A will be given with a warning and recorded and if it happens again, an I will follow and then an S.

A = Acceptable

I = Improvable

S = Standards Not Met

C = Critical Issue

Students are not required self-evaluate themselves with AIS's, but rather to write thoughtful comments after each session. They should, however, be familiar with the AIS criteria instructors use.

Operatory Set-Up

Used as a basis for grading preparedness.

Restoration Evaluation

Students fill in patient name, procedure and so on, but do not fill out the body of this form.

Daily Evaluation

Students are required to fill out a self-evaluation written-comments sheet, which is on the back of the daily eval, following each session. Rather than having students self-assess by means of circling AIS, the comments sheet is quite comprehensive to facilitate maximum learning.

Please note that the thoroughness and thoughtfulness of the self-evaluation comments will be carefully considered by instructors. In fact, an entire portion of students' grades is related to these comments. This is the case in both lab and clinic.

This portion of the learning process may seem tedious, especially if one does not like writing. However, the value cannot be over-estimated! Restorative duties are difficult to learn and master and clinicians are constantly learning and growing in their ability to create higher quality restorations. What **MUST** be demonstrated at the very least during the educational process, is that students **SEE** and **UNDERSTAND** their strengths and weakness and how these relate to their performance in a clinical atmosphere. They **MUST** be able to critically self-evaluate for continued life-long learning, and for the health and safety of their patients.

Board Approved:

OREGON BOARD OF DENTISTRY
1500 SW 1ST AVENUE, SUITE 770
PORTLAND, OR 97201
(971) 673-3200

RECEIVED

JUN 16 2014

Oregon Board
of Dentistry

**Dental Hygiene
Request for Approval of Restorative Curriculum**

Dental Hygiene Program

Dental Hygiene CE Course

Name of Institution/Program: University of Alaska Anchorage - Dental Hygiene Program

Name of Program Director: Sandra Pence

Address: 3211 Providence Dr, AHS 148

City: Anchorage State: AK Zip code: 99508 Telephone: (907) 786-6929

Date Institution/Program adopted/revised current Curriculum: Jan 2013

Any changes to the course curriculum must have prior approval from the Board. Please provide the Board with adequate notice so that approval can be obtained before any changes to the curriculum are implemented.

Program Director's Signature: Sandra Pence

Date: 6/10/14

Course Content Guide

College of Health
Dental Hygiene Program
DH A360 Restorative Techniques for Dental Auxiliaries
5 Credits

January 2013

I. Course Description

Builds on previous coursework to introduce restorative skills for allied dental personnel. Provides supervised laboratory instruction on typodonts, with initial emphasis on Class I and Class II restorations. Emphasizes Class III and IV and multiple-surface posterior restorations towards the end of the course. Applies restorative function skills in the clinical situation under direct supervision of clinical faculty.

II. Course Design

- A. Designed for second year dental hygiene students, licensed dental hygienists, or certified dental assistants interested in restorative functions.
- B. Credits: 5; Contact hours: 1+12
- C. Total student involvement time: 225 hours
 - 1. Lecture: 15 hours
 - 2. Lab: 135 hours
 - 3. Clinic: 45 hours
 - 3. Outside work expected: 30 hours
- D. DH A360 is a selective course for the BS in Dental Hygiene.
- E. This course has fees.
- F. This course may be taught in any time frame, but not less than 1 week per credit.
- G. This is a new course.
- H. This course is coordinated with list serve and the UAA Dental Assisting Program.
- I. This course is a 300-level course because it requires students to integrate previous knowledge with complex new skills.

III. Course Activities

This course will be conducted in classroom, laboratory, and clinical settings.

IV. Course Prerequisites and Registration Restrictions

- A. Course Prerequisites: [DA A110 and (DA A150 or DH A204)] with a minimum grade of C.
- B. Registration Restrictions: Second year dental hygiene student, licensed dental hygienist, or certified dental assistant; departmental approval.

V. Course Evaluation

Grades will be A-F.

VI. Course Curriculum

- 1.0 Safety
 - 1.1 University safety
 - 1.2 Laboratory safety
 - 1.2.1 Standard precautions
 - 1.2.2 Hazardous equipment and chemicals
 - 1.2.3 Mercury hygiene

- 2.0 Dental Materials Review
 - 2.1 Amalgam
 - 2.1.1 Physical, chemical, and biological considerations
 - 2.1.2 Limitations and uses
 - 2.2 Composite
 - 2.2.1 Physical, chemical, and biological considerations
 - 2.2.2 Limitations and uses
 - 2.3 Preparatory Materials
 - 2.3.1 Bases
 - 2.3.2 Dentinal bonding agents
 - 2.3.3 Cements
 - 2.3.4 Liners

- 3.0 Dental Anatomy Review—Occlusal Emphasis
 - 3.1 Incisors
 - 3.2 Cuspids
 - 3.3 Premolars
 - 3.4 Molars

- 4.0 Occlusion Review
 - 4.1 Angle's classification
 - 4.2 Centric relation and centric occlusion
 - 4.3 Crossbite, overjet, overbite
 - 4.4 Centric stops

- 5.0 Treatment Planning
 - 5.1 Informed consent
 - 5.2 Treatment alternatives
 - 5.3 Post-treatment considerations

- 6.0 Matrix Bands
 - 6.1 Metal band systems
 - 6.2 Sectional systems
 - 6.3 Other

- 7.0 Laboratory Class I, II, and Multi-Surface Amalgam Restorations
 - 7.1 Placement
 - 7.1.1 Titration
 - 7.1.2 Condensing
 - 7.2 Carving
 - 7.3 Polishing

- 8.0 Laboratory Single and Multi-Surface Composite Restorations
 - 8.1 Placement
 - 8.2 Finishing

- 9.0 Temporary Restoration Placement

- 10.0 Clinical Restorative Procedures
 - 10.1 Initial patient preparation
 - 10.1.1 Medical history review
 - 10.1.2 Treatment options
 - 10.1.3 Informed consent
 - 10.2 Treatment preparation
 - 10.2.1 Armamentarium
 - 10.2.2 Oral pain control
 - 10.2.3 Rubber dam
 - 10.2.4 Matrix band
 - 10.3 Restoration preparation
 - 10.3.1 Liners, varnishes, and bases
 - 10.3.2 Dentin bonding agents
 - 10.4 Placement
 - 10.5 Carving amalgams
 - 10.6 Finishing
 - 10.7 Occlusion adjustment
 - 10.8 Post-operative considerations

VII. Suggested Texts

Bath-Balogh, M., & Fehrenback, M. (2011). *Illustrated dental embryology, histology, and anatomy* (3rd ed.). St. Louis, MO: Elsevier Saunders.

VIII. Bibliography

Anusavice, K. J. (2012). *Phillips' science of dental materials* (12th ed.). St. Louis, MO: Saunders.

Hatrick, C. D., Eakle, W. S., & Bird, W. F. (2011). *Dental materials: Clinical applications for dental assistants and dental hygienists* (2nd ed.). Philadelphia, PA: Saunders.

Phinney, D. J. & Halstead, J. H. (2012). *Delmar's dental assisting: A comprehensive approach* (4th ed.). Clifton Park, NY: Delmar Learning.

Roberson, T., Heymann, H., & Swift, E., Jr. (2012). *Sturdevant's art and science of operative dentistry* (6th ed.). St. Louis, MO: Mosby Elsevier.

State of Alaska, Department of Commerce, Community, and Economic Development, Division of Corporations, Business and Professional Licensing. (latest). *Statutes and regulations: Dentists and dental hygienists*. Juneau, AK: Author.

IX. Instructional Goal, Student Learning Outcomes, and Assessment Measures

- A. Instructional Goal: Allow students to develop expanded-duties restorative skills in laboratory and clinical situations.
- B. Student Learning Outcomes/Assessment Measures:

Student Learning Outcomes: <i>On completion of this course, the student will be able to:</i>	Assessment Measures <i>One or more of the following will be used:</i>
1. Demonstrate safety procedures as they pertain to laboratory and clinical activities.	Laboratory participation
2. Demonstrate knowledge of amalgam and composite characteristics.	Examination or assignment
3. Demonstrate competence in rubber dam placement.	Task analysis
4. Demonstrate competence in matrix band placement.	Task analysis
5. Demonstrate competence in mixing liners and bases.	Task analysis
6. Select and apply appropriate liners, bases, dental bonding agents, and/or varnishes when necessary.	Skills assessment
7. Select appropriate restorative materials for each clinical situation.	Skills assessment
8. Place and finish single and multi-surface composite restorations to laboratory and clinical competence.	Task analysis
9. Place, carve, and polish Class I, II, and multi-surface amalgam restorations to laboratory and clinical competence.	Task analysis
10. Reproduce dental anatomy using amalgam and composite materials.	Task analysis
11. Evaluate and adjust occlusion.	Task analysis
12. Document restorative procedures in patient chart.	Chart entries
13. Develop post-operative recommendations for patient care.	Skill analysis

7. SOFT RELINE COURSE- HELEN MASSAR, RDH & KARA ATKINSON, EFDA

The Board has received a request for approval of a Soft Reline Course. This course would be provided so the EFDA Dental Assistants could qualify to apply soft relines in accordance with OAR 818-042-0090.

"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 providing that the procedure is checked by the dentist prior to the patient being dismissed:

- (1) Apply pit and fissure sealants providing 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.
- (2) Apply temporary soft relines to full dentures."

Helen Massar
10203 SW 32nd Place
Portland, OR 97219

April 7, 2014

Oregon Board of Dentistry
1500 SW 1st Avenue
Suite 770
Portland, OR 97201

Dear Members of the Oregon Board of Dentistry,

Please find enclosed my proposal for a Temporary Soft Reline course, as well as a copy of my Oregon Hygiene license and Pit and Fissure instructor certificate

I am currently the Dental Hygienist Development Specialist for Willamette Dental Group. A large portion of this position involves training and credentialing Dental Assistants within our Company. I am asking the Board to approve the enclosed curriculum so that I may provide the necessary training and credentialing to our employees.

I graduated from the University of Oregon School Of Dentistry in 1979 with a Bachelor's Degree in Dental Hygiene. I have been employed with Willamette Dental Group for over 34 years and have performed many soft relines lines over these years. I am also a certified instructor to teach Pit and Sealant courses in Oregon.

Thank you for considering this course for Board approval.

Best regards,

A handwritten signature in cursive script that reads "Helen Massar".

Helen Massar, RDH, BSDH

H1523
LICENSE NUMBER

**OREGON BOARD OF DENTISTRY
2013/2015 Dental Hygiene License**

Helen L Massar RDH

PERMITS:
Nitrous Oxide
Expanded Practice

ENDORSEMENTS:
Local Anesthesia

Expires: 09/30/2015

THIS LICENSE MUST BE POSTED IN A CONSPICUOUS PLACE IN PLAIN SIGHT OF LICENSEE'S PATIENTS

**CERTIFICATE OF INSTRUCTOR APPROVAL
The OREGON BOARD OF DENTISTRY certifies that:**

11101
LICENSE NUMBER

Helen L Massar RDH

**has met the requirements
to teach courses in
Pit and Fissure Sealants.**

Issued: 09/25/2009
Expires: 09/25/2015

Kara Atkinson
7015 SW Merry Lane
Beaverton, OR 97008

April 3, 2014

Oregon Board of Dentistry
1500 SW 1st Avenue
Suite 770
Portland, OR 97201

RECEIVED

APR 21 2014

Oregon Board
of Dentistry

Dear Members of the Oregon Board of Dentistry,

Please find enclosed my proposal for a Temporary Soft Reline course, as well as copies of my Oregon credentials.

I am currently the Dental Assistant Development Specialist for Willamette Dental Group. A large portion of this position involves training and credentialing Dental Assistants within our Company. I am asking the Board to approve the enclosed curriculum so that I may provide the necessary training and credentialing to our employees.

I graduated from Portland Community College in 2003. I have been employed with Willamette Dental Group since 2003 and have held various positions. From 2003 to 2008, I assisted a general dentist who routinely fabricated his own dentures, in lieu of referring to a denturist. From 2008 to 2010, I assisted a periodontist who utilized soft relines during the healing process from implant surgery. From 2010 to 2013, I assisted an emergency dentist who often had patients that required denture adjustments and soft relines.

Thank you for considering this course for Board approval.

Best regards,

Kara A. Atkinson

Kara Atkinson

CDA, CPFDA, CRFDA, EFDA, EFODA, Sealant, Soft Reline

Portland Community College

Portland, Oregon

The Board of Directors on the recommendation of the Staff has awarded

Kara Ann Ficker

this certificate for the completion of the course of study for

Dental Assisting (One Year)

Given at Portland, Oregon, this fourteenth day of June, 2003



Doreen Margolin
Chair of the Board

Jeanne Carver
President

This certifies that
Kara Atkinson

has successfully completed
A "SOFT RELINE" Course



**Portland
Community
College**

Ginny Jorgensen

MARCH 2005

CDA, EFDA, EFODA

Date

Ginny Jorgensen

OREGON BOARD OF DENTISTRY

Dental Assistant

115713

CERTIFICATE NUMBER

Kara A Atkinson

Expanded Functions Dental Assistant
Expanded Functions Orthodontic Assistant
Radiological Proficiency

Issued: July 31, 2003

THIS CERTIFICATE MUST BE POSTED IN A CONSPICUOUS PLACE IN PLAIN SIGHT OF PATIENTS

TEMPORARY SOFT RELINES FOR FULL DENTURES

INSTRUCTOR(S): Kara Atkinson CDA, CPFDA, CRFDA, EFDA, EFODA,
Sealant, and Soft Reline

Helen Massar, RDH, BSDH, Soft Reline

COURSE DESCRIPTION: This class will provide Expanded Functions Dental Assistants (EFDA) with the education and certificate required in order to apply soft relines for patients with full dentures.

COURSE OBJECTIVES: Upon successful completion of this course, as approved by the Oregon Board of Dentistry, the Expanded Functions Dental Assistant will be able to apply temporary soft reline material to a full denture under the indirect supervision of a dentist or dental hygienist, providing that the denture is checked by the dentist or dental hygienist prior to patient dismissal.

DELIVERY METHOD: Lecture, Power Point presentation including handouts, instructor demonstration, group discussion, and laboratory practice.

EVALUATION: Class grade and certification will be determined by a written exam and laboratory performance evaluations. A score of 80% or higher must be achieved for successful completion.

REFERENCES:

1. Phinney and Halstead, Dental Assisting: A Comprehensive Approach, 3rd Edition, 2008.
2. Torres & Ehrlich, Modern Dental Assisting, 10th Edition, 2012.
3. Finkbeiner & Halstead, Comprehensive Dental Assisting, A Clinical Approach.
4. Product manufacturer information.
5. Product Material Safety Data Sheets.
6. Dental Practice Act 2011 Division 35 and Division 42.

LEARNING OBJECTIVES

Upon successful completion of this course, the student should be able to:

1. Explain the legal requirements to place soft relines.
2. Distinguish between the different types of relines.
3. Explain the difference between relining and tissue conditioning.
4. Understand the purpose of soft relines.
5. Evaluate the patient's medical and dental history.
6. Understand the physiological aspects of dentures.
7. Understand the psychological aspects of dentures.
8. Understand the use of the powder and liquid.
9. Understand the polymerization process in the reline material.
10. Understand the health hazard and first aid of the reline material.
11. List and describe purpose of armamentarium.
12. Describe the steps for applying a soft reline.
13. Provide proper home care instructions for denture(s).
14. Make accurate and appropriate chart entry in patient's chart.
15. Demonstrate in lab setting the ability to properly mix, apply, and trim material.

COURSE CONTENT

1. Review Dental Practice Act Divisions 35 and 42
2. Introduction
3. Differences in Relines.
4. Ingredients
5. Hazards and First Aid
6. PPE
7. Medical and Dental History
8. Indications
9. Contraindications
10. Procedure
11. Patient Instructions
12. OTC reline material
13. Proper chart documentation

KEY TERMS

Alveoplasty: Surgical reduction and reshaping of the alveolar ridge.

Border Molding: Process of using the finger to contour a closer adaptation of the margin of an impression while still in the mouth.

Centric Relation: Having the jaws in a position that produce a centrally related occlusion.

Edentulous: Without teeth.

Flange: Part of the denture that extends from the teeth to the border of the denture.

Full Denture: Prosthesis that replaces all of the teeth in one arch.

Lateral Excursion: Sliding position of the mandible to the left or right of the centric position.

Mastication: Chewing.

Posterior Palatal Seal: Seal in back of a full denture that holds it in place.

Pressure Points: Specific areas in the mouth where a removable prosthesis may rub or apply more pressure.

Relining: Procedure to resurface the tissue side of a partial or full denture so that it fits more accurately.

Resorption: The body's process of removing existing bone or hard tissue structure.

Retrusion: Position of the mandible posterior from the centric position as related to the maxilla.

Tori: Abnormal growth of bone in a specific area.

COMMON BRAND NAMES FOR SOFT RELINE MATERIALS AND TISSUE CONDITIONERS

Every manufacturer has their own product line for relining dentures. These are just a few examples. Willamette Dental Group has specified the brand(s) currently available for use. Be sure to read the instructions and review safety information before using product.

- Coe-Comfort – GC America**
- Coe-Soft – GC America**
- Dentusil/Silicone Soft Reline – Bosworth
- Duz-All Denture Reline – Bosworth
- Flexacryl – Lang Dental
- Lynal – Caulk
- Molloplast – Buffalo
- Softline – Kerr
- Visco-gel – Dentsply**

**These products currently available on the Willamette Dental Formulary.

Soft Reline Post-Operative Instructions

Why do I need a soft reline?

Sometimes dentures can become uncomfortable, either through the process of healing after surgery or after many years of wear. A soft reline is designed to make your denture more comfortable and to provide a better fit for use.

How should I clean my soft lining?

Clean your soft lining with wet cotton and cold tap water. A rough abrasive or brush will cause you to scar the lining or even separate it from the denture. If possible, rinse your denture in cold water after meals. Clean the rigid portion of the denture in your usual manner. Soak your denture overnight in cool water. Your denture should remain moist.

How long will my soft reline last?

Your new soft reline can remain soft and comfortable for months. How long it will remain depends on many factors. It is important to never use warm or hot water, or abrasive cleaning brushes or products when caring for your denture soft reline.

Will a soft reline change the appearance of my denture or face?

A reline will generally not change the appearance of the denture or the appearance of your face.

COE-SOFT™

Prior to use, carefully read the instructions for use. (EN)

RESILIENT DENTURE LINER

Prior to use, carefully read the instructions. For use only by a dental professional in the recommended indications.

CONTRAINDICATIONS:

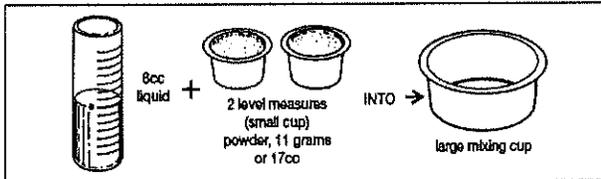
Patients who have shown sensitivity to the material. In case of allergy refer to a physician.

RECOMMENDED INDICATIONS:

A temporary lining for acrylic dentures. For use in chairside procedures.

DIRECTIONS FOR USE:

- Preparation of the denture:** Relieve and roughen the area of the denture to be relined. Clean and dry the denture thoroughly. Coat labial and buccal surfaces of the denture with COE LUBRICANT. Do not apply coating within 3mm (1/8 inch) of the peripheral border. If the denture has plastic teeth also protect them with COE LUBRICANT. Note: COE-SOFT will not adhere to surfaces coated with COE LUBRICANT.
- Preparation of COE-SOFT:** Recommended powder / liquid ratio is 11g powder to 8ml liquid. Pour the liquid into the large mixing cup. Then add the powder slowly. Stir mixture thoroughly for 30 seconds. A suitable spatula is provided for this purpose. To avoid introducing bubbles into the mixture, do not spatulate for more than 30 seconds. Do not whip.



- Application:** Spread the mixture of COE-SOFT over the area to be relined. Seat the denture in the manner of taking an impression and instruct the patient to close lightly into occlusion. After 3 minutes instruct the patient to move lips and cheeks so that a muscle trimmed periphery is obtained. Remove the denture and rinse under cold water. Trim away excess material. Re-seat the denture and instruct the patient to close FIRMLY into occlusion, and to hold this position for 5 minutes. Remove the denture and rinse again in cold water.
- Finishing:** When curing is complete, trim away excess. For smoothing the edges use a hot spatula.
- Patient Advice:** Advise the patient NOT to use a brush or abrasive (such as toothpaste) on the lining. Cleaning is best achieved by holding it under cold running water and wiping with wet cotton.

STORAGE:

Store in a dry location at room temperature (70° to 77°F; 21° to 25°C). (3 year shelf-life guarantee).

PACKAGES:

COE-SOFT Professional Package	COE-SOFT Economy Package
COE-SOFT Powder, 5.5 oz (156g)	COE-SOFT Powder, 5lb (2.27kg)
COE-SOFT Liquid, 5.5 oz (163mL)	COE-SOFT Liquid, 32oz (946ml)

Last revised: 1/2013

GC

MANUFACTURED BY
GC AMERICA INC.
3737 West 127th Street, Alsip, IL 60803, U.S.A.

7350113

COE-SOFT™

Avant toute utilisation, lire attentivement les instructions d'emploi. (FR)

MATÉRIAU DE REBASAGE SOUPLE

Avant toute utilisation, lire attentivement la notice. Ce produit est exclusivement réservé aux professionnels de l'art dentaire selon les recommandations d'utilisation.

CONTRE-INDICATIONS :

Patients qui présentent une sensibilité au matériau. En cas d'allergie, consulter un médecin.

INDICATION :

Matériau de rebasage temporaire pour prothèses en résines acryliques. Pour une utilisation au fauteuil.

MODE D'EMPLOI :

- Préparation de la prothèse :** Ebarber et dépolir la surface de la prothèse à rebaser. Nettoyer et sécher soigneusement la prothèse. Recouvrir les faces vestibulaires et linguales de la prothèse avec COE LUBRICANT; Laisser une marge d'au moins 3mm tout autour du joint périphérique. Si la prothèse a des dents en résine, protégez-les avec du COE LUBRICANT. Note : COE-SOFT n'adhère pas aux surfaces enduites de COE LUBRICANT.
- Préparation de COE-SOFT:** La dose recommandée de poudre et de liquide est de 11g de poudre pour 8ml de liquide. Versez le liquide dans le verre à mesurer. Ajoutez la poudre et mélangez doucement. Mélangez complètement pendant 30 secondes. Une spatule est fournie avec le sachet afin d'effectuer le mélange. Afin d'éviter la formation de bulles dans le mélange, veuillez ne pas mélanger avec la spatule pendant plus de 30 secondes. Ne pas battre.



- Application :** Etaler le mélange COE-SOFT sur toute la surface à rebaser. Positionner la prothèse comme pour une prise d'empreinte et demander au patient de mordre doucement. Après 3mn, demander au patient de remuer lèvres et joues pour obtenir un enregistrement périphérique. Enlever la prothèse et rincer sous l'eau froide. Eliminer les excès de matériau. Repositionner la prothèse et demander au patient de mordre FERMEMENT et de rester en relation cantrée pendant 5mn. Retirer la prothèse et la rincer de nouveau sous l'eau froide.
- Finition :** Après la prise complète, éliminer les excès restants. Pour adoucir les bords, utiliser une spatule chauffée.
- Avertissement au patient :** Avertir le patient de NE PAS utiliser de brosse ou de substance abrasive sur le rebasage. Le nettoyage sera plus efficace en passant la prothèse sous l'eau froide et en l'essuyant avec un coton mouillé.

CONSERVATION :

Conserver ce produit dans un endroit sec et à température ambiante (De 70°F à 77°F; de 21°C à 25°C). (3 ans de conservation garantis.)

CONDITIONNEMENT :

COE-SOFT Coffret	COE-SOFT Coffret économique
COE-SOFT Poudre, 5.5 oz (156g)	COE-SOFT Poudre, 2.27kg (5lbs)
COE-SOFT Liquide, 5.5 oz (163mL)	COE-SOFT Liquide, 946ml (32oz)

Dernière mise à jour: 1/2013



MS329345

COE-SOFT POWDER

Page 2 of 2

SECTION 6 - HEALTH HAZARD DATA and FIRST AID INFORMATION - continued

ROUTES OF ENTRY: Inhalation Skin Ingestion

HEALTH HAZARD (Acute and Chronic): Ingestion may cause nausea and vomiting. May cause eye irritation.

SIGNS AND SYMPTOMS OF OVEREXPOSURE: N.E.

CONDITIONS GENERALLY AGGRAVATED BY EXPOSURE: N.E.

EMERGENCY FIRST AID PROCEDURES:

INHALATION: Remove victim to fresh air.

INGESTION: Give one or two glasses of water to drink. If gastrointestinal symptoms develop, seek medical attention.

SKIN: Wash with soap and water.

EYES: Flush with water for 15 minutes. If redness, itching, or a burning sensation develops, seek medical attention.

SECTION 7 - PRECAUTIONS FOR SAFE HANDLING AND USE

IN CASE OF RELEASE OR SPILL: Sweep up and recover or mix material with moist absorbent and shovel into waste container. Wash spill area with hot water and detergent.

WASTE DISPOSAL METHOD: In accordance with local, state, federal regulations.

STORAGE, HANDLING, AND SPECIAL PRECAUTIONS: Store in a cool dry place; keep away from heat or open flame.

SECTION 8 - CONTROL MEASURES

RESPIRATORY PROTECTION: Minimize exposure in accordance with good hygiene practice. Use MSHA-NIOSH approved respirator for dusts, mists and fumes.

VENTILATION: Local Exhaust: N.E. Mechanical: N.E. Special: N.E. Other: N.E.

PROTECTIVE GLOVES: Disposable vinyl gloves

EYE PROTECTION: Safety glasses

OTHER PROTECTIVE CLOTHING OR EQUIPMENT: Eyewash station

WORK/HYGIENIC PRACTICE: Follow safe hygiene practice.

SECTION 9- PREPARATION INFORMATION

This data is supplied to comply with OSHA Hazard Communication Standard 29 CFR 1910,1200 and W.H.M.I.S. CPR

DATE: 26 July 2012

REVIEWED: 20 February 2012

N.A. = NOT APPLICABLE
N.E. = NOT ESTABLISHED

The information herein is given in good faith. No warranty expressed or implied is made.

FIRE - 0

TOXICITY - 1

NFPA
REACTIVITY - 1

SPECIAL - OXY



MS329346

COE-SOFT LIQUID
MATERIAL SAFETY DATA SHEET

Page 1 of 2

SECTION 1 - SOURCE/IDENTITY/USE INFORMATION**MANUFACTURER**

GC AMERICA INC.
 3737 West 127th St.
 Alsip, Illinois, 60658
 Telephone: 708-597-0900
 Hours Mon.-Fri: 8:00 a.m.-5:00 p.m. C.S.T.
 Transportation Emergency No. 800-424-9300

COMMON NAME: COE-SOFT LIQUID**CHEMICAL NAME:** N.A.**PRODUCT USE:** Denture reliner - liquid component.

The following information is provided with regard to the toxicity and hazards of the pure components present in this portion of the unmixed powder/liquid system.

SECTION 2 - HAZARDOUS INGREDIENTS/IDENTITY INFORMATION

COMPONENT	C.A.S.	EXPOSURE LIMITS	LD50/LC50	%
Benzyl salicylate	118-58-1	N.E.	N.E.	35-40
Ethyl alcohol	64-17-5	TWA=1000ppm (ACGIH) STEL=1000ppm (ACGIH)	N.E.	10-15

SECTION 3 - PHYSICAL/CHEMICAL PROPERTIES**BOILING POINT:** 173° - 180°F**VAPOR PRESSURE:** N.E.**VAPOR DENSITY:** N.E.**SOLUBILITY IN WATER:** N.E.**COEFFICIENT OF OIL/WATER DISTRIBUTION:** N.E.**SPECIFIC GRAVITY:** N.E.**MELTING POINT:** N.E.**EVAPORATION RATE:** N.E.**ODOR THRESHOLD:** N.E.**APPEARANCE AND ODOR:** Clear liquid**SECTION 4 - FIRE AND EXPLOSION DATA****FLASH POINT:** 16°C/61.5°F (CC)**FLAMMABLE LIMITS:** N.E.**EXTINGUISHING MEDIA:** Dry chemical foam, carbon dioxide, alcohol-type foam, water spray.**SPECIAL FIRE FIGHTING PROCEDURES:** Wear protective clothing including self contained breathing apparatus.**UNUSUAL FIRE AND EXPLOSION HAZARDS:** Contains Denatured Alcohol; vapors are heavier than air and may travel to flame source.**HAZARDOUS COMBUSTION PRODUCTS:** Carbon Dioxide, Carbon Monoxide**SECTION 5 - REACTIVITY DATA****STABILITY:**Stable Unstable **POLYMERIZATION:**Will Not Occur Will Occur **CONDITIONS TO AVOID:** High temperatures, fire, severe oxidizing conditions.**INCOMPATIBILITY (MATERIALS TO AVOID):** Nitric acid, sulfuric acid, strong oxidizing agents.**HAZARDOUS DECOMPOSITION OR BY-PRODUCTS:** Carbon monoxide, carbon dioxide.



SECTION 6 - HEALTH HAZARD DATA and FIRST AID INFORMATION

	YES	NO	NE	NA	NTP	IARC	OSHA	OTHER
MUTAGENIC AFFECTS		X						
TERATOGENIC AFFECTS		X						
REPRODUCTIVE TOXIN		X						
CARCINOGENICITY		X						
SENSITIZER		X						

ROUTES OF ENTRY: Inhalation Skin Ingestion

HEALTH HAZARD (Acute and Chronic): Ingestion may cause nausea, vomiting diarrhea, drowsiness, stupor cramps, loss of consciousness. Possible liver damage. Difficulty with speech. Central nervous system depression. May cause headache, if inhaled. Dizziness, drowsiness can occur. Skin and eye irritation can occur.

SIGNS AND SYMPTOMS OF OVEREXPOSURE: Liver damage has been reported from high exposure that approaches the lethal level.

CONDITIONS GENERALLY AGGRAVATED BY EXPOSURE: N.E.

EMERGENCY FIRST AID PROCEDURES:

INHALATION: Remove to fresh air. If breathing is difficult give oxygen. Seek medical attention.

EYES: Flush eyes with water for at least 15 minutes. Seek medical attention.

SKIN: Wash with soap and water. Remove and wash contaminated clothing promptly. Seek medical attention if irritation develops.

INGESTION: If swallowed, induce vomiting. Seek medical attention.

SECTION 7 - PRECAUTIONS FOR SAFE HANDLING AND USE

IN CASE OF RELEASE OR SPILL: Collect large spills for disposal. Flush small spills with water.

WASTE DISPOSAL METHOD: In accordance with state, local, federal regulations.

STORAGE, HANDLING, AND SPECIAL PRECAUTIONS: Store in a cool dry place.

SECTION 8 - CONTROL MEASURES

RESPIRATORY PROTECTION: Use an MSHA-NIOSH approved respirator.

VENTILATION: Local Exhaust: Mechanical: Special: Other:

PROTECTIVE GLOVES: Disposable vinyl gloves are recommended.

EYE PROTECTION: Safety glasses

OTHER PROTECTIVE CLOTHING OR EQUIPMENT: Eyewash station

WORK/HYGIENIC PRACTICE: Avoid contact with clothing, may stain

SECTION 9- PREPARATION INFORMATION

This data is supplied to comply with OSHA Hazard Communication Standard 29 CFR 1910,1200 and W.H.M.I.S. CPR

DATE: 19 July 2007

REVIEWED: 20 February 2012

N.A. = NOT APPLICABLE
N.E. = NOT ESTABLISHED

The information herein is given in good faith but no warranty expressed or implied is made.

FIRE - 3

TOXICITY - 1

NFPA
REACTIVITY - 0

SPECIAL -

Soft Reline Lab Check-Off Sheet

Student Name _____

Date _____

Lab Partner _____

You will be working with a partner to accomplish the following tasks. You are the assistant getting ready to place a reline for a patient (partner). Each task should be performed in order. You are not required to have instructor initials for the first 3 tasks, however these are points that will count against you if do not have task signed off.

Task: Soft Reline for Full Denture Lab Scenario	Student Initial	Partner Initial	Instructor Initial
Review Medical History.			N/A
Explain the steps involved in placing a soft reline to your "patient".			N/A
As the "patient" as a question that might be asked by a real patient. (If you're not sure how to answer, ask your instructor).			N/A
1. Student has reviewed product instructions.			
2. Student has assembled all necessary materials to complete the entire task, including but not limited to: reline material, basic set-up, scissor or Bard Parker with #15 blade, etc...			
3. Appropriate PPE is worn, including: gloves, glasses, mask, and gown.			
4. Student properly cleans the denture utilizing a denture brush and cool water.			
5. Student removes any existing reline material, possibly using slow-speed handpiece and lab bur.			
6. Student roughens the tissue surface to enhance material adhesion using slow-speed handpiece and lab bur.			
7. Student applies Vaseline or lubricant provided with material to labial and buccal surfaces, avoiding 3 mm from peripheral border.			
8. Student accurately measures, mixes, and spatulates material for 30 seconds.			
9. Reline material is spread on tissue surface of denture that is to be relined			

10. Applies denture to model, applying firm pressure to replicate Centric occlusion.			
11. After approximately 3 minutes, the denture is removed from model and rinsed under cool water.			
12. Excess material is trimmed away using a Bard Parker with #15 blade or scissor.			
13. Denture is remounted onto model and the student applies firm pressure (to replicate Centric occlusion) again for another 5 minutes.			
14. Student removes denture and rinses it under cold water.			
15. Final adjustments are made to denture.			
16. Student has instructor evaluate denture for accuracy of material placement.			

Instructor will review all tasks with student and give advice if necessary.

Proficient: (100%) 19 points received out of 19 possible.

Not Proficient (95%) 18 points or less received out of 19 points possible.
 Student must attempt check off until 100% proficiency is achieved.

Soft Reline Clinic Check-Off Sheet

Student Name _____

Date _____

Patient Name _____

Examining Dentist _____

Before participating in the clinical aspect of this course, the following are required:

- Student has passed the written examination with 85% or better.
- Student has obtained 100% proficiency in laboratory session.
- Doctor has prescribed the soft reline and is documented in chart accordingly.

Task: Soft Reline for Full Denture			Satisfactory	
Max	Mand	Both	Yes or No	
Dentist has prescribed the soft reline(s).			Yes	No
Health History has been reviewed by examining dentist.			Yes	No
1. Student has set up operatory with all necessary materials/instruments present.			Yes	No
2. Student reviews Health History and discusses any concerns with examining dentist			Yes	No
3. Patient is escorted into the operatory. The student briefly explains the procedure to the patient, showing them the materials to be used, and answers any questions the patient has.			Yes	No
4. Patient bib is placed and safety glasses are given to the patient.			Yes	No
5. Patient is asked to rinse with mouth rinse to reduce bacteria. Ask patient to apply chap stick or Vaseline, or to moisten lips to avoid cracking or adhesion of material to soft tissues.			Yes	No
6. Student washes hands and dons PPE: gloves, glasses, mask, and gown.			Yes	No
7. Properly cleans the denture utilizing denture brush.			Yes	No
8. Removes, or has dentist remove, any existing reline material using slow speed handpiece and lab bur.			Yes	No
9. Roughens, or has dentist roughen, tissue surface for better adhesion.			Yes	No
10. Has dentist check denture before you begin.			Yes	No
11. Applies Vaseline or lubricant provided with material to labial and buccal surfaces, avoiding 3 mm from peripheral border.				
12. Measures, mixes, and spatulates material for approximately 30 seconds, and load into denture, being careful not to over-fill. (This could cause patient to gag.)			Yes	No
13. Inserts denture into patient's mouth and has them close in Centric (Normal) occlusion.			Yes	No
14. After approximately 3 minutes, with the patient remaining closed, has the patient start to move their lips and cheeks to obtain good muscle periphery. Mimic chewing.			Yes	No

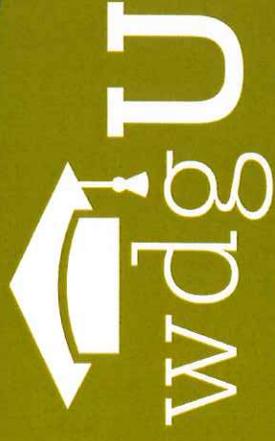
15. Student removes denture and rinses it under cold water.	Yes	No
16. Excess material is trimmed away.	Yes	No
17. Student re-inserts denture and has the patient close in Centric (Normal) Occlusion. Has patient remain closed for 5 minutes.	Yes	No
18. Student removes denture one last time and rinses it thoroughly with cold water.	Yes	No
19. Student makes any final adjustments.	Yes	No
20. Has dentist evaluate denture prior to patient dismissal.	Yes	No
21. Provides patient with home care instructions about caring for soft reline(s).	Yes	No
<p>This portion to be completed by examining dentist:</p> <p>Maxillary Soft Reline _____</p> <p>Mandibular Soft Reline _____</p> <p>Max and Mand Soft Reline _____</p> <p>Student correctly applied soft reline material: PASS</p> <p>Student did not correctly apply soft reline material: FAIL</p>	<p>Assistant must pass this check off with 100% proficiency.</p>	



Willamette Dental Group

First In Proactive Dental Care

Soft Reline Course

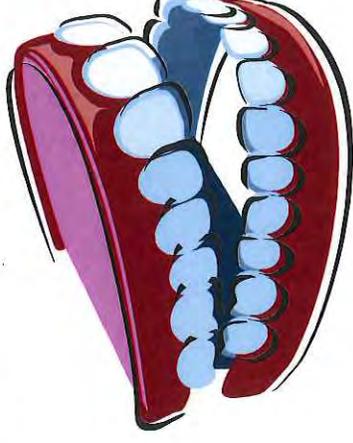


Let's Get Learning.

Oregon Law OAR 818-042-0090
OAR 818-035-0030

Willamette[™]
Dental Group

- In order to apply a soft reline, you must be an Expanded Functions Dental Assistant or a Hygienist (this task is included as “additional functions of a Dental Hygienist.”)
- The soft reline must be prescribed by a Dentist, and denture must be checked prior to placing soft reline.
- You can apply a soft reline under Indirect Supervision of a Dentist or Dental Hygienist, as long as denture is checked by the Dentist or Dental Hygienist prior to patient dismissal.





Types of Relines

Types of Relines



- **Rebase**
 - Entire denture base is replaced.
 - Original denture acts as impression tray.
 - New denture processed around existing denture teeth.
 - **Patient will be without denture while process is completed.

Types of Relines



- **Hard Reline**
 - Existing denture is used as impression tray.
 - New resin is applied to existing resin, then cured.
 - Resurfaces the denture, filling in the gaps between tissue and denture base.
 - **Patient will be without denture. Process can usually be completed within 24 hours.

Types of Relines

- Soft Reline aka “Chairside Reline”

- Chemically activated, self-curing.
- Quick and simple to apply.
- Temporary solution.

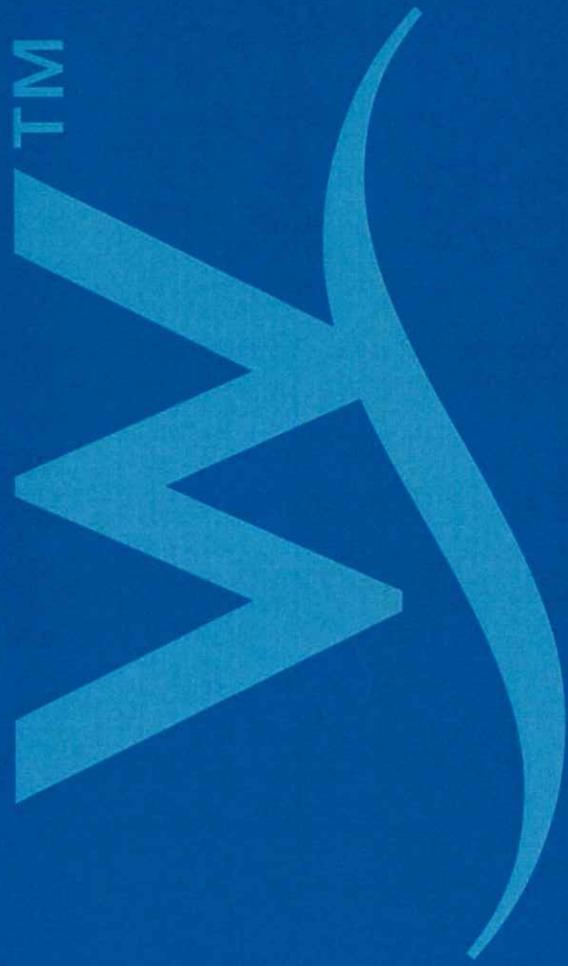


- Elastically deforms with low applied stress, but recovers shape when stress is removed.
- **Patient is not without denture.

Types of Relines

- Tissue Conditioner
 - Used when tissues are inflamed or irritated.
 - Could be from ill-fitting denture, or recent procedure.
 - Tissues must be healed before applying relines.
 - Allows healing and cushioning by adapting to shape of underlying tissues as they recover to a healthy state.
 - **Patient is not without denture.





Reline Materials

What's in the box?



- **Ingredients (Check instructions for product you're using)**
 - Powder
 - Liquid
- **Mixing cups**
- **Measuring cups**
- **Spatula**
- **Lubricant**



What's In the Box?



- Soft reline material is *self-curing*
 - A chemical reaction occurs when you mix the powder and liquid.
 - The material will harden on its own over the course of a few minutes.
 - No additional curing lights or products are necessary.

Hazards and First Aid



- Always review the instructions prior to use.
- Tell someone **right away** if there is a splash or spill. This person will help you seek the proper treatment.
- Is there a spill? Splash to the eye? You can access the MSDS for both the powder and liquid:
 - At msdsonline.com
 - Call MSDS Online at 1-888-362-7416

Hazards and First Aid



- Powder, sometimes called Polymer
 - Inhalation
 - Eyes
 - Skin
 - Ingestion
 - Spill

Hazards and First Aid



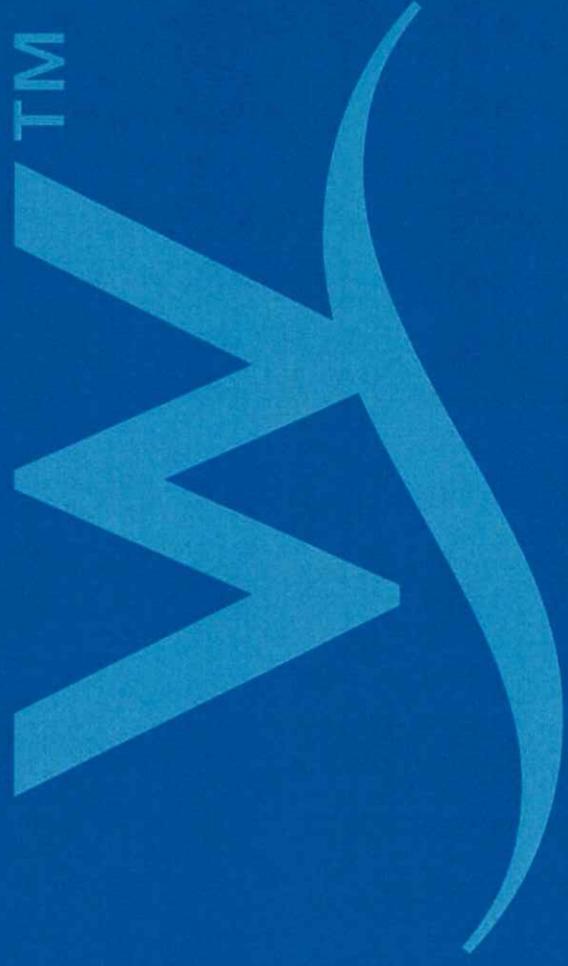
- Liquid, sometimes called Monomer
 - Inhalation
 - Eyes
 - Skin
 - Ingestion
 - Spill

Personal Protective Equipment

- PPE!!!

- Glasses
- Gloves
- Mask
- Gown





Patient Considerations

Medical History

- Overall Health
- Medications
- Conditions
 - Malnutrition
 - Stroke
 - Cancer



Dental History

- Exam, cancer screen
- Age of present denture
- Progression of bone loss
- Occlusion/Bite Relationship
- Present comfort



Indications for Soft Reline

- Loss of suction
- Uncomfortable, ill-fitting
- Loss of chewing capability
- Angular Cheilitis
- Oral habits – grinding, clenching, mouth breather
- Anatomic features – palatal tori
- Patient's age and/or health



Contraindications for Soft Reline



- Patient is allergic to reline material
- Only a temporary measure
- Material could discolor over time
- Softness is short-lived
- Could support growth of yeasts
- Material could become detached from denture base
- Patient not interested in soft reline





Procedure

Armamentarium

- Basic setup
- Slow-speed handpiece with acrylic bur
- Reiline material, including lubricant provided with product (Vaseline can be used, also.)
- Paper cup or mixing cup provided with product
- Tongue blade, spatula, or brush for mixing
- Scissors and/or bard parker with #15 blade for trimming

Procedure

Willamette
Dental Group



- Review product instructions prior to seating patient.
- Medical history has been updated.
- Doctor prescribes the soft reline.
- Plan the procedure in axiUm and check estimator. Inform patient of any fees.
- Explain the procedure to the patient, ask if they have any questions before you begin.
- Have the patient remove denture and rinse with mouth rinse to reduce the bacteria load. Ask them to apply chapstick, vaseline, or moisten lips to avoid cracking or adhesion of material to soft tissues.

Procedure

Willamette
Dental Group



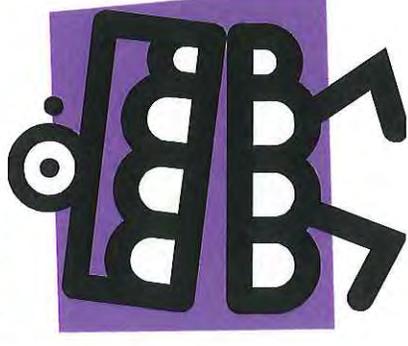
- Examine the patient's mouth for any anatomical features that may make this process difficult or uncomfortable for the patient.
 - Cracking at the corners of the mouth
 - Tori
- Examine the denture.
- Clean the denture utilizing a denture brush and cool water.
- Dentist may remove any existing relined material and/or roughen the tissue surface.
 - In Oregon, the Assistant may remove existing relined material, and/or roughen the tissue surface, and/or adjust the denture outside the patient's mouth if directed to do so by the Dentist.
- Have the dentist check the denture before you begin.

Procedure

- Lubricate the labial and buccal surfaces, avoiding within 3 mm of the peripheral border. If the denture has plastic teeth, coat the teeth as well.
- Measure, mix, and spatulate material for 30 seconds (do not whip or over-spatulate), and load into denture. Spread on the surfaces to be relined.
- Insert denture and have patient close to centric occlusion. Have patient remain closed for approximately 3 minutes.
- After approximately 3 minutes, have the patient remain closed but ask them move their lips and cheeks (mimic chewing) so muscle periphery is obtained.

Procedure

- At this point, remove the denture and rinse under cold water.
- Trim away excess material.
- Reinsert denture and have patient hold firmly in centric occlusion for another 5 minutes.
- Remove denture one last time and rinse with cold water.
- Have the doctor evaluate denture before patient is dismissed.
- Denture is now ready for use!



Patient Instructions



- Denture(s) should remain moist.
- Never use hot water!
- No abrasives or brushes, as these can quickly wear away relines.
- Cleaning best achieved by gently holding denture under cold water and wiping lightly with wet cotton.
- Commercial cleaners (like Efferdent) should not affect relines material.

Over the Counter Products



- There *are* OTC temporary products that patients can purchase at their local pharmacy; however, in general:
 - The patient can accidentally misuse the product
 - Incorrect fit
 - Burnt tissues
 - Improper mix, so improper setting
- It is best to visit the dentist!

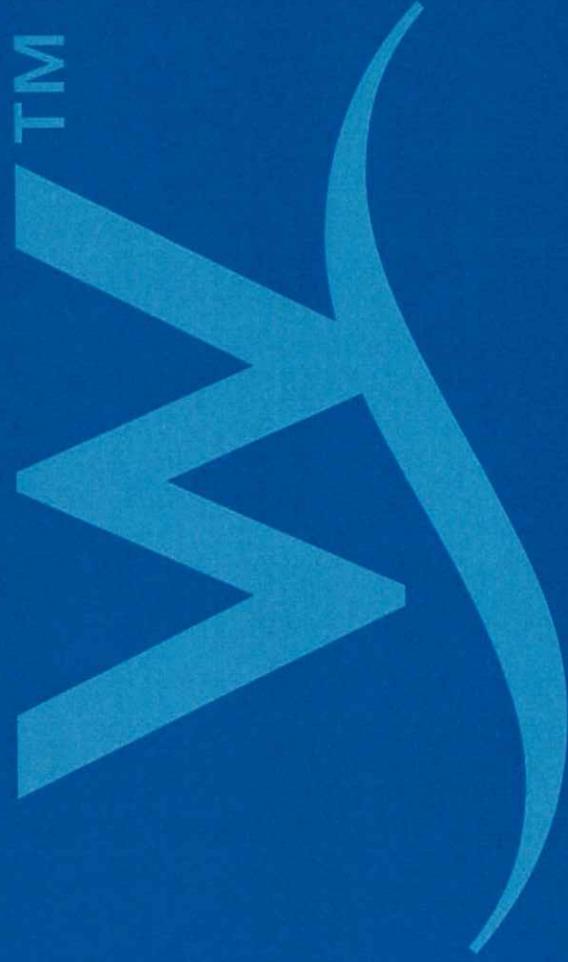


axiUm Documentation

Documentation



- Once treatment is completed, complete the code, and complete the Removable Prosthetic template note.
- Documentation should include:
 - Who performed the reline
 - What material was used
 - Did you provide home care instructions?
 - Any future treatment that might be necessary



Lab Practice/Written Exam

7. PIT AND FISSURE SEALANT COURSE, KARA A. ATKINSON,EFDA

The Board has received a request for approval of a Pit and Fissure Sealant Course. This course would be provided so the EFDA Dental Assistants could qualify to apply pit and fissure sealants in accordance with OAR 818-042-0090.

"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 providing that the procedure is checked by the dentist prior to the patient being dismissed:

- (1) Apply pit and fissure sealants providing 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.
- (2) Apply temporary soft relines to full dentures."

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

#40
RECEIVED

APR 18 2014

Oregon Board
of Dentistry

**APPLICATION FOR APPROVAL AS INSTRUCTOR
IN PIT AND FISSURE SEALANTS
Instructor Permit Fee \$40.00**

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

Kara A. Atkinson

MAILING ADDRESS AND TELEPHONE NUMBER:

7015 SW Merry Lane

City Beaverton State OR Zip 97008 Telephone 503-705-7310

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

EFDA - 2003

Sealant Certificate/PCC - 2005

PCC DA Graduate - 2003

**I certify this application is correct and agree to teach the course according to the outline provided,
and as approved by the Board.**

4/15/14

Date

Kara A. Atkinson
Signature

INSTRUCTOR QUALIFICATIONS:

Instructors should have background in and current knowledge of pit and fissure sealants and must be either a Dentist with an Oregon license; or

A Dental Hygienist licensed in Oregon who has completed 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 Oregon Board of Dentistry on pit and fissure sealants (818-035-0040); or

A Dental Assistant certified by the Dental Assisting National Board, Inc., as a current Oregon "EFDA" who has successfully completed a course of instruction approved by the Oregon Board of Dentistry on pit and fissure sealants and shows proof of having successfully placed sealants on not less than ten (10) patients and on not less than twenty-five (25) teeth (Attachment 3).

**VERIFICATION OF PLACEMENT
OF PIT AND FISSURE SEALANTS
FOR INSTRUCTOR APPLICATION**

EMPLOYER/DENTIST

Name Mahmoud Maghsoudlou, DMD - Willamette Dental Group

Address 7095 SW Gonzaga Street

City Tigard State OR Zip 97223 Telephone 503-620-6715

I hereby certify that KARA A. ATKINSON
(Assistant's Name)

has successfully performed 28 sealants on 13 patients.

3/21/14
Date

Kara A. Atkinson
Dental Assistant's Signature

Mahmoud Maghsoudlou, DMD
503-620-6715
NPI# 1871602417

03-21-2014
Date

M. Mag
Dentist's Signature

(Use more than one form if necessary)

Portland Community College

Portland, Oregon

The Board of Directors on the recommendation of the Staff has awarded

Kara Ann Ficker

this certificate for the completion of the course of study for

Dental Assisting (One Year)

Given at Portland, Oregon, this fourteenth day of June, 2003



Doreen Marsolin
Chair of the Board

Jenna Carreon
President

OREGON BOARD OF DENTISTRY

Dental Assistant

115713

CERTIFICATE NUMBER

Kara A Atkinson

Expanded Functions Dental Assistant
Expanded Functions Orthodontic Assistant
Radiological Proficiency

Issued: July 31, 2003

THIS CERTIFICATE MUST BE POSTED IN A CONSPICUOUS PLACE IN PLAIN SIGHT OF PATIENTS

This certifies that

Kara Atkinson

has successfully completed

A "Sealant" Course



**Portland
Community
College**

Ginny Jorgensen
CDA, EFDA, EFODA

MARCH 2005

Date

Ginny Jorgensen

The Application of Pit and Fissure Sealants

A Certification Course

Course Description

The primary purpose of this course is to certify dental assistants to legally apply sealants within their state of practice. An overview of the material and steps required to correctly apply sealants will be given during the lecture portion of the course. The student will be required to pass a written examination, participate in laboratory demonstrations, and apply sealants in a clinical environment.

Course Objectives

After successfully passing this course, the student will:

- Understand the clinical reasoning for sealant placement
- Demonstrate the correct application of sealants to the satisfaction of an examining dentist
- Obtain their Sealant Certification; enabling them to legally apply sealants in their state of practice.

Course Requirements

1. Student must be currently licensed or registered to provide dental assisting services in their state.
2. Must be currently employed with Willamette Dental.
3. Idaho Assistants: In order for this certification to be valid you must have your CDA or have completed a Fundamental Course or have challenged and passed a Fundamentals Course (please refer to The Idaho Board of Dentistry, Administrative Rule #35, subsection #3 on EFDA qualifications). Please provide proof to Instructor.
4. Students must wear scrubs to the clinical and laboratory portion of the course.
5. PPE: Please bring your own protective eyewear. Gloves, masks, over-gowns will be provided.
6. Bring one to two patients to participate in the clinical application portion of the course; clinic is held from 2:20 p.m. to 5:00 p.m. (subject to change based on pace of course.) The patient's insurance will not be billed nor will they have a co-pay. A signed consent form, medical history, and a prescription for sealants form must be completed for the patient and submitted on the day of the course.

Materials

The following materials are presumed to be present in our instructional location.

- Basic set-up (mirror, explorer, and forceps)
- Hydrogen peroxide
- Etch and sealant material
- Bristle brush/Toothbrush
- Sealant application device
- Curing light
- Rubber dam, clamps, frame, forceps
- Suction tips
- Slow speed handpiece
- Patient bib and bib clip
- Disposable mixing well
- Cotton supplies: dri-aids, cotton rolls, 2x2s
- Air/water syringe tips
- Articulating paper and floss
- Slow speed round burs
- Patient safety glasses

Evaluation and Grading

This course is designed on a Pass/Fail basis. In order for the student to receive their certification they must fulfill the above mentioned requirements and:

1. Take a 25 question multiple choice exam with a minimum passing score of 85%.
2. Place two sealants on two extracted virgin teeth mounted in stone*
3. Place a minimum of six acceptable sealants on clinical patients with 100% proficiency (determined by an examining dentist) on three maxillary teeth and three mandibular teeth.

*Please bring the teeth to class with you on the day of the course! Extras will not be provided.

Sealant Course

Torres and Ehrlich, Modern Dental Assisting Ninth Edition, 2009. Saunders/Elsevier.

Finkbeiner and Johnson, Comprehensive Dental Assisting. Mosby.

Phinney and Halstead, Dental Assisting: A Comprehensive Approach, 3rd Edition, 2008.
Delmar.

Pit and Fissure Sealants

Course Agenda

8:00 a.m.	Introductions, attendance taken, handouts, course overview
8:10 a.m.	Two Truths and a Lie
8:30 a.m.	Module 1: Origins, Materials, Implications
9:10 a.m.	Break
9:20 a.m.	Module II: Clinical Sealant Placement
10:20 a.m.	Break
10:30 a.m.	Module III: Supervision and Legal Aspects
10:50 a.m.	Review
11:10 a.m.	Written Assessment (Must pass at 85% to continue to Lab and Clinic Session)
12:00 p.m.	Lunch
1:00 p.m.	Laboratory Session
2:10 p.m.	Break
2:20 p.m.	Clinical Session
5:00 p.m.	Conclusion



Medical & Dental History

Patient's Name: _____ Date of Birth: _____

Medication/Supplement List

List all medications, herbal remedies, and nicotine replacement therapy you are taking, including over-the-counter:

Medical History

1. Do you need (antibiotic) premedication for dental treatment? Yes No
2. Are you now, or have you been in the last year, under the care of a physician? Yes No
3. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No
4. Do you have a history of Endocarditis (infected heart valve)? Yes No
5. Have you had open heart surgery? Yes No
6. Have you ever had an orthopedic total joint replacement (hip, knee, elbow, finger)? Yes No
7. Have you ever had any radiation therapy or chemotherapy for a growth tumor or other condition? Yes No
8. Do you use or have you used tobacco? Yes No if Yes, Past Use Current Use
9. Do you drink alcoholic beverages? Yes No
10. Do you use prescription or street drugs or other substances for recreational purposes? Yes No
11. Have you taken, or are you scheduled to begin taking oral bisphosphonates? Yes No
(Alendronate-Fosamax, Fosamax Plus D; Etidronate-Didronel; Ibandronate-Boniva; Risedronate-AcetoneI; Tiludronate-Skelid)
12. Have you taken, are you taking or are you scheduled to begin taking intravenous bisphosphonates? ... Yes No
(Clodronate-Bonefos, Pamidronate-Aredia or Zoledronic Acid-Reclast, Zometa)

Women Only:

13. Are you pregnant? Yes No
14. Are you trying to become pregnant? Yes No
15. Are you nursing? Yes No
16. Are you taking birth control pills, fertility drugs or hormonal replacement? Yes No

Medical Conditions

Do you or have you had any of the following diseases, problems or symptoms?

17. Cardiovascular/heart problem (heart attack, heart murmur, high blood pressure, etc.) Yes No
18. Respiratory/Lung problem (asthma, emphysema, COPD, tuberculosis, etc.) Yes No
19. Diabetes/Thyroid Problems Yes No
20. Kidney/Urogenital Disorder (renal failure, dialysis, etc.) Yes No
21. Cancer or Tumors Yes No
22. Neurological/Nerve problem (stroke, seizures, MS, mental health disorders, etc.) Yes No
23. Blood/Hematologic disorder (anemia, leukemia, bleeding disorders, etc.) Yes No
24. Gastrointestinal (GI) Disorder (hepatitis, acid reflux, Crohn's, etc.) Yes No



Medical & Dental History continued...

- 25. Musculoskeletal/Connective tissue disorder (arthritis, osteoporosis, fibromyalgia, etc.) Yes No
- 26. Growth/Development problem (developmental delay, learning disability, behavioral problems, etc.) Yes No
- 27. Infectious disease (HIV/AIDS, MRSA, cold sores, STDs, etc.) Yes No
- 28. Head/Eye/Ear/Nose/Throat problem (glaucoma, cataract, hearing impairment, etc.) Yes No
- 29. Eating disorder (anorexia, bulimia, etc.) Yes No
- 30. Immunosuppression (compromised immune system) Yes No
- 31. Are all immunizations/vaccinations up to date? Yes No
- 32. Do you have any other problem, disease or condition not listed? Yes No
- 33. Are you allergic to or have you had a reaction to any substance or medication? Yes No

List all substances/medications you are allergic to:	Reaction:

Dental History

- 1. Chief Complaint? _____
- 2. Date of your last dental visit: _____
- 3. What was done at that time? _____
- 4. Date of your last dental x-rays: _____
- 5. Date of your last dental cleaning? _____
- 6. Are you currently experiencing any dental pain or discomfort? Yes No
- 7. Are your teeth sensitive to cold, hot, sweets or pressure? Yes No
- 8. Do you have swelling in or around your mouth, face or neck? Yes No
- 9. Do you have loose teeth? Yes No
- 10. Do you have bad breath, metallic taste or unpleasant taste? Yes No
- 11. Do you have any clicking, popping or discomfort in the jaw? Yes No
- 12. Do you clench, brux or grind your teeth? Yes No
- 13. Do you have sores, ulcers or tumors in your mouth? Yes No
- 14. Have you had any periodontal treatments? (deep cleanings/gum surgery) Yes No
- 15. Have you ever had orthodontic treatment? (braces, retainers) Yes No
- 16. Have you ever had local anesthetic (numbing) for dental purposes? Yes No
If Yes, have you experienced any problems?..... Yes No
- 17. Have you had problems associated with previous dental treatment? Yes No
- 18. How often do you brush your teeth? Never Sometimes Once a day Twice a day More than twice a day
- 19. How often do you floss your teeth? Never Sometimes Once a day Twice a day More than twice a day
- 20. Do your gums bleed when you brush or floss? Never Sometimes Always
- 21. Do you have any obstacles to cleaning or caring for your teeth? Yes No
- 22. Rate your fear of dental treatment on a scale of 0 (no fear) to 10 (extreme fear):
 0 1 2 3 4 5 6 7 8 9 10

Informed Consent



Willamette Dental is providing a Sealant Certification Course for our current Dental Assistants; after lecture and lab instruction, students will be asked to apply dental sealants on live patients under the supervision of a Dentist and other clinical staff members who are certified instructors.

The treatment of teeth through the use of dental sealants is a preventative measure intended to prevent dental caries (tooth decay or cavities) in the chewing surfaces of the teeth. Prior to placing the Sealant material, a special acid solution is used to clean the surface of the tooth. Sealant material is comprised of a liquid resin (plastic) that adheres and hardens to the grooves and pits of teeth when a specialized light is directed toward the material.

Please initial each of the following paragraphs after reading and sign on back of form. If you have questions, please ask your doctor BEFORE initialing.

_____ I understand a special acid solution is used to etch the surface enamel in the area in which the sealant is to be placed. This etching solution is somewhat caustic and if the patient makes any unexpected movements during the process there is the possibility that a small amount of the solution may attach to the lips or gums which could cause some slight tissue burns. This seldom occurs, but is a possibility.

_____ I understand there is the possibility of the sealant failing, dislodging, or wearing away over time.

_____ I understand that chewing forces differ for each patient and may be much greater in one patient than in another. The way teeth come together in chewing may also have an effect on the life of the sealant.

_____ I understand that very sticky foods like caramels and taffy, and very hard substances can cause the sealant to dislodge or wear away over time.

_____ I understand that inadequate oral hygiene such as infrequent or improper brushing of the teeth may allow decay to develop around the edges of the sealant which can travel underneath the sealant.

_____ I understand that sealants are applied primarily to the pits and fissures that are in the chewing surfaces of the teeth. However, sealants do not protect the areas between the teeth, so thorough brushing and the use of dental floss is necessary to prevent decay.

_____ I understand that it is my responsibility to notify my regular dentist should I experience any unexpected problems relating to the treatment. Routine examinations by a dentist are recommended to allow ongoing assessment of the sealants placed.

_____ I have been given no guarantees regarding the outcome of sealant placement.

_____ I understand that not having sealants applied is an option available to me, but have determined the possible preventative affects of sealants is beneficial and wish to have them applied.

Informed Consent

INFORMED CONSENT: I certify that I have read and fully understand the entire document, have had my questions answered, and give consent for dental sealants to be applied on me. I authorize Willamette Dental and/or all associates involved in rendering the services or treatment necessary to the existing dental condition, including the administration and/or prescribing any anesthetic agents and/or medications. I agree to assume responsibility for the risks, if any, which may be associated with the placement of sealants even though care and diligence will be used during treatment.

Patient Name _____

D.O.B _____

Patient or Guardian Signature _____

Date _____

Prescription for the placement of Pit and Fissure Sealants

Clinic conducted by Willamette Dental

This form **must** be completed and presented on the day of sealant instruction prior to participating in the clinic portion of the sealant course. Copies of this completed form will be given to students who require proof of prescription for state board certification.

This original form will be returned to the patient's dentist of record to be placed in their chart.

I, _____ DMD/DDS performed a comprehensive examination, including the consultation of current radiographs, for the patient named _____ on _____ (date) and find the patient to be in need of the protection offered by the placement of pit and fissure sealants. I hereby prescribe that _____ (DA) place sealant material on the following tooth numbers and surfaces*: _____.

If necessary, I consent to have the dentist present for the course examine the patient to re-diagnose the placement of sealants on the above mentioned teeth if the course is held more than 45 days but less than 60 days after this written prescription.

Signature DMD/DDS: _____

Address: _____

City: _____

State: _____ Zip: _____

To be completed by examining dentist after clinical session of sealant course.

I, _____ DMD/DDS hereby certify that assistant named: _____ has successfully placed sealants on teeth #'s _____ on _____ (patient).

Or/And

Sealants were not placed on teeth #'s _____ due to inhibiting factors such as: inability to obtain isolation, operculum, uncooperative patient etc . . .

Signature DMD/DDS: _____

Date: _____

ATTACHMENT 1

PRESCRIPTION FOR PLACEMENT OF PIT AND FISSURE SEALANTS

I, _____ DMD/DDS have examined the patient
_____ on _____ and find the patient to be in need
of the protection offered by the placement of pit and fissure sealants. I hereby prescribe that
_____ place sealant material on the following tooth surfaces: (must be at least
two molars or premolars)

(Signature)



I, _____ DMD/DDS hereby certify
that _____ has successfully placed sealants on teeth
#s _____ on the above named patient.

Dated: _____ Signed: _____

This document must be returned to the prescribing dentist for placement in the patient's chart.

Pit and Fissure Sealant

Lab Check-off Sheet

Student Name _____ Date _____

Lab Partner Name _____

Place your initials in the appropriate column only after you have either completed the task or have observed the student completing the task successfully.

The following are role playing scenarios in which one of you will be the dental assistant about to apply sealants while the other pretends to be the patient who is about to receive them. "Patients" are encouraged to ask relative questions to the dental assistant. Switch roles once for each task.

Task	Student Initial	Partner Initial
State a clinical definition of a sealant to your "patient".		
Explain the non-clinical definition to your "patient".		
Explain to your "patient" the benefits of placing sealants.		
As a "patient", ask a question that might be asked by a real patient.		
As the dental assistant, answer the question to the best of your ability. If you are uncertain, ask an instructor.		

You will be placing sealant material on two extracted teeth that have been mounted in stone. Complete the application of sealant material on one of the teeth with your partner watching; after they have signed off, you will place sealant material on the other tooth under the supervision of an instructor.

Each task in performed in order:

Task (each task is worth 1 point awarded by instructor)	Student Initial	Partner Initial	Instructor (+/-)
1. Student has assembled all necessary material to complete the entire task including: teeth mounted in stone, basic set-up, 2x2s, toothbrush, etchant, sealant material, sealant application device, micro brushes, curing light. **The following are NOT necessary for lab demonstration: articulating paper, floss, prophy angle, tapered bristle brush, and handpieces.			
2. Appropriate PPE is worn including: over gown, gloves, mask, and eyewear.			
3. The toothbrush was used to pre-clean the tooth prior to etch application.			
4. Tooth is completely rinsed, dried, and isolated			
Continue to page 2			

	Student Initial	Partner Initial	Instructor (+/-)
5. Sufficient etchant is applied and an explorer is used to distribute etch into the grooves and pits of the tooth. The explorer is wiped off immediately after use with a 2x2.			
6. Etchant was left on the amount of time recommended by the manufacturer.			
7. HVE placed over etchant for 5 seconds before rinsing.			
8. Tooth is rinsed for 20-30 seconds without the use of "spray".			
9. Air/water syringe is purged before being used to dry the tooth.			
10. Tooth is dried until it shows a dull chalky appearance.			
11. Sealant is applied in a thin even layer; excess removed with a microbrush to avoid pooling of material.			
12. An explorer is used to trace the fissures eradicating air bubbles within the material.			
13. Student was careful to avoid interproximal areas during application.			
14. Curing light placed 1-2mm over sealant and cured for the appropriate amount of time.			
15. Curing light tip did not contact the tooth or sealant material.			
16. An explorer is used to evaluate the sealant.			
17. If there are voids or incomplete coverage of the sealant, additional material is added.			
18. Student is asked what they would do if moisture had contaminated the finished sealant and they needed to add more. Student will answer successfully.			
19. **Final evaluation of sealant by instructor shows correct application.			
20. Total Points Received			

****Instructor will review all task accomplishments with student and give advice if necessary.**

Grading scale:

- Proficient (100%) 19 point received out of 19 point possible
- Not Proficient (95%) 18 point or less received out of 19 points possible.
Student must redo check-off until 100% proficiency is reached.

Pit and Fissure Sealant Clinic Check-off Sheet

Student Name _____
 Patient Name _____
 Examining Dentist's Name _____

Before participating in the clinical aspect of this course, the following are required prerequisites:

- Student has passed the written examination with 85% or better.
- Student has obtained 100% proficiency in the laboratory session.
- The dental assistant must submit the original prescription form from the patient's dentist of record approving sealant application. After you have completed the clinical session with 100% proficiency, the original form will be signed and a copy will be given to you for Board Certification requirements. The original will be returned to the patient's dentist of record.

You will be observed by an instructor during patient treatment.

Task	Satisfactory Yes or No	
Dentist's Prescription Submitted to Instructor Teeth to be sealed: Maxillary Mandibular # _____ # _____ # _____ # _____ # _____ # _____	N/A	
Informed Consent Submitted to Instructor	Yes	No
Health History reviewed by examining dentist	Yes	No
1. Student has appropriately set up their operatory with all necessary materials present.	Yes	No
2. Student confirms with the instructor that the written prescription is not more than 45 days old. Examining dentist will re-diagnose if appropriate.	Yes	No
3. Student reviews the health history and discusses any concerns with examining dentist.	Yes	No
4. Patient is escorted into the treatment operatory. The student will briefly explain the procedure to the patient, showing them the item that will be used, and answer any questions they may have.	Yes	No
5. Student washes hands and PPE is placed including: gloves, eyewear, mask, and over gown.	Yes	No
6. Patient bib is placed and safety glasses are given to the patient.	Yes	No
7. A pre-placement examination is performed; student confirms teeth to be sealed and consults the examining dentist with any concerns. Anesthesia is placed at this time for rubber dam use if applicable.	Yes	No
8. Rubber dam is placed if utilized.	Yes	No

9. A toothbrush or tapered prophy brush is used to pre-clean the tooth prior to etchant application.	Yes	No
10. The tooth is completely rinsed, dried, and isolated with cotton if no dam is used.	Yes	No
11. Sufficient etchant is applied and an explorer is used to distribute etch into the grooves and pits of the tooth. The explorer is wiped off immediately after use with a 2x2. Special attention is given to avoiding etchant contacting the soft tissues.	Yes	No
12. Etchant was left on the amount of time recommended by the manufacturer.	Yes	No
13. HVE placed over etchant for 5 seconds before rinsing.	Yes	No
14. Tooth is rinsed for 20-30 seconds without the use of "spray".	Yes	No
15. Wet cotton is replaced to avoid contaminating the etched surfaces.	Yes	No
16. Air/water syringe is purged before being used to dry the tooth.	Yes	No
17. Tooth is dried until it shows a dull chalky appearance.	Yes	No
18. Sealant is applied in a thin even layer; excess removed with a microbrush to avoid pooling of material.	Yes	No
19. An explorer is used to trace the fissures eradicating air bubbles within the material.	Yes	No
20. Student was careful to avoid interproximal areas during application.	Yes	No
21. Curing light placed 1-2mm over sealant and cured for the appropriate amount of time.	Yes	No
22. Curing light tip did not contact the tooth or sealant material.	Yes	No
23. An explorer is used to evaluate the sealant.	Yes	No
24. If there are voids or incomplete coverage of the sealant, additional material is added. Tooth is re-etched if sealant has become contaminated with moisture.	Yes	No
25. After the sealant feels smooth and continuous, floss is used to confirm that inter-proximal areas are free of sealant material.	Yes	No
26. Articulating paper is used to evaluate the occlusion; bite is adjusted if necessary with a slow speed handpiece and a white stone, #6 or #8 bur. Student asks the patient how their "bite" feels.	Yes	No
27. After each sealant is placed, the student will repeat the process from task #9 to #26 for all remaining sealants.	Yes	No
28. When the student feels that all of the sealants are correctly and completely applied, the examining dentist will be asked to evaluate them.	Yes	No

This portion to be completed by the examining dentist

Assistant must make this check off with 100% proficiency.

Separate on each

Manually	Manually
✓	✓
✓	✓
✓	✓

Are applied correctly **PASS**

Are not applied correctly **FAIL**

Examined by the dentist

Date



Willamette
Dental Group

First In Proactive Dental Care

Pit and Fissure Sealants

After successfully passing this course the student will:

- Understand the clinical reasoning for sealant placement
- Demonstrate the correct application for sealants
- Obtain their Sealant Certification; enabling them to legally apply sealants in their state of practice

- Module I

Learning Objectives Module I
At the conclusion of Module I, the
student will be able to:

- Define sealants using clinical and non-clinical terminology.
- Recognize the properties of different sealant materials.
- Identify indications and contraindications for sealant placement.

Learning Objectives Module I

At the conclusion of Module I, the student will be able to:

- Communicate the benefits of sealant application and how sealants relate to preventive dentistry. (pt scenarios)
- Identify sealant retention rates.
- Recognize myths associated with the use, application, and aftercare of sealants.

- Sealants were developed to help prevent carious lesions on the pits and fissures of the molars and premolars.
- Sealants first came to the forefront by the adhesive resin research of Dr. Michael Buonocore in 1965, and put into practice by Simonsen and Stallard in 1967.*
- Research began in the 1960's and the first commercial sealant was released in the early 1970's.

*http://www.dentaleconomics.com/display_article/187325/56/none/none/Feat/Sealed

Ask: Commercially available sealant material was released in what year? (1971)
Emphasize need to study this slide.

- **Clinical Definition:**

- Sealants are resin based materials bonded to the occlusal surfaces and in pits and fissures of teeth to seal these normally occurring structures from the oral environment and bacteria.

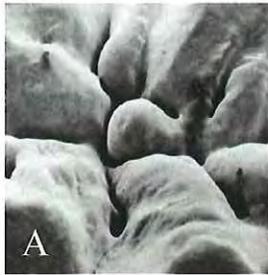
- **Non-Clinical**

- Sealants are made of clear or shaded plastic and are applied on the grooves, pits, and chewing surfaces of the back teeth where childhood decay is often found. They help to “seal out” bacteria, plaque, and food debris to help prevent decay.

- If you are talking with patients or their parents; use non-clinical terminology when explaining what sealants are, how they are applied, and what benefits they provide.

- Sealants inhibit plaque and food debris from collecting in the anatomical pits and fissures of teeth; thus, helping to preventing carious lesions.

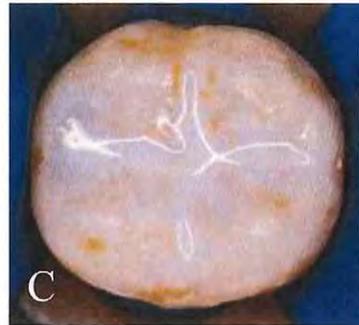
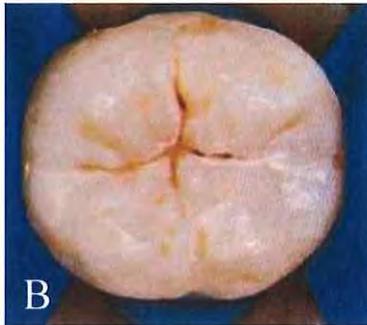
Ask-“Why would a dentist prescribe the placement of a Sealant, what exactly does a sealant do?”



A. Microscopic view

B. Un-sealed tooth

C. Sealed tooth



www.childrensoralcare.ca/faq_prevention.html, www.dcadental.com/sealants.html

- Sealants are resin based materials.
- Some are glass ionomers that release fluoride. Ionomers come from a reaction of silicate glass powder and polyalkenoic acid.
- Can be light cured or self cured.
- Come in different colors; clear, tinted or opaque.
- No one material has been proven to be better than another.

- Store material according to manufacturer directions; some brands stored in fridge.
- Do not expose to elevated temperatures
- Keep away from eugenol containing materials

- Use at room temperature
- Shelf life approx~18-36 months
- Application technique and etch times may vary depending on brand.
- If in doubt, consult manufacturer directions
- Replace lids or caps immediately after use
- DISINFECT all reusable application

Self-Cured

- Two part system containing a base and catalyst; mixing required.
- Can take up to 2 minutes to polymerize (harden).
- Follow manufacturer directions for application and storage.

Light Cured

- One part system, no mixing required.
- Polymerized by a curing light.
- Usually refrigerated and allowed to warm to room temp prior to application.
- Follow manufacturer directions for application and storage.

Caution!

- The dentist is the only one allowed to diagnose the need for sealants.
- An assistant cannot imply, suggest, or recommend sealants under any circumstance.
- An assistant must understand the rationale behind sealant placement but cannot treatment plan their application.

- Dentist prescribes; must be placed within 45 days of diagnosis or re-exam is necessary.
- *Some use sealants for fractured, non-cariou margins on amalgam fillings.
- Non-cariou, deep pits and fissures.
- Tooth is fully erupted with no operculum.
- Moisture control and adequate isolation.
- Patient has a high caries risk due to orthodontia or xerostomia.

Ask “what do you think is an ideal tooth for sealant placement?”

*The decision to apply sealants is completely that of the dentist.

- Pits and fissures are mostly coalesced (smooth).
- Occlusal or inter-proximal decay.
- Incomplete eruption or operculum present.
- Inability to obtain moisture control and isolation.
- Pt has an allergy to component of sealant material.

“So now that you know what situations relate to ideal sealant placement, what situations are not ideal for sealant placement?”

- More cost effective to prevent decay than to repair it.
- Oral health is linked to systemic health.
- Least invasive approach to decay intervention.
- Long term protection potential.

“As we are part of a company that focuses on preventive dentistry, how do you feel that sealants relate to this approach?”

Note:

- Despite their proven benefits, sealants are underutilized in the United States.

- Sealants can be retained for several years.
- Usually last 5 years if applied properly.
- Can last as long as 10 years.
- Protection is reduced or lost when part or all of the sealant is removed or broken.

“How long do you think sealants last?”

*info taken from article from Karina Mascarenhas, B.D.S.,Dr P.H. and Amr M. Moursi, D.D.S., PhD.

And Modern Dental Assisting.

- Sealants are always permanent treatment.
- Flossing and brushing is unnecessary.
- After sealants are applied, fluoride is not needed.
- Sealants do not benefit adults.
- After sealant placement, there is no need for follow up exams.
- Sealed teeth can never get decay.
- Sealants elevate estrogen to harmful levels.*

- Module II

Learning Objectives Module II
At the conclusion of Module II, the
student will be able to:

- Correctly prepare instruments and materials required for sealant application.
- Review the patient's chart for diagnosis date and act accordingly.
- Properly identify and correct any safety hazards related to patient care.

Learning Objectives Module II
At the conclusion of Module II, the
student will be able to:

- Perform a pre-placement oral evaluation and act accordingly depending on findings.
- Place the steps for sealant application in sequential order.
- Evaluate a finished sealant and correct any deficiencies.
- Complete the final evaluation steps.

Armamentarium
(tray set-up/room set-up)

- Basic set-up (mirror, explorer & forceps)
- Etch and sealant material
- Tooth brush or tapered prophyl brush
- Application device.
- Curing light
- Dri-Aids, cotton rolls and holders, 2X2's or rubber dam.
- Air/Water and suction tips.
- Articulating paper and floss
- Slow-speed
- Latch burs: round white stone, #6 or #8 for occlusal adjustment if needed.
- Mixing wells
- PPE

- Review medical history and take necessary precautions. Talk to patient, parent, and doctor about concerns.
- Review chart to confirm teeth to be sealed and diagnosis date.
- If diagnosis is over 45 days old, you must have a Doctor re-examine.

“Why would it be important to review the patients chart before providing treatment?” “What do I mean by necessary precautions?”

RMH- precautions-related to health of pt i.e. reschedule a patient if they are unable to breathe through their nose or are otherwise very ill, BP monitoring if necessary etc . . .

- Patient
 - Review health history, allergies, medications; is history current?
 - Is the patient sick? Consider disease transmission vs. benefit of treatment.
 - Make sure they have protective eyewear.
 - Aspiration concerns.
- Provider
 - PPE: full gown, gloves, mask, and protective eyewear.
 - Infection control.
 - Standard precautions.
 - “Red Packet” if necessary.

Ask “What are some items that a patient could aspirate and what would you do in those scenarios?”

- Check teeth with mirror and explorer to be sealed; consult Doctor for new developments such as: suspicious sticky spots, operculum's, etc . . .
- Anesthesia may be delivered if rubber dam is used. Dependant on patient and doctor preference.

Talk with doctor regarding concerns you may have placing a sealant on a tooth for whatever reason like a large hole in the tooth, bleeding gums, and the like. Avoid discussing concerns directly in front of patient.

Sealant Placement Steps

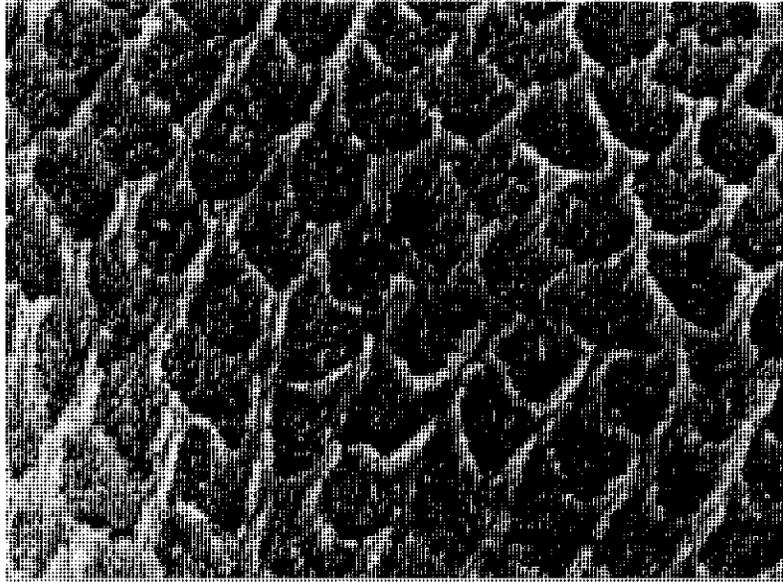
- Confirm diagnosis date; re-exam if indicated.
- Check teeth, consult Doctor with concerns.
- Pre-clean teeth to be sealed
- Isolate and dry teeth
- Etch
- Rinse enamel
- Dry enamel
- Apply Sealant
- Cure Sealant
- Evaluate

Ask “What is the purpose of using a dry brush to pre-clean the tooth?”

- Apply rubber dam if utilized.
- Clean tooth with dry toothbrush or tapered prophylaxis brush, rinse and dry.
- Isolate tooth with cotton products if no dam is used and dry with air/water syringe.

- Etch is composed of phosphoric or citric acid and comes in varying concentrations.
- Etchant produces micro-pores in enamel and allows enamel rods to accept sealant material.
- Etch application times vary; consult manufacturer directions.

Etched Enamel Surface



Avenida Lineu Prestes, 2227 - Caixa Postal 8216
Cidade Universitária Armando de Salles Oliveira
05508-900 São Paulo SP - Brazil

- Use syringe tip to dispense a generous amount over all surfaces to be sealed.
- Pay attention to soft tissues as etch is caustic and can cause burns. If etch contacts tissue, rinse thoroughly.
- Use explorer to “sink” etch into grooves and pits. Wipe explorer after contacting etchant.
- Follow manufacturer etch times. It is essential that etch is allowed to work long enough for proper sealant adhesion.

Etchant should extend slightly beyond the anticipated sealant application area.

- Use HVE and air/water syringe to completely rinse away etchant.
- Rinse for 20-30 seconds before drying.
- Replace wet cotton if needed.
- Avoid using air/water “spray” as it tends to splatter the etch.
- Clear water from syringe and dry the enamel until it appears chalky and dull.
- Evaluate tooth surface for residue, debris, or non-etched surfaces.

HVE is placed over etchant for at least 5 seconds to remove as much etch as possible before rinsing. This avoids spattering of etchant.



Fig. 6. The teeth after etching, rinsing, and drying.

“When would you need to restart the etch process?”
www.agd.org/publications/articles/?ArtID=2502

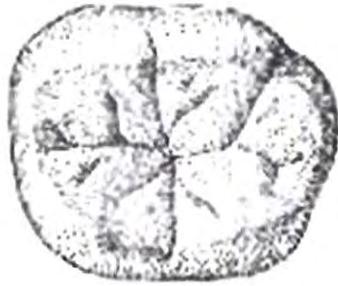
Start Over?

- If enamel does not appear dull and chalky, re-etch.
- If the enamel becomes contaminated with moisture of **any** kind before the sealant is placed or completely cured, re-etch. Or the sealant will not adhere.
- Moisture contamination is the main cause of sealant retention failure.

- Use application method recommended by manufacturer.
- Mixing-well and “quick-tip” or direct application.
- Apply a THIN even layer of material. Use microbrush to remove excess.
- Trace fissures with explorer to remove bubbles and increase flow of material.
- Avoid inter-proximal application.

“Why do air bubbles need to be removed?”

If air bubbles are incorporated into the material, it provides an inferior bond and the material will not “seal” properly. The sealant will be weakened.



- Self-cure
 - Will start to set immediately and should fully polymerize in 2 minutes.

- Light-cure
 - Position light cure tip 1-2mm over sealant; do not touch the tooth or sealant material.
 - Curing times range from 20-30 seconds for each surface. Follow manufacturer instructions.

- Run explorer over sealed area.
 - Should feel smooth and continuous.
 - If there are voids or sealant chips away, re-etch and re-apply.
- *If the tooth has not been contaminated, additional sealant material can be applied. If contamination has occurred, re-etch and apply.

Attempt to pry the sealant off the tooth; if sealant chips away it must be re-applied. Usually a sealant will chip off with an explorer if it was not etched properly.

- Use floss to check contacts.
- Use articulating paper to check occlusion.
- Dental Assistant may adjust with slow-speed white stone, #6 or #8.

**“What are two important checks that you must complete?”
Explain what a “high” sealant looks like.**

- Wipe sealant with cotton roll or 2X2 to remove air-inhibited layer of the non-polymerized resin.
- Dentist or hygienist must check sealant prior to patient being dismissed.
- Allow patient to rinse with mouthwash.
- Enter appropriate codes and descriptions in the chart.
- Dismiss patient.

“

- Module III

Learning Objectives Module III
At the conclusion of Module III, the
student will be able to:



- Identify the supervision requirements of Oregon, Washington and Idaho.
- Define Willamette Dental's supervision policy.
- Recognize the evaluation interval of sealants after application for quality control purposes.
- Ask questions

- **Oregon**
 - OR EFDA may place sealants under indirect supervision with certification.
- **Washington**
 - WA RDA may place sealants under close supervision.
 - WA EFDA may place sealants under general supervision with certification.
- **Idaho**
 - ID EFDA may place sealants under direct supervision with certification.

Emphasize need to study this slide!

Because the guidelines for each state are different, Willamette Dental has created a guideline for all employees to follow.

- Licensed dentist must diagnose the condition to be treated.
- Dentist has authorized treatment.
- Must be physically present in the treatment facility during provided services.

“What is Willamette Dentals supervision policy?”

- The appropriate codes and tooth numbers are completed in the EHR.
- Template note needs to be completed.
- Any complications that were encountered are noted.
- Dentist or hygienist must evaluate sealant before patient dismissal.

Complications include: hard to isolate, pt cried, slight operculum etc. . .

Remember
Even if state guidelines are less
strict; one must follow Willamette
Dentals supervision policy.

- Successful sealant performance requires meticulous application and complete isolation.
- Regular checkups are necessary to determine if sealants are in-fact and dentition is non-carious.
- Margins should be closely inspected.
- Sealants should be checked at each visit and/or at least once annually.

“How often do sealants need to be examined?”

Questions?

**Oregon Board of Dentistry
Committee and Liaison Assignments
May 2014 - April 2015**

STANDING COMMITTEES

Communications

Purpose: To enhance communications to all constituencies

Committee:

Todd Beck, D.M.D., Chair	Barry Taylor, D.M.D., ODA Rep.
Mary Davidson, M.P.H., R.D.H., E.P.P.	Gail Aamondt, R.D.H., M.S., ODHA Rep.
Alton Harvey, Sr.	Linda Kihs, CDA, EFDA, MADAA, ODAA Rep.

Subcommittees:

- Newsletter – Todd Beck, D.M.D., Editor

Dental Hygiene

Purpose: To review issues related to Dental Hygiene

Committee:

Mary Davidson, M.P.H., R.D.H., E.P.P., Chair	David J. Dowsett, D.M.D., ODA Rep.
Amy Fine, D.M.D.	Kristen L. Simmons, R.D.H., B.S., ODHA Rep.
John Tripp, R.D.H., E.P.P.	Mary Harrison, CDA, EFDA, EFODA, ODAA Rep.

Enforcement and Discipline

Purpose: To improve the discipline process

Committee:

Julie Ann Smith, D.D.S., M.D.- Chair
Mary Davidson, M.P.H., R.D.H., E.P.P.
James Morris

Subcommittees:

Evaluators

- Julie Ann Smith, M.D., D.D.S., Senior Evaluator
- Todd Beck, D.M.D., Evaluator

Licensing, Standards and Competency

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

Committee:

Jonna Hongo, D.M.D., Chair	Daren L. Goin, D.M.D., ODA Rep.
Gary Underhill, D.M.D.	Lisa J. Rowley, R.D.H., M.S., ODHA Rep.
John Tripp, R.D.H., E.P.P.	Mary Harrison, CDA, EFDA, EFODA, ODAA Rep.

Rules Oversight

Purpose: To review and refine OBD rules

Committee:

Todd Beck, D.M.D., Chair	Jill M. Price, D.M.D., ODA Rep.
Alton Harvey, Sr.	Lynn Ironside, R.D.H., ODHA Rep.
Mary Davidson, M.P.H., R.D.H., E.P.P.	Bonnie Marshall, CDA, EFDA, EFODA, MADAA, ODAA Rep.

LIAISONS

American Assoc. of Dental Administrators (AADA) — Patrick D. Braatz, Executive Director

American Assoc. of Dental Boards (AADB)

- Administrator Liaison – Patrick D. Braatz, Executive Director
- Board Attorneys' Roundtable – Lori Lindley, SAAG - Board Counsel
- Dental Liaison – Jonna Hongo, D.M.D.
- Hygiene Liaison – Mary Davidson, M.P.H., R.D.H., E.P.P.

American Board of Dental Examiners (ADEX)

- House of Representatives – Jonna Hongo, D.M.D.
- Dental Hygiene House of Representatives - District 2, Mary Davidson, M.P.H., R.D.H., E.P.P.*
- Dental Exam Committee – Jonna Hongo, D.M.D.
- Dental Hygiene Exam Committee - District 2 Representative, Matt Tripp, R.D.H., E.P.P.*

North East Regional Board (NERB) Steering Committee

- Julie Ann Smith, D.D.S, M.D.
- Matt Tripp, RDH. E.P.P.
- Jill Mason, M.P.H., R.D.H., E.P.P.

Oregon Dental Association – Brandon Schwindt, D.M.D.

Oregon Dental Hygienists' Association Matt Tripp, R.D.H.,E.P.P.

Oregon Dental Assistants Association – Brandon Schwindt, D.M.D.

Western Regional Exam Board (WREB)

- Dental Exam Review Committee – Jonna Hongo, D.M.D
- Hygiene Exam Review Committee – Matt Tripp, R.D.H., E.P.P.

OTHER

Administrative Workgroup

Purpose: To update Board and agency policies and guidelines. Consult with Executive Director on administrative issues. Conduct evaluation of Executive Director.

Committee:

Brandon Schwindt, D.M.D, Chair
Mary Davidson, M.P.H., R.D.H., E.P.P.
Alton Harvey, Sr.

Subcommittee:

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

- Brandon Schwindt, D.M.D.
- Alton Harvey, Sr.
- Jonna Hongo, D.M.D.

Anesthesia

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

Committee:

Julie Ann Smith, D.D.S, M.D., Chair
Brandon Schwindt, D.M.D.
Rodney Nichols, D.M.D.
Daniel Rawley, D.D.S.
Mark Mutschler, D.D.S.
Jay Wylam, D.M.D.
Normund Auzins, D.M.D.
Eric Downey, D.D.S.
Ryan Allred, D.D.S.

*Not Selected by the OBD

Presentation on Oregon Public Meetings Law



Senior Assistant Attorney General, Lori Lindley

**BOARDS & COMMISSIONS
ETHICS LAW SUMMARY**

DISCLAIMER: THIS IS ONLY A GENERALIZED SUMMARY AND IS NOT INTENDED TO BE LEGAL ADVICE. PLEASE REVIEW ORS CHAPTER 244 AND CONSULT AN ATTORNEY OR THE ETHICS COMMISSION FOR ADVICE ABOUT YOUR SPECIFIC SITUATION.

Gifts (Except Entertainment)

- **Receiving Gifts:** As a public official, you may not receive gifts worth more than \$50 total per calendar year from a source *with any administrative or legislative interest in your board or commission*.
 - Note: This rule applies regardless of whether you are paid for your service on a board or commission.
 - People you live with as well as your immediate relatives are bound by this rule and cannot receive gifts worth more than \$50 total per calendar year from a source with any administrative or legislative interest in your board or commission.
 - "Legislative or administrative interest" means an economic interest, distinct from that of the general public, in your board or commission's actions.
- **Giving Gifts:** Gift limit does not apply when you are giving gifts to persons who are *not* public officials (or their relatives or members of household).
- **Relative Exception:** Gift limit does not apply to gifts you receive from people you live with or certain relatives (including your spouse, domestic partner, children, siblings and parents).
- **Political Contribution Exception:** Limit does not apply to political contributions.

Food & Drink

- Generally, gift rules and exceptions apply to food and drink.
- **Reception Exception:** You may enjoy *incidental* food and drink that is free to everyone at receptions (does not include sit-down dinners).
- **Speaker or Panel Member Exception:** You may enjoy food or drink when you speak or answer questions as part of a scheduled program.
- **Government / Membership / Nonprofit Exception:** You may enjoy food or drink at an official meeting or convention, or on a fact-finding mission if paid for by:
 - Federal, State or local government;
 - Tribal government;
 - Membership organization to which your board or commission pays dues; or
 - 501(c) (3) nonprofit organizations that receive < 5% of funding from private sources.

Travel

- Generally, gift rules and exceptions apply to gifts of travel.
- All travel paid for by a 3rd Party should be *pre-approved* by your board or commission.
- **Carpool Exception:** You can travel together with another public official to an in-state event you are attending in your official capacity without splitting the cost of travel.
- **Government / Membership / Nonprofit Exception:** Travel and reasonable expenses to attend an official meeting or convention, or on a fact-finding mission if paid for by:
 - Federal, state or local government;
 - Tribal government;
 - Membership organization to which your board or commission pays dues; or
 - 501(c) (3) nonprofit organizations that receive < 5% of funding from private sources.

- **Economic Development Exception:** Certain travel to engage in trade or fact-finding missions.

Entertainment

- **No gifts** of entertainment from any source with a legislative or administrative interest in your board or commission (not even gifts worth less than \$50).
- **Incidental Entertainment Exception:** may enjoy incidental entertainment at an otherwise permissible event (e.g. the guitarist in the corner).
- **First Pitch Exception:** acting in an official capacity for a ceremonial purpose (i.e., first pitch, ribbon cutting).



ORS 260.432 Quick Reference— Restrictions on Political Campaigning for Public Employees rev 12/13

Generally, ORS 260.432 states that a public employee* may not, while on the job during working hours, promote or oppose election petitions, candidates, political committee or ballot measures. Additionally, no person (including elected officials) may require a public employee (at any time) to do so.

*A "public employee" includes public officials who are not elected, whether they are paid or unpaid (including appointed boards and commissions).

As used in this Quick Reference

We use the phrase "advocate(s) a political position" to mean—

promote or oppose an initiative, referendum or recall petition, candidate, political committee or ballot measure.

The term "impartial" means equitable, fair, unbiased and dispassionate.

See the Secretary of State's detailed manual on ORS 260.432 for specific factors to assist in ensuring impartiality in communications about ballot measures. It is posted on the website under Election Laws, Rules and Publications, Manuals and Tutorials.

For more detailed information about ORS 260.432 and information about other election laws, contact:

Elections Division	phone	503-986-1518
Secretary of State	fax	503-373-7414
255 Capitol St NE, Suite	tty	503-986-1521
Salem, OR 97310	web	www.oregonvotes.gov

Prohibited Activities

A public employee, while on the job during work hours may not:

- prepare or distribute written material, post website information, transmit emails or make a presentation that advocates a political position
- collect funds, prepare filing forms or correspondence on behalf of candidates or political committees
- produce or distribute a news release or letter announcing an elected official's candidacy for re-election (except for an elections official doing so as an official duty) or presenting an elected official's political position
- make outgoing calls to schedule or organize campaign events or other political activity on behalf of an elected official or political committee (however, a scheduler may, as part of official duties, take incoming calls about the official's availability and add an event to the schedule)
- grant unequal access to public facilities to candidates or political committees
- direct other public employees to participate in political activities, when in the role of a supervisor
- draft, type, format or edit a governing body's resolution that advocates a political position (except to conform the resolution to a standard format)
- prepare or give recommendations to the governing body urging which way to vote on such a resolution
- sign such a resolution, except if the signature is only ministerial and clearly included to attest the board took the vote
- announce the governing body's position on such a resolution to the media
- include the governing body's position or vote on such a resolution in a jurisdiction's newsletter or other publication

A public employee who provides voter registration assistance under the federal National Voter Registration Act (NVRA) must not, when performing voter registration services, influence a client's political choices. This means no display of political preferences, including a restriction that no political buttons may be worn. ORS 247.208(3)

Allowable Activities

A public employee, while on the job during working hours may:

- prepare and distribute impartial written material or make an impartial presentation that discusses election subjects (using the guidelines provided in the Secretary of State's detailed manual on ORS 260.432.)

The Secretary of State's Elections Division is also available for an advisory review of draft material about ballot measures produced by government agencies.

- perform standard job duties, such as taking minutes at a public meeting, maintaining public records, opening mail, inserting a proposed resolution into a board agenda packet, etc.
- impartially advise employees about possible effects of a measure, but not threaten them with financial loss to vote a particular way
- address election-related issues while on the job, in a factual and impartial manner, if such activity is legitimately within scope of employee's normal duties
- as staff of an elected official, handle incoming calls about the official's availability for political events
- prepare neutral, factual information for a governing body to use in determining what position to take on an issue (planning stage of a governing body's proposed issue before certified as a measure to a ballot is not subject to ORS 260.432)
- in a clerical manner, incorporate amendments into a finalized version of a governing body's resolution on an issue respond to public records request for information, even if the material advocates a political position
- wear political buttons subject to applicable employer policies unless the public employee is providing voter registration services under NVRA, where additional restrictions apply - see note on previous page about ORS 247.208(3)

A public employee, on their own, off duty time, may send letters to the editor that advocate a political position and may participate in any other lawful political activity.

It is advised that a salaried public employee keep records when appropriate in order to verify any such political activity that occurs while off duty.

Prohibited and Allowable Activities for Elected Officials*

*includes a person appointed to fill a vacancy in an elective public office

Elected officials may:

- advocate a political position at any time. Elected officials are not considered a "public employee" for purposes of ORS 260.432. ORS 260.432(4)(a).
- vote with the other elected officials of a governing body (such as a school board, city council or county commission) to support or oppose a measure, and publicly discuss such a vote—but must not use the public employee staff time to assist in this, except for ministerial functions
- perform campaign activity at any time, however must take caution not to involve any public employee's work time to do so

Elected officials may not:

- in the role of a supervisor, request a public employee—whether the public employee is on or off duty—to perform any political activity
A request made by a person in a position of supervisor or superior is viewed as a command for purposes of this election law.
- have an opinion piece or letter advocating a political position published in a jurisdiction's newsletter or other publication produced or distributed by public employees

Department of Justice



2012 Public Meetings Training

1

Department of Justice



June 27, 2014
Oregon Board of Dentistry
Oregon Public Meetings Training

Presented by:
Lori Lindley, Assistant Attorney General
General Counsel Division, Business Activities Section

Oregon Public Meetings Law



Overview Public Meetings Law Format

- Fictional Board – Help Convey Concepts
- Time at End for Questions
- 2 Documents Packet
- Tan - Powerpoint Notes
- White - Substantive Materials

Let's Get Started....

3

Oregon Public Meetings Law



- **Purpose: Open government – 1973 “Sunshine Laws”**
- **ORS 192.610 to 192.690, ORS 244.350 and OREC Enforcement Provisions**
(Reference: AG’s Manual on Public Records and Public Meetings)

Open Decision Making by Public Bodies

ORS 192.620 – Purpose – Open form of government requires an informed public aware of deliberations and decisions of governing bodies and the information on which such decisions are made.

Intent of ORS 192.610 to 690 – Decisions of Governing Bodies Arrived at Openly

4

Bodies Subject to Law

- Covers Meetings of a “governing body” of a “public body” for which a quorum is required to make a decision or deliberate to a decision on any matter.
- “Public body” – includes state, city, county, district, etc., and boards, commissions, departments, or any subcommittee or advisory groups of those entities. ORS 192.610(4)
- “Governing body” – members of public body with two or more members. ORS 192.610(3).
 - With authority to
 - Make decisions for or
 - Recommend actions to a public body
 - On policy or administration

Does not include an individual official.

5

Examples of Bodies Subject to Law:



- Five member city council. (Yes)
- Seven member state board. (Yes)
- Three member subcommittee of seven member state board (yes, *if* authority to make decisions for or recommendations – not making individually).
- Rulemaking advisory committee appointed by a state board. (Yes)
- Rulemaking advisory committee of elected official like A.G. (No)
- NLB – 5-Member Board formed by Legislature appointed by Oregon Technology Taskforce (?)

6

Meetings Subject to Law



Meeting Defined – ORS 192.610(5)

- Convening of governing body "For which a quorum is required" to make a decision or deliberate toward a decision on any matter.
 - Includes general information gathering – except for exception for onsite inspections
 - Includes working lunches
 - Includes meetings using electronic media

Quorum Present

- **Quorum** - General Statute ORS 174.130
 - Authority conferred upon three or more persons may be exercised by majority.
 - Requires majority of all members, not just those present.
- **Specific Quorum Statute** – ORS 670.300(2) – Majority of members of Boards constitutes quorum for transaction business – applies to BOA, CCB, LCB, OSBGE, etc.
- **Less Than Quorum** – Not Meeting for Public Meeting Law Purposes – cannot make decisions or conduct official business

- **Board or Commission with no quorum statute: AG Manual C-8, Table I – Appendix 5**
- **Board or Commission with statute specifying quorum: AG Manual C-9, Table II – Appendix 6**

NLB – Assume 174.130 Applies - 3 members for Quorum and voting
- All 3 have to vote in favor action make decision

7

Meetings Not Subject to the Law

- On-site inspection Project or Program. Exception to information gathering activities. ORS 192.610(5) – Excluded from definition of meeting.

Limitations:

- Observe, but not deliberate
- General Purpose - for when due to practicality of situation cannot have public there
- Rarely used
- PUC site visit Qwest Central Switching Office
- Board of Education – visit Head Start Program
- Boxing Commission – Fight Venue

- Attendance at national, regional or state association meetings. ORS 192.610(5) – Excluded from definition meeting

8

Meetings Not Subject to the Law (Cont'd)



- Purely social gatherings.
 - Beware of quorum discussing official business – annual Board BBQ/Picnic – cannot discuss business
- Otherwise exempt. Examples:
 - State agency deliberations in a contested case only exempts deliberations – not other parts of meeting. ORS 192.690
 - Judicial Proceedings
 - Medical Peer Review Committees under ORS 441.055

9

Procedures: Place of Meeting



- Held within "geographic boundaries". ORS 192.630(4)
 - Exceptions for Training Sessions (no deliberations towards decision); Emergency Meetings necessitate immediate action.
- Nondiscriminatory location. ORS 192.630(5)
 - Accessible to persons with disabilities. Hearing impaired – special rules – ORS 192.630(5).
 - 48 hours prior notice of request to agency
 - Good faith effort by agency have interpreter present
 - Agency pay costs
- No smoking.
- Open to public unless Executive Session.

Public Attendance only. No requirement for public participation unless specific statute provides otherwise.

Note: other laws may require opportunity for public comment on certain actions, e.g. ORS 215.060.

10

Procedures: Notice

- Regular Meetings: Notice in advance reasonably calculated to give notice to "interested persons including news media that have requested notice." Notice of *time place, anticipated principal subjects on agenda* (can add additional items) – ORS 192.640(1). Subjects come up not anticipated – can consider statement regarding accessibility requirements and person contact about request for interpreter or hearing impaired accommodations.
- Special Meetings: 24 hours' notice
- Emergency Meetings: Notice appropriate under circumstances. Need an actual emergency, minutes must reflect reason scrutinized by Appellate Court. Who gives notice to:
 - News Media
 - No requirements to have published
 - General AP service and local Media Representatives adequate
 - Mailing List
 - Interested persons
 - Maintained by Agency
 - Posting
 - NLB Notice
 - Complies
 - What about wrong name location - Probably still reasonable calculation to give notice interested persons

11

Procedures: Minutes or Recording

- Written minutes or recording
- Must show:
 - Members present
 - Motions, resolutions, etc.
 - Result of votes by name if not unanimous
 - Substance of discussion – "true reflection" – not verbatim – what discussed and views of participants – ORS 192.650(1)
 - Reference to any document discussed, subject to Public Records Law
- If Not Recording — Designated Minute Taker
- Made Available to public in a reasonable time after meeting. ORS 192.650(1)
 - Not reasonable, wait until approved
 - What's reasonable depends on length, extent of meeting, issues discussed
 - Allows for consultation with counsel

12

Procedures: Electronic Meetings

- Telephone conference calls and other electronic meetings allowed.
- Must provide Notice and opportunity for public access.
- Problem: A quorum using contemporaneous email or "IM" or Chat Rooms
 - Key - If virtually simultaneous communication or interaction by Quorum → is meeting
 - If communication like traditional letters set by ordinary mail, courier, or fax → OK, not meeting.
- NLB 3 Board Members texting back and forth on cell phones about Gates application → Meeting subject to public meetings law?

13

TRISH'S TEXT MESSAGE



- Not Present in Person or by Phone
- Communication Through Board Member
- OK?
- No.

14

Voting Meeting Administration

- Public vote required when governing body takes official action (exercise of governmental authority)
- Body with under 25 members must reflect the vote of each member.
- NO:
 - Proxy votes cast on behalf person not present at meeting,
 - Absentee vote in advance ballot,
 - Vote in advance by mail
- Absent Specific Statutory Authority → Improper
 - Can only make decision at meeting where Quorum present
 - No Board Member empowered to delegate vote to others.



15

Procedures: Executive Sessions

- "Executive session" – part or all of meeting that is closed to certain persons for deliberations.
 - Don't confuse with exemptions from law.
 - Executive session is still a "public meeting" – i.e., subject to notice, etc.

16

Procedures: Executive Sessions
– **Special Rules**

- Notice of meeting states the specific legal provision authorizing the executive session.
- Chair must announce statutory authority for exec. session before going into executive session.
- No final action or making any final decision in executive session. (Can use session to reach informal consensus).

17

Procedures: Executive Sessions
– **Subjects Allowed**



Permissible subjects (ORS 192.660):

- Consider the employment of a public officer, employee, staff or agent. (ORS 192.660(2)(a)). Subject to conditions of ORS 192.660(7).
- Discipline of public officers and employees; consider the dismissal or discipline of a public officer, employee or staff member or hear complaints or charges brought against said person. (ORS 192.660(2)(b)).
- Considering matters pertaining to the function of the medical staff of a public hospital licensed under ORS Chapter 441.

18

Procedures: Executive Sessions – Subjects Allowed (Continued)

Permissible subjects (ORS 192.660):



- D. To conduct deliberations with persons designated by the governing body to carry out labor negotiations. (ORS 193.660(2)(d)).
- E. To deliberate with persons designated to negotiate real property transactions. (ORS 192.660(2)(e)).
- F. To consider information or records that are exempt by law from public inspection. (ORS 192.660(2)(f)).

19

Procedures: Executive Sessions – Subjects Allowed (Continued)

G. Negotiations involving matters of trade or commerce in which the governing body is competing. (ORS 192.660(2)(g)).



- H. For consultation with counsel concerning legal rights and duties regarding current litigation or litigation likely to be filed. (ORS 192.660(2)(h)).
- I. To review and evaluate the job performance of a chief executive officer or other employees or staff. (ORS 192.660(2)(i)).
- J. To carry on negotiations under ORS chapter 293 with private persons or businesses regarding acquisition exchange or liquidation of public investments. (ORS 192.660(2)(j)).

20

Procedures: Executive Sessions – Subjects Allowed (Continued)

K. To consider information obtained by a health professional regulatory board as part of an investigation of licensee or applicant conduct. (ORS 192.660(2)(k)).

L. The State Landscape Architecture Board may go into executive session to consider information obtained as part of an investigation.

M. To discuss review or approval of programs relating to the security of a number of specified structures, activities and materials relevant to the operation of the state's infrastructure.

21

Executive Session – Sample Notice

- a. Consideration of uber-nerd license application. Agency Case Number 3.14159, pursuant to ORS 192.660(2)(k)
- b. Consideration of appeal to Supreme Court in *Sandkickers Inc. v. Nerd Licensing Board*, Oregon Court of Appeals, Agency Case Number NCC1701, including consideration of information exempt by law from public inspection, pursuant to ORS 192.660(2)(h) and (2)(f).

22

Executive Session – Alternative Sample Notice

- a. Consideration of information obtained as part of an investigation by health professional licensing board pursuant to ORS 192.660(2)(k).

23

Procedures: Executive Sessions – News Media

- News media permitted.
- Can require news media not to report, except to state the general purpose.
- If not directed properly – media can report.
- No right to copy of exempt documents being reviewed.
- No right to record executive session.
- If exceed scope of properly announced basis – can report on such matters.



24

Executive Session

– Practical Tips



- Use checklist – Appendix 3
 - properly refer to statute; make sure all purposes for executive session identified.
- Use script – Appendix 4
 - properly refer to statute again.
- Stay within announced scope. Help other members to stay on track. Minutes/recordings of Executive Session discussions of unauthorized subjects subject to public disclosure.
- Can use session to reach informal consensus – but always vote in open session.

25

Tips for Pre-Meeting Planning

- **Will you allow public comment?** (A policy choice. If provided, consider where to place comments on the agenda – beginning or end of meeting).
- **Committing to Timelines on Agenda** (Agenda may be amended in general session. But if items are moved to an earlier time, public may not attend discussion. Consider whether a timeline will be helpful or a hindrance).
- **Security Concerns** (Is location secure? Should law enforcement be present? What to do about individuals who have disrupted prior meeting?).

26

Legislative Updates

- Senate Bill 2 (Oregon Equality Act) [Effective 1/1/08]. Amends ORS 192.630(3) to prohibit using meeting place where discrimination on the basis of sexual orientation is practiced.
- Senate Bill 83 [Effective 1/1/08]. Amends ORS 192.630 to change references to the disabled to “persons with disabilities” and references to deaf or hard-of-hearing persons to “persons who are deaf or hard of hearing.”

27

Public Meetings Violations
- Enforcement of Executive Session Violations

- OGE (HB 2595 and SB10 formerly GSPC) investigates executive session violations – ORS 192.685(1) and 244.260 – Not role of A.G. or D.A.
- OGE may impose civil penalties up to \$1,000 for violations – ORS 244.350(2).
- No civil penalty if relied upon advice public body's counsel. (Must be ORS chapter 180 – not just any attorney can be state agency's legal counsel). ORS 244.350(2).
- State Agencies
 - Can be SAAG
 - Not Private Attorney
 - Not Board Member also Attorney
 - Not Administrator also Attorney

NLB could not rely on counsel → Not Present. 2 Potential Violations:
 1. Voted Executive Session on License Application
 2. Discussed topic not on Agenda and not appropriate for Executive Session

28

Public Meeting Law Enforcement
– Private Right of Action

- "Any person affected by a decision" may sue for injunctive or declaratory judgment action for violation of Public Meetings Law.
 - Suit filed within 60 days of becoming a public record ORS 192.680(5)
 - Decision not voided if properly "reinstated" – Redo & Do It Right – Effective as if done right to begin with
 - Intentional disregard for law may still void decision. ORS 192.680(3) → Even if properly reinstated
- Equitable relief and attorney fees and costs → ORS 192.680(4)
- Potential personal liability for court costs and attorney fees for governing body for "willful" violations
 - > Each member or members engaged in willful conduct
 - > Joint and Several Liability

29

Confidentiality ORS 676.175

WHAT DOES IT COVER?

**INVESTIGATION
 HEARING
 EXHIBITS AND DOCUMENTS
 PROPOSED ORDER
 EXECUTIVE SESSION
 DISCUSSIONS
 BOARD DELIBERATIONS**

30

What's open to the public?

**PROPOSED NOTICES FOR DISCIPLINE
EMERGENCY SUSPENSIONS
FINAL CONSENT ORDERS
FINAL ORDERS**

31

Cases: Dumdi v. Lane County Commissioners

- **City Counselors had various e mail and phone conversations; formed a quorum; did not give public meeting notice**
- **Tallied the votes in advance for a budget supplement; knew the votes in advance**
- **Court found public meeting violations; held personally liable for costs and attorney fees**

32

Are you covered?

- **Risk Management, a division of Department of Administrative Services will cover you under Board premium**
- **Actions must be in course and scope of your duties as a board member; ie, not covered if you assault someone at meeting**

33

FILED
AT 12:42 O'CLOCK 4 M

JAN 18 2011

Circuit Court For Lane County, Oregon
BY 

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27

IN THE CIRCUIT COURT FOR THE STATE OF OREGON
FOR THE COUNTY OF LANE

ELEANOR S. DUMDI,
EDWARD M. ANDERSON,

Plaintiffs,

v.

ROB HANDY, PETER SORENSON,
and BILL FLEENOR, individuals, and
LANE COUNTY BOARD OF
COMMISSIONERS, a governing
body of Lane County Oregon,

Defendants.

Case No. 16-10-02760

Findings of Fact and
Conclusions of Law

The above matter came on for trial on December 8 through 10, 2010. The court heard the sworn testimony of witnesses, received exhibits and considered the arguments of counsel. The court sets out below its findings of fact and conclusions of law on the issues raised in the pleadings and at trial, including its opportunity to evaluate the credibility of the witnesses.

Findings of Fact

Lane County, Oregon, a political subdivision of the State of Oregon, is governed by a five member Board of Commissioners [hereinafter the "Board"]. At all times relevant to this proceeding, the Board was comprised of Rob Handy, Peter Sorenson and Bill Fleenor, all individual defendants in this case, as well as Faye Stewart and Bill Dwyer [hereinafter "Handy", "Sorenson", "Fleenor", "Stewart" and "Dwyer" respectively]. Each of the five individual commissioners are elected from districts, each district representing one part of a five part division of the County. An

1 affirmative vote of at least three commissioners is required to take any formal action
2 by the Board. Dwyer testified at trial that commissioners regularly speak to each
3 other about county business.

4 Lane County's administration is generally located in the "CAO", which stands
5 for County Administrative Offices. Each commissioner has an office in that area.
6 Lane County government is managed by an appointed administrator who is
7 accountable to the Board. At all times relevant to this proceeding, Jeff Spartz was
8 the Lane County Administrator [hereinafter "Spartz"]. Lane County also employs
9 attorneys in the County Counsel's office. At all times relevant to this proceeding,
10 that office was managed by Liane Richardson who held the position of County
11 Counsel for Lane County [hereinafter "County Counsel"]. One of County Counsel's
12 responsibilities was to provide legal advice to the Board regarding the conduct of
13 county business.

14 Handy first assumed the office of commissioner in January 2009. At the time
15 of trial, Fleenor was concluding his first four year term as a commissioner. He did not
16 run for re-election his term is set to expire in January 2011. The evidence did not
17 establish when Stewart first assumed the office of commissioner, but his service
18 included all periods relevant to this proceeding. At the time of trial, Dwyer had been
19 a commissioner for approximately 12 years. Sorenson has been a commissioner since
20 1997. During the year 2009 Sorenson acted as the Board Chair. In addition to
21 presiding over the meetings of the Board, he set the agenda. Sorenson has
22 substantial prior governmental experience, including serving in the Oregon Legislature.
23 Sorenson is also an attorney who has worked with the Oregon Public Meetings law,
24 ORS 192.610, *et. seq.*

25 At issue in the present case is the Lane County budget for fiscal year 2009-
26 2010. In particular, plaintiffs challenge the actions of the individual defendants and
27 the Board leading up to the adoption of Fiscal Year 2009-2010 Supplemental Budget

1 #2, adopted on December 9, 2009 [hereinafter "Supplemental Budget #2"].
2 Specifically, plaintiffs are aggrieved by the inclusion in that amended budget of 1.7
3 FTE (full time equivalents) which money was used and/or intended to be used¹ to
4 fund a one-half time assistant for each commissioner.² The particular posture of this
5 case involves plaintiffs' complaint about the events surrounding re-allocation of funds
6 to be used for these particular positions. Supplemental Budget #2 was adopted with
7 Handy, Sorenson and Dwyer voting to adopt and Stewart and Fleenor voting to
8 oppose adoption.

9 The public funds involved in Supplemental Budget #2, which were reallocated
10 to these particular positions, had already been allocated to be spent in Lane County's
11 2009-2010 budget year, albeit for different purposes/positions. That occurred with
12 the adoption of the 2009-2010 Lane County Budget on June 24, 2009. Exhibit 302.

13 The individual plaintiffs are each Oregon electors and taxpayers domiciled in
14 Lane County, Oregon. The individual plaintiffs oppose the expenditures contained in
15 Supplemental Budget #2, and in particular each oppose the decision to expend
16 taxpayer money to hire new office support staff for Lane County Commissioners.
17 The individual plaintiffs believe Lane County is facing a budget crisis and cannot
18 afford basic services, including keeping criminals in jail.

19 The particular positions, which would be funded by the 2.5 FTE, have been
20 called by several titles. The official title for the position is "Constituent Service
21 Aide."³ For all purposes in this case, the position will hereinafter be referred to by

22 _____
23 ¹Not all commissioners have filled or intended to fill the position for their particular assistant.

24 ²A total of 2.5 FTE's was necessary to fully fund the positions (five .5 FTE positions).
25 Because there was already .8 FTE in the budget for an un-filled position, that .8 FTE could be used
26 for this purpose. It was necessary to only create an additional 1.7 FTE to fully fund these positions.

27 ³It is unclear how this could have been the official title of the position before December 9,
2009, as neither that title nor any reference to "commissioner aide" or "commissioner assistant"
appears in any Lane County budget document this court has seen or heard about.

1 the court as a "commissioner aide." Commissioner aides, or something similar to the
2 positions created and funded in Supplemental Budget #2, have previously existed as
3 a part of Lane County Government, but those positions were eliminated in previous
4 years' budget processes when they were not funded. When Lane County
5 Commissioners last had commissioner aide positions available was not established by
6 the evidence.

7 Plaintiffs' complaint is focused on the events surrounding the adoption of
8 Supplemental Budget #2. However, their evidence addresses the Lane County budget
9 process for 2009-2010 starting in the early spring of 2009. The general budget
10 process, for the adoption of the annual budget, begins in the spring of each year with
11 the county's Budget Committee. That is a process of several meetings culminated
12 by the approval of a budget that is a recommendation to the Board. The Board then
13 goes through a process wherein they may make adjustments to the approved budget
14 (within limits) culminating in the adoption of the annual budget by the Board by July
15 1 of each year.

16 In Lane County, the Budget Committee is comprised of five county citizens and
17 the five elected commissioners. Each Lane County Commissioner nominates a
18 particular individual for the Budget Committee who is then presented to the Board.
19 The Board, in a formal action, then decides on the appointment of that individual to
20 the annual Budget Committee for that particular year. As part of the 2009-2010 Lane
21 County budget process, the individual defendants appointed: Sorenson - Alice
22 Kaseberg; Fleenor - Cindy Land; and, Handy - Rose Wilde [hereinafter "Kaseberg",
23 "Land" and "Wilde" respectively]. Those appointees were formally appointed to the
24 2009-2010 Lane County Budget Committee by the Board.

25 In the conduct of its business, the Board has adopted a set of rules. Exhibit
26 33. Those rules include provisions relating to the formal conduct of Board business
27 as well as rules concerning individual board members' direction to staff whereby

1 requested staff time would exceed 15 minutes, *i.e.*, the "15-minute Rule." Exhibit
2 33, page 9. As it relates to all time periods relevant to this case and the budget
3 process described in the evidence, that 15 minute rule was uniformly not enforced
4 by either the Board, county administration nor staff.⁴

5 Shortly after taking office as commissioner, Handy believed that the position
6 of commissioner aide was needed. That view was shared by both Sorenson and
7 Fleenor. Spartz was aware Sorenson, Handy and Fleenor were interested in adding
8 commissioner aides to the 2009-2010 budget. Fleenor had the assistance of Diane
9 Burch as his assistant and, except for the fall of 2009, paid for the cost of her
10 services out of his personal funds. After taking office, Handy had the assistance of
11 Phyllis Barkhurst, on a "volunteer" basis [hereinafter "Barkhurst"]. Barkhurst had
12 formerly acted as Handy's campaign chairman when he was elected commissioner.
13 She did many things to assist the new commissioner including very fundamental
14 actions like helping him set up his office, obtaining office furnishings, getting money
15 for office supplies, answering phones and setting up a constituent response system.
16 At no time was Barkhurst an employee of Lane County. Barkhurst helped Handy
17 select the computer he wanted. Barkhurst was Handy's close and trusted aide. She
18 would be in the CAO on a regular basis. Other county employees were confused
19 about her role in county administration/government. Barkhurst had access to Handy's
20 county office and email. Although she maintained her own email account, Barkhurst
21 would send emails in her name using Handy's county email account.⁵ She would
22

23 ⁴It would appear that the lack of enforcement of this Board order goes beyond the issues of
24 this case and includes, at least, budget matters generally. As an example, Christine Moody testified
25 that Fleenor included in 2009-2010 Supplemental Budget # 1, a resident deputy position that was not
approved previously by the Board.

26 ⁵In a rather strange discussion at trial, it was pointed out to Handy that in his deposition he
27 stated that Barkhurst had no permission to use his county email and had not done so. He was shown
an email where she had used his email address, exhibit 34. His testimony concluded, however, with
the statement that his deposition testimony about her use of his email was true. That statement is

1 request, on Handy's behalf, action by the county's employees. At times, she sent
2 emails on Handy's county email account in his name (as if he had written them). Her
3 testimony at trial indicated that the emails she sent in his name were "his words."
4 In addition, using her own email account, Barkhurst would send emails on items she
5 was assisting Handy with. She would also deal with other commissioners on Handy's
6 behalf. At times, Barkhurst shared her thoughts and opinions with other
7 commissioners if she thought her opinions would be helpful to them. Further,
8 Barkhurst would do things at the request of Sorenson. While testifying, she
9 acknowledged the possibility that she also had assisted Fleenor.

10 Barkhurst had a background in politics. She had worked for Oregon Attorney
11 General Hardy Myers, in a political capacity. In addition to never being employed at
12 Lane County, she had never served on a county committee. She had never served
13 on any entities' budget committee and had no experience with county budgeting.
14 Barkhurst had no local budget law experience as of the spring of 2009. She had
15 some "informal" Public Meetings law training. With that background, Barkhurst
16 undertook to help Handy with the 2009-2010 Lane County budget process.
17 Barkhurst testified that process began in February 2009. Barkhurst further testified
18 her primary focus was to look at old budgets in order to get a deeper understanding
19 that would be helpful in developing the next fiscal year's budget.

20 The formal process for considering including the position of five commissioner
21 aides in the 2009-2010 Lane County Budget began on April 1, 2009, when Barkhurst
22 sent an email to county staff using Handy's county email. Exhibit 34. That email
23 stated:

24 "Hi Jenn:
25 _____

26 simply not credible, and his credibility is in question on other issues as well, as discussed below. To
27 the extent that Handy's trial testimony states or suggests that Barkhurst acted independently of
Handy's delegation of authority in any regard as discussed in this decision, such testimony or
suggestion is also not credible.

1 "Could you please prepare an add package for the BCC Program
Budget/010 account for 2009-2010 that reflects these two items:

2 "1) 2.50 FTE (5 people at .5FTE), level 3 of the administrative Tech
position (benefits for staff, not for family)

3 * * * *

4 "Please let me know if you have any questions.

5 "Thanks

6 "Phyllis Barkhurst, at the request of Commissioners Sorenson and Handy"

7 That request ultimately made its way into the formal proposed budget to be
8 considered by the Budget Committee. Also in consideration as part of that proposed
9 budget was the position of "Intragovernmental Affairs Coordinator." That position is
10 described in Exhibit 35. The Intragovernmental Affairs Coordinator position survived
11 the Budget Committee and Board budget adoption process and was included in the
12 County's 2009-2010 approved budget at .8 FTE. Despite being approved for 2009-
13 2010, that was the position that went unfilled and in part funded the 2.5 FTE
14 commissioner aide positions approved on December 9, 2009, as part of Supplemental
Budget #2.

15 In addition to her other efforts, Barkhurst assisted Handy with "BIG."⁶ BIG is
16 the acronym for Budget Interest Group. For no apparent reason, it also was referred
17 to as "Book Club." Book Club was a phrase that Sorenson primarily used. This group
18 is hereinafter referred to as "BIG." BIG was a gathering of individuals, which by May
19 2009 might consist at any one time of Handy, Sorenson, or Fleenor and/or their
20 respective Budget Committee appointees, Kaseberg, Land and Wilde, as well as
21 Barkhurst.⁷ There was a conscious effort made to not have more than two
22 commissioners nor any more than five members of the Budget Committee at any BIG
23
24

25 _____
26 ⁶In her testimony at trial, Land described Barkhurst as the "facilitator" of these meetings.

27 ⁷Both Handy and Barkhurst testified at trial that Barkhurst kept Handy informed of what was
occurring at BIG meetings.

1 meeting.⁸ All of the participants knew those numbers were important because to
2 exceed them meant that there was a quorum of either the Board or the Budget
3 Committee, hence a "public meeting."⁹ Spartz was aware a group was meeting
4 outside the regular budget process. Initially, he had seen them meeting in the CAO
5 conference room late in the afternoon. The participants Spartz observed most
6 frequently in the meetings were Kaseberg, Wilde and Land. He also observed
7 Barkhurst in the meetings. He thought he had seen a commissioner sitting in on a
8 meeting. Spartz never saw more than five Budget Committee members in attendance
9 at any meeting he observed.

10 According to Handy's testimony, the concept of BIG developed out of meetings
11 he had with his appointee, Wilde. Handy testified that Kaseberg became involved
12 at Sorenson's request. From there it expanded to include Land, Fleenor's Budget
13 Committee appointee. Barkhurst became the de-facto coordinator of BIG. See
14 Exhibits 74 and 75. Handy testified that he did not want these meetings to be the
15 usual "dog and pony show." He never explained his use of the phrase specifically,
16 but the clear implication is a criticism of what he considered to be the usual Budget
17 Committee presentations. BIG never included Stewart or Dwyer nor their Budget
18 Committee appointees.

19 While BIG was active at the same time as the county's budget process, BIG
20 further evolved. According to a May 5, 2009, email from Barkhurst to Sorenson and
21 Handy, a conflict was already developing in the budget process. Exhibit 48. That
22

23 ⁸Barkhurst testified at trial that she did not understand quorum rules to apply to email
24 communications. Handy's trial testimony as to his ignorance about the Oregon Public Meetings law
25 and an Oregon Attorney General's Handbook does not suggest he was so ignorant of the law that
26 he did not understand the complications that would arise if a quorum of either the Board or the
27 Budget Committee met in this context.

26 ⁹At some point in the BIG meeting process, Kaseberg testified that she tried to even modify
27 her email practices so as to make sure she was sending her messages to a number of participants that
would be less than a quorum of the budget committee.

1 conflict included the issue of the funding of additional jail beds. Barkhurst made the
2 following suggestion in her May 5 email:

3 ** * * *
4 "I am suggesting that the BIG be the place where the strategizing occurs
5 along with the budget committee meetings and any meetings where two of you
6 can gather and discuss
7 ** * * *"

8 Exhibit 48, page 1. Handy responded to Barkhurst's message with approval. There
9 is no indication of Sorenson's response to this message, but he continued to
10 participate in BIG. BIG meetings continued to occur after May 5, 2010, up until May
11 19, 2010. May 19 was the date of the 2009-2010 Budget Committee's final meeting
12 where the budget was approved by that group and forwarded to the Board for its
13 consideration.

14 Although BIG was active and meeting regularly during the same time frame as
15 the county's formal Budget Committee process, BIG met with less formality. BIG
16 members did get assignments to work on between meetings, primarily in formulating
17 questions to be asked regarding county budget items. No evidence was presented
18 that BIG or its members ever prepared or kept meeting minutes. Participation was
19 limited to those previously described and, although BIG met in public places, like in
20 the restaurant of the Hilton Hotel, it was never a public process. The public was not
21 invited to participate in BIG. None of the commissioners involved with BIG considered
22 it to be a public meeting within the context of ORS 192.610 *et. seq.* Despite the lack
23 of formality, certain documents developed as part of the BIG process in addition to
24 email messages between members. The preponderance of evidence shows that those
25 documents were prepared by Barkhurst.

26 The BIG documents are variations of a spread sheet containing items under
27 consideration or proposed for consideration by the county's Budget Committee.
28 Exhibits 77, 78, 90 and 93. The spread sheet includes costs associated with each
29 item. Fund numbers and the necessary FTE's are set out. Unusual for a budget type

1 document is a column for "YES" and "NO" which represents a consensus of all of the
2 participants of BIG as to whether there are six votes either in favor of (YES) including
3 them in the final budget or opposed to including them (NO) in the final budget. Like
4 preparing the document, the person tallying the votes was Barkhurst.¹⁰ Barkhurst
5 explained the "YES" "NO" indications on the spread sheet to a county staff person,
6 Christine Moody, and compared it to knowing how a member of the United States
7 Congress would vote before a vote was taken.¹¹ Christine Moody [hereinafter
8 "Moody"] was, until December 2009, a Senior Budget Analyst for the county. In
9 December 2009 she became the county's Budget Manager. In those positions,
10 Moody was intimately familiar with budget documents of the county. These spread
11 sheet documents were circulated to members of BIG up to and including the May 19,
12 2009, Budget Committee meeting where they formed the basis for the motion that
13 modified the approved budget by those additions or deletions.

14 Without regard to what Budget Committee members were doing generally, the
15 time period immediately before May 19, 2009, was a busy time for BIG members and
16 the BIG process.¹² Much of that activity involved communications between BIG
17 members solidifying the understanding as to what was the agreement they had
18

19 ¹⁰Barkhurst's trial testimony equivocated on this issue. She did not deny it was her work, but
20 claimed a lack of recollection of the document. Further testimony generally demonstrated a lack of
21 memory on many actions that her emails demonstrated she took. Despite her memory problem at
22 trial, Barkhurst definitely remembered at trial that she did a head count to see where people stood
23 before the May 19 vote. Her efforts at trial to distance herself from this work product were not
24 credible.

25 ¹¹To the extent that the Fleenor's and Handy's trial testimony disclaimed knowledge of and/or
26 participation in this process of vote counting, that testimony is not credible. Sorenson was not asked
27 that question.

28 ¹²Although there is no evidence that the suggestion ever came to fruition, as of May 11, 2009,
29 Sorenson was so satisfied with the BIG process that he suggested that the group continue to meet
30 into June 2009, at the same time that the approved budget would be being considered by the Board.
31 Exhibit 73. That email was sent to Kaseberg, Wilde, Land, Handy and Barkhurst.

1 reached. On May 12, 2009, at 3:09 a.m., Barkhurst sent an email noting a BIG
2 meeting would occur "Wednesday" at 5:30 p.m. at the Hilton,¹³ Exhibit 75. That
3 email also summarized some of the pending issues. Barkhurst stated:

4 * * * *

5 "The plan for this meeting is to use the CA's budget as a default
6 document for you to bring your lists of additions, deletions, and revisions that
7 you would like to see happen as part of this budget.

8 "Also part of the discussion will be the projected cuts from H & HS and
9 your opinion on the items that you want more info on and/or want to see
10 receive general fund support in lieu of some or all of the cuts that are being
11 projected.

12 * * * *

13 *Id.* The earliest dated spreadsheet of the BIG work is dated May 13, 2009. Exhibits
14 77 and 78.

15 By May 17, 2009, Land was concerned that the "list" she received was not the
16 same as her recollection from Wednesday. Exhibit 88. By May 18, 2009, Land was
17 meeting with Barkhurst at 1:00 p.m.¹⁴ *Id.* On May 18, 2009, Fleenor sent a morning
18 email to Barkhurst and Sorenson expressing a concern about needed additional
19 Budget Committee and BIG meetings to allow the rhetoric to settle down. Exhibit 83.
20 Fleenor proposed in that message holding "two 'mini' BIG meetings (with 5 members
21 per meeting), back to back, this Wednesday to re-position ourselves for the heavy lift
22 on Thursday." *Id.* Also on May 18, 2009, Fleenor sent Handy an evening email
23 summarizing the agreement on the budget issues. Exhibit 91. Fleenor also forwarded
24 that email to Land, who in turn forwarded it to Kaseberg. Land characterized the list
25 as a "compromise." *Id.* That same email, Exhibit 91, was forwarded by Handy on
26 the morning of May 19, 2009, to Barkhurst and Sorenson. By 11:30 a.m. on May
27 19, 2009, the day of the scheduled final meeting of the Budget Committee, Barkhurst
sent an email to Land, Kaseberg and Wilde with the subject "after checking in with

¹³This court takes notice that May 12, 2009, was a Tuesday.

¹⁴Land confirmed in her trial testimony that this meeting took place, but indicated she had no current memory of what was discussed.

1 everyone last night." Exhibit 96. That email began "[h]ere is the last list of agreed
2 upon items with six votes for the meeting tonight." *Id.* The last BIG spread sheet is
3 dated May 19, 2009. Exhibits 90 and 93. According to Barkhurst, that list was
4 complete "* * * although the Resource Development Analyst position may be taken
5 off after the commissioners contact me at lunch time." Exhibit 96. Almost
6 immediately, Land responded to Barkhurst with concerns. Exhibit 97. In addition, on
7 May 17, 2009, Fleenor had sent Kaseberg a message encouraging her to stay the
8 course in the face of the "* * * Register Guard's need to exploit controversy to sell
9 advertising." Exhibit 69. In the face of questions she raised about priorities among
10 the various issues the budget process was weighing, Fleenor encouraged her to
11 "[s]tay strong and focused on staying true to basic principles versus political
12 expediency." *Id.* Those words of encouragement were echoed by Barkhurst in an
13 email to Land, Kaseberg and Wilde on May 19, 2009:

14 "* * * *"

15 "I am working on talking points for those who want a few bullet points
16 on specific items. I will share those with you too.

17 "On the rumor front, the room will most likely be packed tonight with
18 angry jail bed voices -- as I keep reminding Rob -- this is *sound and fury* time!
19 And then it will be over.

20 "Thanks!

21 "Phyllis"

22 Exhibit 96 [bold and italics in original] .

23 Without regard to all of the issues that were agreed upon modifications to the
24 county's budget by BIG, commissioner aide funding was always part of the package
25 that BIG agreed would be included in the changes. That package, including
26 commissioner aides, became a part of the approved budget at the Budget Committee
27 meeting on May 19, 2009. Exhibit 1. The motion as set out in the BIG spread sheet
was approved. *Id.*, at page 11. The vote was six in favor and four opposed. All six
BIG members voted in favor. Stewart, Dwyer and their respective Budget Committee
appointees voted against. Land voted in favor of the motion despite continuing to

1 express concerns into the afternoon of May 19, 2009. Exhibit 100.

2 The manner of the conduct of the vote and motion on May 19, 2009, is
3 important to plaintiffs. The motion that included commissioner aides in the budget
4 was clearly scripted from the spread sheet developed at BIG. Exhibit 2.¹⁵ The order
5 of items, their being added or removed from the budget as listed on the May 19 BIG
6 spread sheet, Exhibit 93, tracks identically with the motion made by Fleenor and
7 seconded by Wilde at the Budget Committee's final meeting. Exhibit 1, page 10.
8 However, BIG's achievement of enacting the budget changes it agreed on, including
9 the commissioner aide positions, was not without controversy. Essentially, it became
10 a political discussion of sacrificing jail beds in favor of commissioner aides.¹⁶

11 Both the manner of how the adjustments became a part of the budget as well
12 as the specific inclusion of the commissioner aide positions in the budget approved
13 by the budget committee continued to be the subject of some controversy. By May
14 27, 2009, Fleenor had a change of heart and expressed his position on the budget
15 issues and community discussion in an editorial opinion piece published in the Eugene
16 Register Guard. Exhibit 300. In that op-ed piece, regarding the issue of the
17 commissioner aide positions, Fleenor stated:

18 * * * * *

19 "Why add part-time assistants for commissioners? I pay for my assistant
20 (more than \$50,000 out of my own pocket) so I can provide a high level of
21 constituent services. Some commissioners are struggling with the workload
22 of assisting their constituents through this very difficult period - that is why I
23 voted for modest staffing. But I hear the outcry - the symbolism is like CEOs
24 flying in private jets. I apologize for being insensitive and will vote to reallocate
25 these funds.

26 * * * * *

27 ¹⁵This exhibit is comprised of several video files. Although the entire (five plus hours) May
19 meeting is available to watch and listen to, the issues that this court found important were set out
in a sub-file entitled "May 19, 2009 Clips." Those include the events surrounding the motion to
approve the budget amendments, the vote and the comments of committee members.

¹⁶Although this references the tenor of one part of the continuing political discussion, the
financial impact of the two choices was clearly not a dollar trade-off.

1 *Id.*, page 1.¹⁷ In fact, by the time the budget was adopted by the commissioners on
2 June 24, 2009, the commissioner aide positions were not included. Those positions
3 were removed from the budget in a five to zero vote taken at a meeting of the Board
4 on June 17, 2009. Exhibit 3, page 5. Fleenor made the motion. Although Fleenor's
5 public position was to remove the commissioner aides from the 2009-2010 budget,
6 his private position continued to recognize their importance. In an email to Barkhurst
7 on May 31, 2009, he advocated:

8 * * * * *
9 "I would also support trying to add back commissioner assistants for the
 FY 2010-11 budget year, when there is less heat."

10 Exhibit 104, page 2.

11 At the same time that the Board was finalizing the 2009-2010 budget, there
12 was another issue they were dealing with as a result of the conduct of the May 19,
13 2009, Budget Committee meeting. That was a public records request from the
14 Eugene Register Guard newspaper concerning the activities and communications of
15 the commissioners leading up to the budget approval. The compilation of those
16 documents produced, Exhibit 143, resulted in a cautionary email being sent from
17 County Counsel to her clients, the Board, and Spartz on June 4, 2009.¹⁸ That email
18 stated (in its entirety):

19 "I've mostly completed the public records request from Matt Cooper
20

21 ¹⁷The evidence does not show how much Fleenor paid for Diane Burch's services (Fleenor's
22 assistant) except as claimed in the op-ed piece. However, for August, October and November 2009,
23 the evidence shows that Fleenor was receiving reimbursement from the county for at least \$1,800 per
24 month for the monthly cost of Burch's assistant services as a claimed "constituent services" expense.
25 Exhibit 115. There was no explanation provided at trial as to how this expense was paid during a
26 period when the commissioner aide positions (formally "constituent service aide") were not a part of
27 the 2009-2010 adopted budget.

26 ¹⁸It is important to note that, in general, a string of email communications or the messages and
27 responses is read from back to front or bottom to top. The earliest messages will appear at the end
of the string or on the last page and the last or latest message will appear first in multiple
communications or where there are multiple pages.

1 regarding Commissioner Sorenson's, Fleenor's and Handy's emails from
2 January until May. I have provided Matt Cooper one packet of documents and
I've told him that I'll have the rest done by this afternoon or tomorrow.

3 "This is difficult for me to say, as being the bearer of bad news is never
4 appreciated, but I need to let you know that there are emails that I think will
5 look very badly for the county, and for the three Commissioners if Matt decides
6 to pursue them. There may not have been technical violations of the quorum
laws, but the spirit of the rules appears to have been violated on several
occasions. I'm copying all five Commissioners on this email, as well as County
Administrator Spartz, because Mr. Cooper may contact commissioners outside
of the three whose emails he requested."

7 Exhibit 105, page 3. County Counsel's perceived criticism was not well received by
8 Fleenor nor Sorenson.

9 Responding to County Counsel, Fleenor suggested "[t]hanks - I'm sure if
10 somebody wanted to look hard enough they can find a 'violation of the spirit' of just
11 about anything." Exhibit 105, page 3. The next morning Fleenor further responded
12 and said "I can state no deliberations toward a conclusion ever occurred. If I'm not
13 mistaken, fact gathering and exchanging ideas would be considered a prudent form
14 of governing." Exhibit 105, page 2. He dismissed the Register Guard's efforts as "
15 * * a witch hunt driven by political motives." *Id.* For her part, County Counsel took
16 a much more direct approach to Fleenor and his two responses to her original email.
17 On June 5, 2009, she wrote:

18 "Commissioner - I an [sic] not a stupid person. * * * *
19 "I've reviewed the emails, and I believe the RG's attorneys will see
20 enough evidence there to allow reporters to state that the three of you were
21 deliberating; not necessarily via email, but via a combination of meetings and
22 emails. Whether all three of you were in the room at the same time is
23 irrelevant to whether or not the spirit of rules was being violated. I believe
they will come to the determination that you were using Phyllis as a conduit to
try and avoid the public meetings law. The same arguments can be made in
regards to a quorum of the budget committee. From County Counsel's
perspective, these actions will be difficult to defend * * * *
24 " * * * * My advice is this: do not try and circumvent the rules."

24 Exhibit 105, page 1.

25 Sorenson also responded negatively to County Counsel's initial warning about
26 the disclosure of records pursuant to the request. Exhibit 106. He suggested she
27 had the wrong perspective. Sorenson wrote:

1 "[Addressing County Counsel's perceived failure to provide
2 commissioners copies of what was produced] I [sic] would like you to look at
3 this from your client's point of view.

4 "here [sic] you provide information to the news media, thereby
5 blindsighting [sic] the elected officials of the county you represent. this [sic]
6 engenders the view that you really don't look at it from the county's view, only
7 the view of the media making the inquiry."

8 Exhibit 106, page 1 and 2. County Counsel was equally more direct in her response
9 to Sorenson's message. She wrote:

10 "Commissioner, your email feels like retaliation for my compliance with
11 a public records request. I take that very seriously. Not only did I previously
12 offer to give copies to the commissioners, I kept you up to date on the request.
13 I never heard from you personally regarding this request. The only
14 communications I received were some from Commissioner Fleenor and Joe
15 regarding how time-consuming dealing with this request would be. If a client
16 does not respond to my communications, I cannot help them."

17 Exhibit 106, page 1. As of the effective date of the fiscal year 2009-2010 budget
18 on July 1, 2009, it was clear to Sorenson, Fleenor and Handy that County Counsel
19 viewed their conduct in the activities leading up to the adoption of that budget as
20 potentially violating the Public Meetings law.

21 Without regard to his role in the May 2009 consideration of the commissioner
22 aide positions, Handy took the lead in securing those positions as part of
23 Supplemental Budget #2. On August 18, 2009, Handy reached out to Barkhurst in
24 an email seeking her further help on budget issues. Exhibit 108, page 1. Stating
25 "Fleenor is pushing - to spend more LC \$ on things," Handy wanted Barkhurst's
26 view " * * * on a general timeline you may feel ready to implement the Constituent
27 Service staff for commissioners." *Id.* Concerning Fleenor's proposed spending,
28 Handy stated "I'd like to tell him no more adds until he helps us get the staff put in
29 the budget." *Id.*

30 Responding to Handy's request for assistance (after clarifying which budget
31 item the money was being spent from) Barkhurst stated "I'll be ready to present info
32 to you and Pete by the middle of next week - how do you want me to do this?"
33 Exhibit 108, page 1. Handy responded "[y]ou tell us how you want to do it, let's get

1 it scheduled, thank you. Fleenor has lots of ideas that require dough and he is looking
2 everywhere for it. Nothing is safe from him." *Id.*

3 On September 14, 2009, Moody responded to Handy's request for information
4 about the costs associated with "Office Support Assistant" positions including a
5 comparison of the cost of full time positions and one-half time positions. Exhibit 109.
6 Apparently, there would be a cost savings associated with a full time person working
7 part time for two commissioners because it would not duplicate the costs of benefits
8 and supply/work space. *Id.* It was Moody's work that included the commissioner
9 aide positions in the proposed Supplemental Budget #2 at the request of Handy.¹⁹
10 In the lead up to the process of commissioner aides being considered by the board
11 as part of Supplemental Budget #2, Moody had personal conversations with Handy,
12 Sorenson and Fleenor about those positions. The manner in which commissioner
13 aides were presented for consideration in Supplemental Budget #2 was identical to
14 how they had been presented in May 2009, *i.e.*, five .5 FTEs, one for each
15 commissioner, even though a lower cost alternative had been discussed.

16 The 2009-2010 Budget Committee's role in the budget process ended on May
17 19, 2009, with the approval of the proposed 2009-2010 budget. In addition, despite
18 Sorenson's suggestion that BIG may have a role after the 2009-2010 budget was
19 approved by the Budget Committee, there was no evidence presented that BIG ever
20 met after May 19, 2009. After May 19, Land continued to provide volunteer
21 assistance and advice to Fleenor, however, her role after that date was as a volunteer
22 in his initial campaign effort to seek re-election to the position of commissioner.
23 Barkhurst's post May 19 role as a volunteer assistant to Handy as commissioner was
24

25 ¹⁹Although Moody testified she informed Handy that a Board order would be necessary to
26 include the commissioner aide positions in the supplemental budget, there was no evidence presented
27 at trial that such an order was ever made or even discussed by the Board. That fact did not go un-
noticed when Supplemental Budget #2 was enacted, as it was mentioned in a comment by Stewart
after the vote.

1 not directly addressed by the evidence. However, it is a reasonable inference that her
2 role in that capacity was significantly reduced. Barkhurst however, continued to
3 provide assistance as described above as well as assistance to Handy in his dealing
4 with the politics of including assistants in Supplemental Budget #2.

5 On October 19, 2009, Barkhurst sent Handy a memo on "Talking Points"
6 related to the politics of funding assistants for the commissioners. Exhibit 110. In
7 general terms, those talking points would point out the benefit to commissioners as
8 well as county residents if the commissioner aide positions were available. It appears
9 those talking points were part of a forwarded message string sent from Handy to
10 Fleenor. *Id.*, page 2. Moody testified that she entered the commissioner aide
11 positions in Supplemental Budget #2 documents on November 25, 2009.

12 On December 4, 2009, the Eugene Register Guard published the Notice of
13 Supplemental Budget Hearing. Exhibit 308. On December 9, 2009, the Board met
14 for the required public hearing on Supplemental Budget #2. No member of the public
15 appeared to speak on the subject of any proposed changes in the budget. Exhibit 6,
16 page 1. Handy moved and Dwyer seconded a motion to approve Supplemental
17 Budget #2, which contained the commissioner aide positions. The budget
18 amendment was adopted on a vote of three to two. Sorenson, Handy and Dwyer
19 voted to approve and Fleenor and Stewart voted no.

20 On December 11, 2009, Handy sent a message to Barkhurst describing the
21 events leading up to the vote on December 9 as well as the vote itself. Handy wrote:

22 " * * * * "

23 "I tossed and turned all night before, getting up a few times to review
24 my moves and conversations come morning. When I woke up to the RG
25 demagoguing [sic] on the front page and in the editorial, I was breathless for
26 a moment, then thoroughly determined to kick ass and get after it. When I got
27 to CAO, I could see Dwyer was there. So, for the second time this year, I
came in and knocked everyone over with my booming voice ragging the RG for
trying to intimidate some Commissioners about how they should make their
budget decisions. Zimmer was in Dwyers [sic] doorframe chatting with him,
my voice almost knocked her over and she shrunk off somewhere. After
strongarming him the afternoon before after the Management Team at PW (and

1 sharing your work for him and Janet - he liked it!), I put it to him bluntly. I
2 needed his support, was he still with me. He said yes. I told him I would
3 make the motion, would he second. he [sic] said yes. I said not just for
'discussion' but for support, yes? he [sic] said yes. Faye could hear the whole
4 conversation in the next room - doors were open.

5 "Then, I dipped into Faye's office, told him I knew he was not
6 supporting this, but I set this up, so that he could direct his funds toward Jeff
7 if he wants. He seemed appreciative. Dwyer poked his head in Faye's, told
8 me, and he wanted me to come back into his office. he [sic] said, just vote -
9 don't say anything. He said when you have the votes lined up, just vote, don't
10 give the press any further fodder, by getting into debates and arguments. I
11 told him that knowing you were with me, I would do that.

12 "Wrapped around with Pete, he is still amazed I am working with Dwyer
13 successfully. He's still telling me Dwyer is going to screw me, then fuck me.
14 I told him turn to me first after Christine's intro, so I could make the motion
15 immediately. Despite having spent an hour with Pete the afternoon before
16 (including ½ hour with Christine and I), he asked how I planned to insert this
17 into the budget. I said PETE-IT'S ALREADY IN THERE YOU FOOL!-THEY
18 HAVE TO TAKE IT OUT!

19 "It was all relatively quick and painless. Faye complained and asked
20 Christine how this got stuck in the supplemental, which commissioner did it.
21 She handled it adroitly, without naming names. FS said he would not hire
22 assistants. Mia's work with Fleenor was effective. He made his speech,
23 emphasis on returning his share to the general fund, mentioned that he funded
24 constituent aides out of his pocket because they were important, but that the
25 timing of this was wrong. Went to Pete 'let's go to a vote.' No one showed
26 up for the public hearing.

27 "Pete is on cloud nine. I don't think it has set in yet for me. Press
crawled over it, Pete did all of the media requests, he is on message. Sue
Palmer filling in for Matt Cooper this week-yea! You should read her piece in
Thursday's paper-how refreshing!

*** **

Exhibit 112, pages 1-2 [capital letters in original].

In his trial testimony, Handy addressed his comments in Exhibit 112. Handy
claimed in his testimony that Exhibit 112 was intended to be humorous; some attempt
at private humor. Handy's trial testimony admitted these "meetings" took place, but
he also took issue with how he had characterized the discussions in his email. In his
trial testimony, Handy also claimed a lack of memory as to who made the motion on
December 9, 2009, for approval of supplemental budget #2. Regarding specific
statements he made in Exhibit 112, Handy repeatedly described them at trial as an
embellishment or embellishments of the facts. Handy specifically denied, in his trial
testimony, that he orchestrated the vote for the approval of Supplemental Budget #2.
When confronted at trial, Handy did admit that the events surrounding the vote to

1 approve Supplemental Budget #2 played out exactly as he had described them in
2 Exhibit 112. Handy denied speaking to Fleenor before the December 9 vote.

3 Having had the opportunity to carefully review all of the evidence presented in
4 this matter, this court accepts that the manner of presenting the description of
5 activities by Handy in Exhibit 112 could be characterized as an effort at self-
6 grandiosity. After all that occurred, he obviously had reason to boast as the matter
7 was now a *fait accompli*. The salty language suggests it was a message meant for
8 a close and trusted friend. He may have had reason to share his success with his
9 friend, but nothing suggests that the events portrayed as occurring were made up.
10 Any claim by Handy that the actual events he described as occurring in Exhibit 112
11 are somehow made-up or exaggerations is not credible.

12 The Supplemental Budget #2 calendar, Exhibit 400, indicates that by November
13 25, 2009, the proposed supplemental budget needed to be sent to the Register Guard
14 for publication. For some unexplained reason, that notice for publication was faxed
15 to the newspaper on December 1, 2009, for publication on December 4. Exhibit 307.
16 That December 4 publication date conforms with the calendar's schedule. Exhibit
17 400.

18 Handy, Sorenson and Fleenor were aware that Supplemental Budget #2 would
19 re-allocate funds to allow the employment of commissioner aides.²⁰ Although the
20 exact date Sorenson and Fleenor became aware of that fact is unclear, it was
21 certainly several weeks in advance of the scheduled meeting on December 9. Handy
22 was aware Fleenor would not be supporting the proposed enactment in the vote on
23

24

25

26

27

²⁰Fleenor's trial testimony to the effect that he first learned of the inclusion of commissioner aide positions in Supplemental Budget #2 on December 9 is not credible. It is directly refuted by the fact that his campaign workers were communicating about his position on the matter on December 8. It is further refuted by Moody's testimony about a conversation she had with him. Exhibit 111.

1 December 9.²¹ On December 8, Handy and Sorenson met to discuss the issue of
2 enacting Supplemental Budget #2. A portion of that discussion included the
3 participation of Moody, who explained the budgetary issues as they related to
4 including the positions of commissioner aides as 2.5 FTE²². Handy knew Sorenson
5 was supporting the enactment of Supplemental Budget #2 including the commissioner
6 aide positions. Handy knew that he needed three votes for the enactment. As of
7 December 8, his December 11 missive, Exhibit 112, suggests he only had two, his
8 and Sorenson's.²³ On the morning of December 9, Handy approached Dwyer in his
9 office confirming his support for the enactment of Supplemental Budget #2.²⁴ That
10 was a follow-up to a conversation the two had the day before on the subject of
11 including commissioner aides in the supplemental budget. On December 9, Handy

12 _____
13 ²¹There was no evidence that Fleenor's position was ever a surprise or even a secret. Handy's
14 August 18, 2009, email makes it clear that Fleenor's Fall 2009 spending priorities did not include the
15 commissioner aide positions and Handy needed to take action. Moody testified Fleenor told her,
16 shortly before the December 9 meeting, that he was concerned about how Handy and Sorenson felt
17 about the fact that he wasn't planning on supporting the commissioner aide positions in the
18 supplemental budget. Handy admitted in trial testimony that both he and Barkhurst knew Fleenor's
19 position.

20 ²²There is additional evidence of these events, confirming Handy's narrative in Exhibit 112.
21 The testimony of Moody confirms that this Handy-Sorenson-Moody meeting took place and lasted
22 20 minutes in her estimation. A part of that discussion involved the choice between temporary
23 compared to permanent positions for the commissioner aides. The significance of that discussion,
24 according to Moody, was that the temporary positions had no "FTE", but would be limited to
25 working 1040 hours per year.

26 ²³At least through Fleenor's inner circle, it appears there was more confidence that Handy had
27 the three votes at least as early as December 8. In an email on that December 8 date, Land, now a
Fleenor campaign volunteer wrote to the campaign general message board "I understand that Rob
& Pete want assistants and the political cover to do it, and with Dwyer they'll have the three votes
necessary." Exhibit 111, page 1. Dwyer's earlier commitment is also described by Handy in Exhibit
112, when Handy says he asked Dwyer when he first arrived on December 9 "was he [Dwyer] still
with me" clearly indicating a prior commitment. *Id.*

²⁴Handy's trial testimony that he did not ask for Dwyer's support is not credible. Handy
needed to confirm that support on December 9 - to make sure that Dwyer was not intimidated by the
Register Guard article Handy had read.

1 wanted Dwyer to not only make the motion, but to vote in favor of enactment.²⁶
2 Dwyer agreed. Dwyer wanted the enactment voted on with the least amount of
3 public discussion. Also on the morning of December 9, Handy was aware that
4 Stewart would not support the enactment, but Handy informed Stewart in his office
5 that the budget was structured in a way so as to allow Stewart's use of the money
6 in a manner other than the hiring of an assistant.²⁶

7 The conclusion of Handy's December 9 pre-public meeting efforts included a
8 final meeting with Sorenson, in Sorenson's office. Handy made sure Sorenson knew
9 that Dwyer had agreed to support the enactment of Supplemental Budget #2. Handy
10 made sure Sorenson knew to get to him immediately after Moody's presentation so
11 that the motion could be made immediately. Sorenson may not have shared Handy's
12 belief that Dwyer would actually vote in favor of enacting Supplemental Budget #2
13 when it came time to vote. The conduct of the Board meeting on December 9, so far
14 as it concerns the presentation and enactment of Supplemental Budget #2, went
15 exactly as Handy had orchestrated it in the few days before. Exhibit 7²⁷. Handy was
16 pleased that Moody did not give his name for the public meeting record as the person
17 who had requested that the commissioner aide positions be included in the

18
19 ²⁵Although the specifics of what was overheard did not corroborate exactly what was said,
20 Melissa Zimmer's testimony was sufficiently specific to indicate she overheard at least a part of this
21 conversation. Ms. Zimmer is the Board's Secretary.

22 ²⁶Stewart's trial testimony indicated that Handy actually asked Stewart if he would support
23 the positions and that Stewart said no. Perhaps Handy was looking for more support than he
24 described in his email. It is also possible that Stewart interpreted Handy's approach and the
25 suggestion of an alternate use for the money by Stewart as a request for support. This court believes
26 Stewart was credible when he testified to his understanding of Handy's approach as a request for
27 support that morning, as that could be a matter of interpretation from a particular point of view.

28 ²⁷This exhibit received at trial, a USB thumb drive, is corrupted according to the court's
29 technical staff. Staff reported the data, if recoverable, could not be recovered with the tools on hand.
30 Upon notice of the defect, plaintiffs' attorney provided a replacement DVD disk containing the
31 excerpted portions of video from the December 9, 2009, Board meeting. The DVD has been viewed
32 by the court. Both items have been kept and are part of the court's exhibits.

1 supplemental budget. To the extent that Handy has denied in trial testimony that he
2 "orchestrated" the December 9 vote on the enactment of Supplemental Budget #2,
3 that denial is not credible. That is exactly what he did.

4 Neither the Budget Committee nor BIG played any part in the processes leading
5 up to or included in the enactment of Supplemental Budget #2. Although Fleenor did
6 not vote to support adoption of Supplemental Budget #2, he took advantage of the
7 opportunity it afforded him and hired an assistant. His efforts in doing so created
8 some consternation among county administrative staff because he was not following
9 county procedures for "fair and open competition" for the position. Exhibit 126.
10 Although not clearly stated in the trial testimony, a reasonable inference from Melissa
11 Zimmer's testimony, that Fleenor has had the same assistant for four years, is that
12 Diane Burch got the job. She was the person Fleenor privately funded - expensed to
13 the county - as his aide.

14 The present case was filed on February 5, 2010, within 60 days of the
15 enactment of Supplemental Budget #2. Plaintiffs' First Request for Production of
16 Documents Directed to Defendant Bill Fleenor was dated February 19, 2010. Exhibit
17 138. Fleenor was aware of that request. This request was disputed and various
18 other requests for documents from defendants, including Fleenor, were made. In his
19 deposition on September 20, 2010, because of a personal computer hard drive failure
20 in July or August 2009, Fleenor testified that had been unable to produce requested
21 documents from his personal computer. He testified, however, that the failed hard
22 drive was still available. On October 21, 2010, within 30 days of his deposition as
23 provided in ORCP 39F(2), Fleenor corrected his deposition and then wrote that the
24 hard drive failed on April 19, 2010, had been replaced and the failed drive had been
25 discarded. Exhibit 130. Several of the emails in the time frame of this case reflect
26 that Fleenor used a non-county email address. See Exhibit 74. That email address
27 was info@kimillia.com. Fleenor's campaign "whiteboard" communication system and

1 its stored messages were apparently also not available, according to Fleenor.

2 In addition to Fleenor's problem with his personal computer hard drive, issues
3 arose with respect to his "Outlook" calendar after this case was filed. Before this
4 case was filed, his calendar was maintained on the county system and accessible to
5 several individuals, including Zoanne Gilstrap, Lane County Administrative Services
6 Supervisor [hereinafter "Gilstrap"]. Gilstrap testified that she had seen entries related
7 to Book Club in various calendars, including Fleenor's. After this case was filed,
8 Gilstrap observed that references to Book Club had been removed from Fleenor's
9 calendar and then she no longer had access to that calendar. Gilstrap also observed
10 Book Club meetings in the CAO conference room. One of Gilstrap's responsibilities
11 was to supervise the employees who work in the CAO, including the persons who
12 worked at the front desk. One of the front desk people she supervised in the period
13 after the case was filed was Rudy Chavarria [hereinafter "Chavarria"].

14 An incident occurred on June 30, 2010, between Chavarria and Fleenor. A
15 portion of the incident was observed by Gilstrap. She could see Fleenor and
16 Chavarria in the CAO conference room, where they had gone at Fleenor's request and
17 Fleenor had closed the door. Chavarria interpreted Fleenor's approach and comments
18 as suggesting Chavarria was now somehow involved in the present case. The incident
19 confused Chavarria and was very upsetting to him. In addition, the incident was
20 upsetting to Gilstrap. The next day, based on what she had seen and that Chavarria
21 had reported to her, she made notes of the incident. Those notes are Exhibit 120.
22 Chavarria felt he was being pressured by Fleenor after Fleenor received some
23 information that Chavarria was going to be a witness in the case. As he was leaving
24 the contact, Fleenor said to Chavarria that he should remember that he "hadn't seen
25 anything." In their conversation, Fleenor poked Chavarria in the chest as he spoke
26 to him. Gilstrap got involved because she was worried about what effect the
27 conversation was having on Chavarria. The next day, Fleenor approached Chavarria

1 to apologize to him. Fleenor told Chavarria that he didn't mean to scare him and
2 shook Chavarria's hand. At that point Fleenor reminded Chavarria to tell the truth.
3 Although the incident obviously upset and disturbed Chavarria, he testified at trial
4 that it did not affect his trial testimony, which was truthful.

5 Several county employees testified that they had observed Fleenor, Handy and
6 Sorenson in a county office or conference room together at various times.²⁸ In one
7 particular occasion, the testimony indicated that the three of them met with Eugene
8 Mayor Kitty Piercy in a commissioner's office.²⁹ Fleenor, Handy and Sorenson each
9 testified that the three of them had never been together in any one room/office in the
10 CAO and that the three of them did not meet with Mayor Piercy in the CAO. Mayor
11 Piercy was not a witness. Regarding any of the observed "meetings" between the
12 three individual defendants or any two of them as observed by any county employee,
13 none of the witnesses to those meetings were aware of any subject that the
14 commissioners were discussing beyond the hearing of a single word or two. In
15 particular, other than discussed above, no witness testified they were aware of a
16 commissioners' discussion(s) including the subject of commissioner aide positions in
17 the general county budget in the spring of 2009 nor the supplemental budget in
18 December 2009.

19 Conclusions of Law

20 Oregon Public Meetings law is set out in ORS 192.610 *et seq.* The policy of
21 these provisions is set out in ORS 192.620 which states:

22 "The Oregon form of government requires an informed public aware of
23 the deliberations and decisions of governing bodies and the information upon

24 ²⁸No witness who testified that they participated in any BIG meeting nor any witness who
25 testified that they observed any BIG/Book Club meeting occurring indicated that they observed any
26 three of the participating commissioners in the same meeting at the same time.

27 ²⁹The witnesses' testimony differed as to which commissioner's office the meeting took place
in.

1 which such decisions were made. It is the intent of ORS 192.610 to 192.690
2 that decisions of governing bodies be arrived at openly."

3 Plaintiffs alleged in their Second Amended Complaint that "[b]etween April of 2009
4 and December 9, 2009, defendants Sorenson, Handy and Fleenor met privately on
5 multiple occasions to deliberate toward decisions ultimately contained in *FY 2009-*
6 *2010 Supplemental Budget #2.*" *Id.*, page 5, paragraph 17 [italics in original].

7 Oregon Public Meetings law further provides in ORS 192.630(1) that "[a]ll
8 meetings of the governing body of a public body shall be open to the public and all
9 persons shall be permitted to attend any meeting except as otherwise provided by
10 ORS 192.610 to 192.690." As used in Oregon Public Meetings law, "meeting" is
11 defined to mean:

12 " * * * the convening of a governing body of a public body for which a
13 quorum is required in order to make a decision or to deliberate toward a
14 decision on any matter. 'Meeting' does not include any on-site inspection of
15 any project or program. 'Meeting' also does not include the attendance of
members of a governing body at any national, regional or state association to
which the public body or the members belong."

16 ORS 192.610(5). As to the actual vote and decision process on December 9, 2009,
17 as depicted in Exhibit 7, the parties agree that process was a lawful public meeting.
18 The disputes in this case surround the events leading up to that vote, *i.e.*, a claim of
19 improper deliberations and pre-public meeting decision making. Oregon Public
20 Meetings law does not define deliberate or deliberations. Merriam-Webster's
21 Collegiate Dictionary, 10th Ed. [hereinafter "Webster's"], defines "deliberate" as "to
22 think about and discuss issues carefully" and "to think about deliberately and often
23 with formal discussion before reaching a decision." It also provides a definition of
24 "deliberation" as "a discussion and consideration by a group or persons of the
25 reasons for and against a measure." *Id.*

26 Defendants raise two legal issues related to the events presented in the
27 evidence concerning the 2009-2010 budget process. The first of those issues is the

1 statute of limitations applicable to these proceedings set out ORS 192.680(5) and
2 raised as an affirmative defense by all defendants. That statute provides "[a]ny suit
3 brought under subsection (2) of this section must be commenced within 60 days
4 following the date that the decision becomes public record." *Id.* ORS 192.680(2)
5 provides:

6 "Any person affected by a decision made by a governing body of a
7 public body may commence a suit in the circuit court for the county in which
8 the governing body ordinarily meets, for the purpose of requiring compliance
9 with, or the prevention of violations of ORS 192.610 to 192.690, by members
10 of the governing body, or to determine the applicability of ORS 192.610 to
11 192.690 to matters or decisions of the governing body."

12 The statute of limitations defense attacks plaintiffs evidence surrounding the events
13 leading up to and including the May 19, 2009, Budget Committee approval and the
14 Board's June 24, 2009, adoption of the 2009-2010 Lane County budget. That legal
15 theory also was the basis for defendants' trial objections to that evidence.

16 As to any claim by plaintiffs that the deliberations occurring by BIG and/or the
17 Budget Committee in relation to approval of the proposed budget and/or any claim
18 that deliberations by the Board in relation to adoption of the 2009-2010 budget
19 constitute a continuing process culminating in the adoption of Supplemental Budget
20 #2, this court agrees with defendants.³⁰ This court rejects any such continuing
21 process argument. This court has previously stated and re-affirms here that plaintiffs'
22 evidence, to the extent it only proves that there were improper deliberations toward
23 the Budget Committee's approval of the budget in May 2009 and/or the Board's
24 adoption of the Budget in June 2009, would not be sufficient to establish improper
25 deliberations in the adoption of Supplemental Budget #2. This court is satisfied that
26 the earlier two actions by the public bodies were separate decisions under ORS
27 192.610(1) and that the statute of limitations on those two actions expired some time

³⁰This is the argument that plaintiffs make on page 11 of Plaintiffs Trial Memorandum.

1 in July and August 2009 pursuant to ORS 192.680(5), as defendants' claim.

2 As is more specifically discussed below, a plaintiff's right of action derived
3 from ORS 192.680(2) includes the right to require compliance with the statutory
4 scheme, prevent violations of it or seek a determination that is applicable to matters
5 or decisions of the governing body. A "meeting" of the governing body requires at
6 least a quorum of the governing body making or deliberating toward a decision. A
7 decision is:

8 " * * * any determination, action, vote or final disposition upon a
9 motion, proposal, resolution, order, ordinance or measure on which a vote of
a governing body is required, at meeting at which a quorum is present."

10 ORS 192.610(1). While this court agrees with defendants' claims regarding the
11 statute of limitations on those earlier events, as this court has previously ruled, that
12 does not mean the evidence surrounding those events should not have been
13 presented in this trial. As stated on multiple occasions, that evidence was within the
14 scope of the pleadings. Further, as is more fully explained below, that evidence has
15 direct relevance on at least two issues in this case.

16 The second legal issue defendants pled as an affirmative defense is a lack of
17 standing on the part of plaintiffs to challenge the decision to include the commissioner
18 aide positions in Supplemental Budget #2. Standing to make a claim under Oregon
19 Public Meetings law is derived from ORS 192.680(2). In the context of that
20 argument, defendants were careful to not stipulate that plaintiffs, or either of them,
21 would testify that, because they were opposed to expenditures in Supplemental
22 Budget #2, *i.e.*, commissioner aide positions, they were thereby "adversely affected"
23 by the Board's decision to adopt that supplemental budget. See Plaintiffs' Second
24 Amended Complaint, page 2, paragraph 8.

25 Initially, while recognizing the sparsity of appellate interpretation by Oregon
26 courts concerning the Oregon Public Meetings law, the Oregon Court of Appeals
27 decided *Harris v. Nordquist*, 96 Or App 19, 771 P2d 637 (1989), and included in a

1 discussion of the case the issue of "standing" in the context of a claim under ORS
2 192.610 to 192.690. Although an earlier version of the statute examined in *Harris*
3 was organized differently, the verbiage concerning standing is virtually identical. In
4 *Harris*, plaintiffs were a labor organization which included as members employees and
5 residents of the Phoenix-Talent School District. Defendants were the district, its
6 board of directors, the superintendent and the board clerk. The issue was alleged
7 secret meetings of a quorum of the board in various restaurants where it was alleged
8 they discussed and decided district issues. In *Harris*, those defendants contended
9 "that it is necessary for a plaintiff to allege specifically that he has been affected by
10 a decision of the governing body in order to have standing and that the plaintiffs have
11 no such allegation," *Id.*, 96 Or App at 22. In resolving the question of plaintiffs'
12 standing to bring the complaint, the court in *Harris* stated:

13 "Although a literal reading of the first phrase of the statute might support
14 defendants' contention, that interpretation would run counter to the clear
15 policy of the statutory scheme to keep the public informed of the deliberations
16 and decisions of governing bodies and of the information on which decisions
17 are made. ORS 192.620. That is not to say that ORS 192.080(1) permits just
18 anyone to bring an action. To have standing, one must be affected by a
19 decision, if one is made, and, if that is the case, the statute, read as a whole,
20 authorizes the commencement of an action. If, for example, it were necessary
21 to allege that a specific decision had been made that affected the plaintiff, it
22 would be too late to bring an action 'for the purpose of requiring compliance
23 with' the law; the decision would have been made. Although a decision may
24 be voided, the statute provides that the court 'shall not' void it, if other
25 equitable relief is available, and it is difficult to perceive what other effective
26 relief would be available, if the decision is an accomplished fact.

27 "The same is true with respect to an action brought 'for the prevention
of violations' of the law. That cannot be accomplished with respect to a
decision that has already been made, unless the court voids that decision; yet,
the courts are told not to do that, except as a last resort. Furthermore, an
action may be commenced to determine the applicability of the law to
'decisions of the public body;' it seems clear that, to maintain an action for
that purpose, there need not have been a decision affecting the plaintiff.
Considering the statute as a whole, we conclude that the statute contemplates,
at least, that any person who might be affected by a decision that might be
made has standing to see that the decision is made in compliance with the
Open Meetings Law.

"Plaintiffs allege that they are residents of the district, that some
members of OSEA are its employees and that at least some of them are
taxpayers in the district; they also allege that all of them are 'vitally interested
in all manner of decisions made by Defendants and the input, comments and

1 deliberations incident to such decisions by school board members,
2 administrators and advisers whose counsel members seek preparatory to make
3 decisions.' They also allege that defendants are not complying with the Open
4 Meetings Law, referring to specific instances of 'secret' meetings attended by
a quorum of the board. That is enough to show that plaintiffs are affected by
defendants' decisions and to permit them to maintain this action seeking
compliance with the law. * * * *"

5 *Id.*, 96 Or App at 22-23. As stated in *Harris*, standing is a threshold issue for the
6 court.

7 Defendants in the present case take a slightly different approach to the
8 standing question as it relates to plaintiffs claims here. Essentially, they argue: (1)
9 the decision to expend the funds included in Supplemental Budget #2 was a decision
10 made in the adoption of the 2009-2010 budget in June 2009; (2) there is no new
11 consideration of money expenditures in relation to the commissioner aide positions
12 as that money was actually available to be expended as of July 1, 2009, albeit for
13 a different position and different purposes – It was still part of the budget for the
14 board; (3) therefore, defendants' conclude that because the money was previously
15 authorized to be expended and there was no new money nor increased total
16 expenditures involved, plaintiffs could not have been affected by the enactment of
17 Supplemental Budget #2.

18 In plaintiffs' Second Amended Complaint, they initially sought: (1) a judgment
19 declaring that defendants made the decision to adopt Supplemental Budget #2 in
20 violation of the Public Meetings law making that decision in private meetings; (2)
21 invalidating the enactment of Supplemental Budget #2; (3) an injunction restraining
22 defendants from future violations of the Public Meetings law; (4) a judgment for their
23 costs and attorney fees; and (5) a judgment for personal joint/several liability by the
24 individual commissioner defendants for attorney fees based on the claim that their
25 actions were willful violations of the Public Meetings law. The previous sentence
26 refers to the past tense because this court, in ruling on Defendants' Motion for Partial
27 Summary Judgment, entered partial summary judgment in favor of defendants on

1 plaintiffs' request for this court to invalidate the enactment. This court determined
2 that question was moot as of July 1, 2010, and signed an order on November 23,
3 2010, allowing the motion for partial summary judgment. *Also see* this court's letter
4 opinion dated October 25, 2010, page 3. Plaintiffs' remaining claims are what this
5 court is obligated to decide. It is in the context of those remaining questions that this
6 court examines plaintiffs' standing.

7 In resolving this issue, this court looks again at the policy for this statute that
8 the court recognized in *Harris*. That court stated "* * * that interpretation would run
9 counter to the clear policy of the statutory scheme to keep the public informed of the
10 deliberations and decisions of governing bodies and of the information on which
11 decisions are made." *Id.*, 96 Or App at 22. At its essence, defendants argument
12 would mean that no person could be "affected," as used in ORS 192.680(2), by a
13 decision of the Board related to any future decision on the budget after its adoption,
14 so long as the decision did not include new money being expended. In defendants'
15 view, apparently no person could be affected by the decision to adopt Supplemental
16 Budget #2. This court concludes that is too narrow a reading of the meaning of
17 "affected."

18 Returning to *Harris*, the kernel this court derives from that decision as to the
19 meaning of "affected" is "the statute contemplates, at least, that any person who
20 might be affected by a decision that might be made has standing to see that the
21 decision is made in compliance with the Open Meetings Law." *Id.*, 96 Or App at 22.
22 To have an affect, or be affected, "implies the action of a stimulus that can produce
23 a response or reaction." Webster's. The dispute in this case now surrounds the
24 actions of the Board members leading up to what was adopted as Supplemental
25 Budget #2. Defendants produced no evidence to refute plaintiffs' claims that they
26 opposed those expenditures, and particularly the inclusion of commissioner aide
27 positions in the budget. They have a reason they oppose those expenditures, that

1 being a belief that the money should be spent on other county priorities.

2 The important part of the statutory policy in the context of this case is the
3 obligation to allow the public to be informed of the decisions and deliberations of the
4 governing body. Defendants' position would exempt a huge portion of decision
5 making from that policy. In *Harris*, the claim the court rejected was the claim that the
6 lack of an allegation of a specific decision meant that plaintiffs could not have been
7 "affected." Here, by plaintiffs' alleging specific actions leading up to the decision to
8 adopt Supplemental Budget #2, defendants somehow translate the "affect" of the
9 decision on plaintiffs to be well beyond the right plaintiffs shared under the statute
10 with other Lane County citizens to simply be informed of the decisions and
11 deliberations.³¹

12 In Supplemental Budget #2, the Board's action was a decision to eliminate a
13 position created in June 2009 at .8 FTE. An additional expenditure of \$20,000 from
14 another previously approved source was combined with the .8 FTE added to 1.7 FTE
15 to create the total 2.5 FTE necessary to fund five one-half time commissioner aide
16 positions. Simply because the expenditure of funds is authorized for a particular
17 purpose in the budget does not mean they must be expended for that or any other
18 purpose. The Board could have not used those funds or could have allocated them
19 in the 2009-2010 budget year for a purpose plaintiffs supported. Because the matter
20 was properly before the board as a "decision," that being the question of whether or
21 not to adopt a proposed supplemental budget, the Public Meetings law required that

22
23 ³¹It is hard to understand how this court could find no standing for plaintiffs to challenge a
24 specifically identified decision and seek to enforce the statutory obligations of the Public Meetings
25 law surrounding that decision when the court in *Harris* found standing by similarly situated plaintiffs
26 to enforce compliance with Public Meetings law without regard to any particular decision being
27 identified. That may be a particular way defendants in the present case view *Harris* as wrongly
decided, as they stated. In fact, that ultimately was the downfall of the plaintiffs in *Harris*. They did
not prevail because they could not produce any evidence that the quorum of defendants' board was
deliberating as opposed to information gathering as a group. *Id.*, 96 Or App 25.

1 the actions of the governing body on the question presented were required to be
2 taken in compliance with those laws. Plaintiffs have produced sufficient facts to
3 demonstrate they have standing to challenge the actions of the Board and the
4 individual defendants in the decision that ultimately was the adoption of Supplemental
5 Budget #2.

6 Defendants raise the issue of how a meeting occurs in the context of the
7 evidence presented. ORS 192.670 recognizes that a "meeting" occurs outside of a
8 quorum of the governing body in the same room, face to face. It states:

9 "(1) Any meeting, including an executive session, of a governing body
10 of a public body which is held through the use of a telephone or other
11 electronic communication shall be conducted in accordance with ORS 192.610
12 to 192.690.

13 "(2) When telephone or other electronic means of communication is used
14 and the meeting is not an executive session, the governing body shall make
15 available to the public at least one place where the public can listen to the
16 communications at the time it occurs by means of speakers or other devices.
17 The place provided may be a place where no member of the governing body
18 of the public body is present."

19 *Id.* Defendants argue that it is not clear that Oregon Public Meetings law applies to
20 email communication. In distinguishing an email communication, they argued "[t]he
21 statute gives no indication that a 'meeting' occurs when members of the governing
22 body send one another written letters - there is no principled reason why a 'meeting'
23 should arise when members send a copy of the same letter electronically."
24 Defendants Rob Handy, Peter Sorenson and Bill Fleenor's Trial Memorandum
25 [hereinafter "Individual Defendants' Trial Memorandum"], Page 5. The last
26 amendment to ORS 192.670 occurred in 1979. 1979 Oregon Laws, Chapter 361,
27 section 1. There was no evidence presented when the concept of email was created
or when it became common knowledge what an email was, but this court concedes
that it seems unlikely that the legislature conceived of email in its present form in
1979. That being said, it does not mean the law as written is not broad enough to
encompass email communication as a possible manner of deliberation by the

1 governing body of a public body at this time.³² According to Webster's, published
2 in 1999, "electronic" means "relating to or utilizing devices constructed or working
3 by the methods or principles of electronics; implemented on or by means of a
4 computer." Without regard to defendants' argument as to how the email
5 communication is used, *i.e.*, in lieu of a written letter or like a short telephone
6 message, this court concludes that email is a means of communication and is an
7 "electronic communication" as that term is used in ORS 192.670(1). With regard to
8 this court's decision about the events surrounding the December 9, 2009, adoption
9 of Supplemental Budget #2, that conclusion is probably of no consequence to this
10 court's decision.

11 The question now posed for this court is whether the evidence shows that it
12 is more likely true than not true that the defendants, including at least a quorum of
13 the Board, conducted a meeting or meetings in violation of Oregon Public Meetings
14 law in either deliberating on or deciding on the adoption of Supplemental Budget #2.³³
15 Broken down, that question determines: (1) did at least three members of the Board;
16 (2) make a decision or deliberate toward deciding Supplemental Budget #2; (3) in any
17 setting that was private and was not open to the public.

18 In addressing the above question, this court has struggled with the view that
19 there ought to be some bright line rule that can be identified by the court for the
20 benefit of these defendants as well as others that may be concerned about this
21 question. In the context of the case before this court, this court is satisfied that a
22 continued search for a bright line rule is a fool's errand. Further, and more
23

24 ³²Based on the evidence presented in the present case, this court rejects defendants' analogy
25 to email as the equivalent of a letter. As the various emails show, they are far more like the normal
26 back and forth in conversation than correspondence in letter form. There is the opportunity for
immediate viewing and response. That in fact occurred in several emails in this case.

27 ³³This definition of "preponderance" of evidence is derived from the 2009 version of UCII
14.02.

1 Importantly, it is unnecessary in order to answer the questions raised in this case.
2 In the present case, it is this court's conclusion that it is certainly more likely true that
3 defendants engaged in a process that involved at least a quorum of the board
4 deliberating toward and deciding on the adoption of Supplemental Budget #2 in
5 private and in meetings that were not open to the public. In answering this basic
6 question, this court looks only to the evidence of the actions of defendants after June
7 24, 2009.

8 From about August 2009, the evidence is clear that Handy was almost single-
9 minded in his determination to pursue inclusion of commissioner aides in the Lane
10 County budget, including the 2009-2010 budget year. He had the support of
11 Sorenson, who shared his view that commissioner aides were needed. No matter
12 who else participated in the process individually, this issue was obviously owned by
13 Handy. He brought in his trusted aide, Barkhurst, to assist and together they put the
14 package together for Moody. Moody, as a county staff member, included it in the
15 supplemental budget proposal.³⁴ If that were all of the evidence plaintiffs' presented,
16 they could not prevail as there is nothing wrong up until that point.³⁵ As *Harris*
17 makes clear, the fact that multiple commissioners constituting a quorum of the Board
18 may be together in one place, discuss county business while together, have personal
19 agendas on matters they consider important, and are even pursuing those issues by
20 seeking the support of fellow commissioners is not, of itself, a violation of Oregon
21 Public Meetings law.

22
23 ³⁴Moody's motives here are not really in question and her actions are certainly not a part of
24 any decision making, but this court is troubled as to why she felt obligated to essentially cover for
25 Handy when she was asked specifically by Stewart at the public meeting on December 9, 2009, for
26 the name of the commissioner who inserted the commissioner aide positions back in the supplemental
budget. It is clear that, on December 9, Moody was protecting Handy.

27 ³⁵This court sees no connection between any violation of unenforced Board rules, Exhibit 33,
and a Public Meetings law violation.

1 There comes a point however, when these issues rise to the level of a matter
2 that is pending for decision by the board. In the present case, that date can be
3 specifically identified and is certainly no later than December 1, 2009. That is the
4 date that the issue of proposed Supplemental Budget #2 was sent to the Eugene
5 Register Guard for publication. At that point, it was clear or should have been clear
6 to all involved, that what was proposed as Supplemental Budget #2 was going to be
7 decided by the Board on December 9, 2009. The county even publishes a calendar
8 so everyone involved in the process knows when a final action is expected to take
9 place. Exhibit 400. As of December 1, there is no question that there was a
10 "proposal" pending before the Board on the question of adoption of Supplemental
11 Budget #2 within the meaning of ORS 192.610(1). Even looking at December 1,
12 there is no evidence this court saw that would indicate that a Public Meetings law
13 violation had taken place as of that date in relation to Supplemental Budget #2.

14 Whether it was Handy alone, and he was clearly the one out front pushing this
15 matter, or Handy working with Sorenson, the matter couldn't just be allowed to run
16 its course at the public meeting on December 9. It is obvious that it was extremely
17 important that the matter be resolved as Handy envisioned the outcome for that date.

18 The evidence is clear that between December 1 and December 9, the fate of
19 Supplemental Budget #2 was decided outside the public meeting context. Handy, in
20 the lead, made sure that he had the votes lined up. That process was wrapped up
21 during the afternoon of December 8 and was confirmed by Handy on the morning of
22 December 9, just prior to the "public meeting." That occurred in a series of
23 discussions among Handy, Sorenson, Dwyer and Stewart. The primary participants
24 were Handy and Sorenson, but Dwyer and even Stewart participated in the process
25 in violation of the Public Meetings law. The evidence did not show that any three
26 commissioners were ever in the same room at the same time talking about this
27 matter. That does not mean that the continuing multiple conversations were not a

1 deliberation. All involved knew that a quorum of the board was working toward a
2 final decision outside of the public meeting context. Just like in May 2009 when the
3 votes of a quorum were being tracked, Handy was counting them in December. In
4 effect, the public meeting vote on December 9 was a sham. It was orchestrated
5 down to the timing and manner of the vote so as to avoid any public discussion. The
6 defendants' purpose in that regard was clear - to avoid adverse public comment or
7 criticism as that appears to be how a quorum of the Board viewed the Register
8 Guard's reporting on the subject. Stewart may not have been working toward the
9 same goal as Handy, but it is obvious he knew what was happening at least as late
10 as in the office on the morning of December 9, before the public meeting. Why
11 Dwyer chose to involve himself in the non-public deliberations process is not at all
12 clear, but he clearly did involve himself.

13 This court concludes that plaintiffs have proven their case that defendants
14 violated the Public Meetings law in relation to the adoption of Supplemental Budget
15 #2. The question now presented is whether the conduct of any of the three
16 individual defendants, Handy, Sorenson or Fleenor constituted "willful misconduct"
17 in relation to the violation(s) that occurred. ORS 192.680(4). If that conduct was
18 willful misconduct, they are jointly and severally liable individually for attorney fees
19 and costs ordered to be paid by the public body. *Id.*

20 The parties do not agree on what constitutes "willful misconduct." Oregon
21 Public Meetings law does not define that phrase. Neither party suggests the
22 legislative history of the statute offers any guidance. In an attorney disciplinary
23 proceeding, the Oregon Supreme Court has examined the meaning of "willfully" in the
24 context a contempt finding under ORS 33.015(2) compared to the mental state of
25 "intent" as used by the American Bar Association's *Standards for Imposing Lawyer*
26 *Sanctions*. In *In re Chase*, 339 Or 452, 121 P3d 1160 (2005), the court stated "*
27 * *the two definitions do not equate: 'willfulness' under ORS 33.015(2) does not

1 require the conscious purpose that describes 'intent' in the ABA Standards." *Id.*, 339
2 Or at 457. The ABA Standards defined "intent" as "the conscious objective or
3 purpose to accomplish a particular result."³⁶ *Id.*

4 In *Chase*, the court further directed its attention to *State ex rel Mikkelsen v.*
5 *Hill*, 315 Or 452, 847 P2d 402 (1993) and the application of the willfulness standard
6 in a Chapter 33 contempt proceeding. *Mikkelsen* was a criminal contempt proceeding
7 for failure to pay child support.³⁷ The underlying issue in that case was whether
8 inability to pay was a burden the state must overcome in proving willfulness or an
9 affirmative defense. The court in *Mikkelsen* decided inability to pay was not an
10 element of the offense. Characterizing the meaning of willfulness from *Mikkelsen*, the
11 court in *Chase* stated "'proof that a party had knowledge of a valid court order and
12 failed to comply with that order' establishes a finding of 'willfulness' under ORS
13 33.015(2)." *Chase*, 339 Or at 457.

14 Defendants did submit authority on this issue. They argue "willful" is "* * *
15 synonymous with 'intentional.'" Individual Defendants Trial Memorandum, page 8.
16 Defendants cite another attorney discipline case in support of their assertion, *In re*
17 *Gatti*, 330 Or 517, 8 P3d 996 (2000). In the context of the court's decision to

18
19 ³⁶This court would note that the ABA Standards definition of "intent" is virtually identical to
20 the Oregon criminal law definition of that term in ORS 161.085(7) "* * * a person acts with a
conscious objective to cause the result or to engage in the conduct * * *."

21 ³⁷Although plaintiffs in the present case did not submit any authority for the definition of
22 "willful" they felt was applicable to this proceeding, they did argue that it should be the standard
23 courts in Oregon have applied in the remedial context, not in a punitive setting. This court has not
24 found that Oregon courts have applied a different definition to willful conduct or different standard
25 of "willfulness" in the remedial as compared to punitive contempt context. Rather, in the context of
26 punitive contempt as well as remedial contempt where a jail sanction is sought, the law imposes on
27 the state the burden of proof of "beyond a reasonable doubt." ORS 33.065(9) and 33.055(11).
Remedial contempt without a jail sanction requires proof by a "clear and convincing evidence"
standard. ORS 33.055(11). In fact, a defendant in a punitive contempt case is afforded all of the
constitutional protections available to a criminal defendant, except the right to a jury trial. ORS
33.065(6). As the discussion continues above, however, depending on the context, Oregon courts
have applied different standards to "willful."

1 discipline a lawyer for "* * * willful deceit or misconduct * * *" pursuant to ORS
2 9.527(4), the court in *Gatti* stated "[w]illful deceit or misconduct is synonymous with
3 intentional deceit or misconduct. It is conduct that is intended to cause a particular
4 result." *Id.*, 330 Or 529. The Supreme Court relied in *Gatti* on its earlier decision in
5 *In re Morris*, 326 Or 493, 953 P2d 387 (1998), on this issue. *Morris* was also cited
6 in support of defendants' position. This definition of willful is consistent with the
7 Oregon Supreme Court's interpretation of "willful" in the context of a violation of the
8 Oregon Code of Judicial Conduct. *In re Gallagher*, 326 Or 267, 951 P2d 705 (1998).
9 In *Gallagher*, the court stated "[i]n this context, the court has defined a 'willful' act
10 to mean an act done with a conscious objective of causing the result or acting in the
11 manner contrary to the applicable rule." *Id.*, 326 Or at 269.

12 In the context of Unlawful Trade Practices, ORS 646.605 *et seq.*, subsection
13 (1) of that section includes the following definition:

14 "A willful violation occurs when the person committing the violation
15 knew or should have known that the conduct of the person was a violation."

16 That statutory definition is more in line with the court's interpretation of "willful" in
17 the context of ORS Chapter 33 contempt.

18 Willful misconduct in the context of a Public Meetings law violation could
19 require that it be proven that the person acted with a conscious objective to violate
20 those particular statutory provisions. That is defendants' position. The burden this
21 court assumes plaintiffs' would support is that they are required to prove that the
22 person had knowledge of the law's requirements and thereafter failed to follow those
23 requirements. In the context of this court's conclusions, it will be left to a higher
24 court to decide which burden must be met if that court believes that decision needs
25 to be made. Under either standard, this court is convinced that the question is clearly
26 answered as to each individual defendant, albeit differently.

27 With regard to Fleenor, there is a conspicuous absence of evidence that he

1 participated in any way (not simply--not in any meaningful way) in the efforts to avoid
2 the requirements of the Public Meetings law in the adoption of Supplemental Budget
3 #2. His position - that he would not vote to include commissioner aides in the
4 supplemental budget - was well known and known early on. In fact, according to
5 Handy's own words, Fleenor's efforts to look for other uses for unspent money was
6 one of the precipitating factors encouraging Handy to act. Essentially, the only
7 testimony or evidence as to further actions by Fleenor was Moody's conversation
8 with him about the supplemental budget before it was enacted. In addition, he
9 showed up at the meeting and voted no.

10 On this issue, it becomes clear why plaintiffs would like to bootstrap Fleenor's
11 conduct from the events of April and May 2009 so as to view them as a continuing
12 deliberation on Supplemental Budget #2. Plaintiffs' argue "* * * the same
13 deliberations that led the Defendants to initially fund the assistants in the proposed
14 budget in May informed their decision to finalize funding for the assistants in the
15 supplemental budget in December." Plaintiffs' Trial Memorandum, page 11. As
16 stated above, this court simply disagrees that the events are somehow a continuing
17 deliberation.

18 There can be no question Fleenor knew exactly what was happening on
19 December 9, 2009. That is established through Land's December 8, 2009, email.
20 This court notes with interest that, while criticizing the enactment of the supplemental
21 budget on December 9, stating the timing was wrong (Exhibit 6, page 2), by
22 December 23, 2009, Fleenor was causing consternation among county staff with his
23 pronouncements about already having decided who he was hiring to fill the position.
24 That may be seen as hypocritical, but it is not evidence of participation in the scheme
25 to avoid the Public Meetings law under either standard set out above.³⁸ The evidence
26

27 ³⁸Although not specifically raised, in the context of this case, this court would not accept that simply showing up and voting in the public meeting as a member of the Board is a willful violation

1 is insufficient to establish that Fleenor acted wilfully in violating the Public Meetings
2 law in the events surrounding the adoption of Supplemental Budget #2. Fleenor is
3 entitled to a judgment dismissing him as an individual defendant in this case.

4 With regard to Handy, there is equally no question that his organization of the
5 scheme to enact Supplemental Budget #2 was willful under either standard discussed
6 above. Although this court may have felt that plaintiffs could have produced the
7 evidence in lesser detail, as it relates to Handy, the evidence from the earlier Spring
8 2009 budget process weighs directly on his mental state in the events surrounding
9 the enactment of Supplemental Budget #2. As stated previously, this court rejects
10 his efforts to suggest his ignorance of the Public Meetings law's requirements.
11 Warranting particular emphasis here is County Counsel's written reaction to the Board
12 and then to Handy personally about her opinion of the activities she was aware of
13 from the emails produced in response to the Register Guard's public records
14 request.³⁹ Even ignoring County Counsel's very pointedly critical commentary to him
15 personally in her second email, her first email to the Board and Spartz made it clear
16 there was a problem. It was clear County Counsel viewed with great concern the
17 conduct of the group Handy was working with. In addition, she expressed her view
18 that others were likely to view that conduct as a violation of the statute. Judging
19 from Handy's response, he is not a person who tolerates being criticized. At that
20 point, whether he agreed or disagreed, Handy clearly understood that the county's
21 attorney believed there was a problem that needed to be avoided.

22 Except for the meeting process, Handy's efforts in the adoption of
23 _____
24 of the statute, even with prior knowledge of a scheme of this nature, if the member has voted no. A
25 much closer question is raised if the person would vote in favor of the question, *i.e.*, consistent with
the scheme, and the willfulness standard is consistent with its application in ORS Chapter 33.

26 ³⁹This court would note that Handy had to know, at the time of County Counsel's emails in
27 June 2009, that County Counsel did not even know of the full extent of the activities of Handy
himself, Fleenor, Sorenson, Barkhurst nor even BIG.

1 Supplemental Budget #2 followed the blueprint from the Spring of 2009. There is
2 simply no question that the evidence establishes that Handy's conduct was willful as
3 that term is used in ORS 192.680(4).

4 Although Sorenson was not the person out front on the issue of including
5 commissioner aide positions in Supplemental Budget #2, this court concludes that the
6 evidence shows, under either definition of willfulness set out above, he did willfully
7 violate the Public Meetings law as well. Like Handy, Sorenson's early support of
8 some proposal to include the commissioner aide positions in the supplemental budget
9 is not in any way a violation of the Public Meetings law. However, the evidence
10 shows that Sorenson's conduct was fully supportive and participatory in Handy's
11 scheme. Not only was he the third and a necessary vote, his vote was organized and
12 decided in the private discussions that took place. He needed to go along with the
13 scheme in order to get the issue addressed and the vote taken with the least amount
14 of public discussion. As the Chair of the Board, he was able to accomplish that task -
15 and he did so.

16 Like Handy, he didn't heed the message from County Counsel either. He knew
17 what had gone on in the Spring of 2009 and he knew County Counsel's opinion
18 about that conduct in relations to the Public Meetings law.⁴⁰ Further, he is a lawyer
19 who had worked with the law. Sorenson acted in concert with Handy and someone
20 he really didn't trust, Dwyer, to make the decisions about Supplemental Budget #2
21 outside of the public meeting and to conduct the meeting so as to simply confirm
22 what had been agreed to, in the exact manner it was agreed it would take place.
23 Sorenson's conduct was willful as that term is used in ORS 192.680(4).

24 Based on the findings of fact and conclusions of law set out above this court
25

26 ⁴⁰There is a strong implication that his use of "Book Club" was a purposeful attempt to
27 disguise the true nature of BIG's activities, which he knew were within the scope of the Public
Meetings law.

1 makes the following determinations in this case. Plaintiffs are entitled to a judgment
2 containing a declaration: (1) that defendant Board made the decision to adopt
3 Supplemental Budget #2 in violation of ORS 192.610 to 192.690; and, (2) that
4 defendant Board violated ORS 192.630(2) and ORS 192.670 by conducting private
5 meetings. Plaintiffs are entitled to request their attorney fees and costs pursuant to
6 ORCP 68. Plaintiffs are likewise entitled to a judgment against Handy and Sorenson
7 individually, awarding any attorney fees and costs jointly and severally against them
8 individually pursuant to ORS 192.680(4). Defendant Fleenor is entitled to a judgment
9 of dismissal as an individual defendant.

10 Under plaintiffs second claim for relief they seek an "injunction restraining each
11 defendant named herein from violating ORS 192.610 to 192.690." Second Amended
12 Complaint, page 12. In support of their claim, plaintiffs allege:

13 "Defendants' violations of Oregon public meeting laws have been
14 regular, sustained and are ongoing. The violations alleged herein are the result
15 of intentional disregard of the law or willful misconduct by a quorum of the
16 members of the governing body, including specifically Handy, Sorenson and
17 Fleenor. Defendants will continue to violate Oregon Public Meeting laws in the
18 absence of injunctive relief."

19 Second Amended Complaint, Paragraph 43, page 10.

20 Plaintiffs have proven those allegations, except as described above concerning
21 intentional or willful misconduct by Fleenor in December 2009. This is the second
22 issue plaintiffs raised where the evidence concerning defendants' conduct in the
23 Spring of 2009 is relevant and bears directly on this court's decision. While it does
24 not weigh in the decision on whether defendants violated the Public Meetings law in
25 the events leading to adoption of Supplemental Budget #2, it is clear that it is more
26 likely true than not true that the scheme involved in the approval of the 2009-2010
27 Lane County Budget on May 19, 2009, also violated Oregon Public Meetings law.
It is so obvious that it is more true that this court won't set out its analysis of the
facts on that conclusion. This court concludes that that conduct was willful as well,

1 under either standard described above.

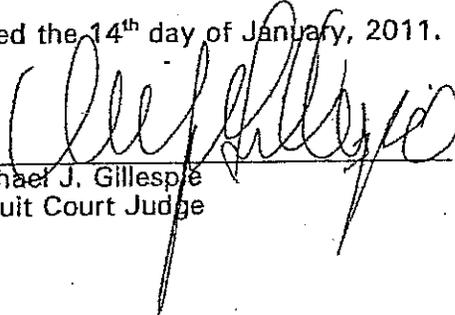
2 This court is unable, based on the evidence received, to formulate terms of an
3 injunction and will conduct an additional hearing, with briefing and argument on the
4 terms of an injunction plaintiffs will be obligated to initially propose. That injunction
5 would not include Fleenor, based both on his dismissal as an individual defendant as
6 well as on the fact that he is no longer a member of the Board.

7

8 Dated the 14th day of January, 2011.

9

10


Michael J. Gillespie
Circuit Court Judge

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

**NEWSLETTERS
&
ARTICLES OF
INTEREST**

Nothing to report under this tab

LICENSE RATIFICATION

This Page

Left Blank

16. RATIFICATION OF LICENSES

As authorized by the Board, licenses to practice dentistry and dental hygiene were issued to applicants who fulfilled all routine licensure requirements. It is recommended the Board ratify issuance of the following licenses. Complete application files will be available for review during the Board meeting.

Dental Hygiene

H6691	JULIA A FOX, R.D.H.	4/16/2014
H6692	ALAINA M DONIS, R.D.H.	4/17/2014
H6693	DANICA R HERRMANN, R.D.H.	4/25/2014
H6694	NATASHA N LUNT, R.D.H.	4/25/2014
H6695	LAUREN KAIMANA MANLEY, R.D.H.	4/29/2014
H6696	ALISA M STEPHENSON, R.D.H.	4/30/2014
H6697	ANFISA A PIATKOFF, R.D.H.	4/30/2014
H6698	VITALY ORMANJI, R.D.H.	4/30/2014
H6699	HEATHER KAY ELLER, R.D.H.	5/1/2014
H6700	MEAGAN E KINTZ, R.D.H.	5/7/2014
H6701	ELIZABETH A THOMPSON, R.D.H.	5/7/2014
H6702	KATHLEEN MARIE LOE, R.D.H.	5/7/2014
H6703	MCKENZIE RACHELLE SCHOFIELD, R.D.H.	5/8/2014
H6704	KATHRYN J PELOSI, R.D.H.	5/15/2014
H6705	KAYLA K ROOKS, R.D.H.	5/15/2014
H6706	LINDSAY ANN OLDHAM, R.D.H.	5/15/2014
H6707	NIKKI NGUYEN, R.D.H.	5/15/2014
H6708	SHANDY LINNE BEAN, R.D.H.	5/15/2014
H6709	RYAN A KRENN, R.D.H.	5/15/2014
H6710	EMILY RAYE SCHWINDT, R.D.H.	5/21/2014
H6711	CHERYL ANN SCHNELL, R.D.H.	5/21/2014
H6712	DOREYDA REYNOSO, R.D.H.	5/21/2014
H6713	TRACI JO EVANS-TUCKER, R.D.H.	5/21/2014
H6714	RUBEN V CHEKHOV, R.D.H.	5/21/2014
H6715	HEATHER DAWN HEMMERT, R.D.H.	5/21/2014
H6716	JUDITH E MIRANDA OLIVARES, R.D.H.	5/21/2014
H6717	LISA SUZANNE STIFF, R.D.H.	5/21/2014
H6718	ALLYSON LYNN WARREN, R.D.H.	5/21/2014
H6719	KAYLYNNE KUENZI, R.D.H.	5/21/2014
H6720	HANNAH GRACE JORDAN, R.D.H.	5/22/2014
H6721	LAUREN G ROTH, R.D.H.	5/22/2014
H6722	KRISTA NICOLE STEWART, R.D.H.	5/28/2014
H6723	AMANDA M BARTELL, R.D.H.	5/28/2014
H6724	WENDY N LEAVITT, R.D.H.	6/2/2014
H6725	MARZURI L WAGGONER, R.D.H.	6/2/2014
H6726	JESSICA LANAE LAWSON, R.D.H.	6/2/2014
H6727	DENISE D WIDNEY, R.D.H.	6/2/2014
H6728	KARLA MAE DETTWYLER, R.D.H.	6/2/2014
H6729	MEREDITH ROBBINS GARRETT, R.D.H.	6/3/2014
H6730	KRISTINA D WOOD, R.D.H.	6/3/2014
H6731	MINH NGOC NGUYEN, R.D.H.	6/3/2014
H6732	REBECCA E POWER, R.D.H.	6/4/2014

Dentists

D10012	FARBOD NADJIBI, D.D.S.	4/25/2014
D10013	IRINEO MARVIN BAUTISTA I PANTANGCO, D.D.S.	4/25/2014
D10014	WILLIAM MOORE, D.M.D.	4/25/2014
D10015	ALEXANDRA C DE MILLO TERRAZZANI, D.D.S.	4/25/2014
D10016	JASON KIM, D.D.S.	4/25/2014
D10017	TONY T NGUYEN, D.M.D.	4/30/2014
D10018	MICHAEL EDWARD HANN, D.D.S.	4/30/2014
D10019	SETH A HOLLAND, D.M.D.	5/1/2014
D10020	NICOLE L OLIVARES, D.D.S.	5/5/2014
D10021	NALANI ODA, D.D.S.	5/7/2014
D10022	RICHARD B BRADSHAW, D.M.D.	5/7/2014
D10023	ALEXIS LEE KLEINMAN, D.M.D.	5/7/2014
D10024	JONATHAN LEE BROWNING, D.D.S.	5/8/2014
D10025	PATRICK J HEAPHY, D.M.D.	5/8/2014
D10026	JOSHUA NELSON GRUBER, D.D.S.	5/8/2014
D10027	OCTAVIA E SWANSON, D.D.S.	5/15/2014
D10028	DANIEL BLACKHAM ADAIR, D.D.S.	5/15/2014
D10029	JOHN A GREEN, D.M.D.	5/21/2014
D10030	MACKENZIE H CRAIK, D.D.S.	5/21/2014
D10031	ANEEL NATH, D.D.S.	5/21/2014
D10032	DAVID B POOR, D.M.D.	5/28/2014
D10033	TIFFANI A LONG, D.D.S.	5/28/2014
D10034	B. JASON FIFE, D.D.S.	5/28/2014
D10035	JENNIFER E POHL, D.D.S.	5/28/2014
D10036	BRYANT RICHARD ZOLLINGER, D.D.S.	5/28/2014
D10037	WILLIAM H SHIPLEY, D.D.S.	6/2/2014
D10038	TYLER BOONE SCHAFFELD, D.M.D.	6/2/2014
D10039	JAEHEE HWANG WILLIAMSON, D.M.D.	6/3/2014
D10040	PAIGE R SCHMIDT, D.D.S.	6/4/2014
D10041	KIMBERLY P WALTERS, D.M.D.	6/4/2014
D10042	MICHAEL LOWE, D.D.S.	6/4/2014
D10043	KALI LLAURAL GRAY, D.M.D.	6/5/2014
D10044	BAYNE HILLEN HEERSINK, D.M.D.	6/5/2014
D10045	MELANIE R RAWLINGS, D.D.S.	6/6/2014
D10046	PHIL L HAN, D.M.D.	6/6/2014