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Governor

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1st Vice President

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Dr. Krista Jones
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Dr. Lisa Nowlin
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Dr. J Mark Folks
Miami, Oklahoma

Chief J.R. Kidney
Tecumseh, Oklahoma

Rachel Ostberg, RDH
Bartlesville, Oklahoma

Dr. Scott Breland
Sapulpa, Oklahoma

Sheriff Andrew Simmons
Muskogee, Oklahoma

OKLAHOMA

AGENDA
Regular Board Meeting and Study Session
Choctaw Casino Resort 4216 US-69
Durant, OK 74701, Cedar Room
October 2-3, 2026 at 9:00am

During the two-day meeting, the Board will be taking breaks for lunch and dinner. During these breaks, Board business will not be discussed. Agenda items may be discussed out of order to accommodate guest speakers.

1. Meeting called to Order.

2. Approval of minutes from August 21, 2026, Regular Board Meeting. Pg 1

3. Executive Director's Report
   a. Budget information and Stats; Pg 5-10
   b. Update Legislative Session and dental related bills; Pg 11

4. President's Report to include AADB Report– Dr. Bobby Carmen.

5. ADEX Report- Dr. Krista Jones.

6. CODA Report- Dr. Lisa Nowlin.

7. Dental Hygiene Advisory Committee Report – Rachel Ostberg, R.D.H.

8. Deputy Director Puckett's report. Pg 51

9. Paul Mullasseril, Dean of Oklahoma University College of Dentistry – Update on activities at OU College of Dentistry.

10. Guest Speaker Dr. Catherine Sherry regarding Myofunctional Therapy. Pg 53

11. Discussion and Possible Action Regarding the reappointment of Advisory Committee Members:

    Nathan Villines, D.D.S. – Open Dental Practice Committee Board Appointment Pg 57-60

12. Discussion and Possible Action Regarding Limited Faculty Application for Mohammed Nizami, B.D.S. (*Possible Executive Session as authorized by 25 O.S. §307(B)(8) regarding the above matter in order to engage in deliberations or rendering a final or intermediate decision in an individual proceeding pursuant to Article II of the Administrative Procedures Act.)* Pg 61-66

13. Discussion and Possible Action Regarding Possible Voluntary Surrender of Dental License for Geoffrey Sims, D.D.S., License #5179. Case #21-109(B), 24-14, and 25-34. (*Possible Executive Session as authorized by 25 O.S. §307(B)(8) regarding the above matter in order to engage in deliberations or rendering a final or intermediate decision in an individual proceeding pursuant to Article II of the Administrative Procedures Act.)* Pg 67-98

14. Discussion and Possible Action Regarding Application for Hygiene Licensure for Chloe Pan, R.D.H. (*Possible Executive Session as authorized by 25 O.S. §307(B)(8) regarding the above matter in order to engage in deliberations or rendering a final or intermediate decision in an individual proceeding pursuant to Article II of the Administrative Procedures Act.)* Pg 99-108

15. Discussion and Possible Action regarding the Jurisprudence Exam and Update with Rachel Ostberg, R.D.H. (*Possible Executive Session as authorized by 25 O.S. §307(7)) to discuss educational testing, review and discussion of dental exams that are confidential pursuant to 20 U.S.C. § 1232h, 34 CFR Part 98.)*

16. Discussion and Possible Action Regarding Board Approval of Allied Health Committee Approved Courses for Expanded Function Courses and Advanced Procedures as Follows: Oklahoma Dental Foundation- Radiation Safety, Nitrous, Sealants, Coronal Polishing, Local Anesthesia
Dental Careers Institute: Radiation Safety, Nitrous, Sealants, Coronal Polishing
Learn Today LLC- Radiation Safety, Nitrous, Sealants, Coronal Polishing, Local Anesthesia, Laser
Dedicated Dental Hygiene- Laser
Laser Hygiene, LLC- Angie Wallace- Laser
Advanced Dental Hygiene- Laser
Steven A Burman, D.M.D. Fontona Laser- Laser
Tulsa Technology Center- Radiation Safety, Nitrous, Sealants, Coronal Polishing
DentaSpa- Neuromodulator Administration
Advanced Dental Institute- Neuromodulator Administration
American Academy of Facial Esthetics- Neuromodulator Administration
Coty Shores, D.D.S., Frank Heinrich, D.D.S., Jamison Spencer, D.M.D., M.S.- Neuromodulator Administration
Elite Smiles-Dr. Michelle Sanor- Neuromodulator Administration
Dr. Jon "Eric" Hopkins – Venipuncture/Phlebotomy

17. Discussion and Possible Action Regarding the Applications for Dental Licenses by Exam as listed in Appendix "A". Pg 109

18. Discussion and Possible Action Regarding the Applications for Dental Licenses by Credential as listed in Appendix "A". Pg 109

19. Discussion and Possible Action Regarding the Applications for Specialty Dental Licenses by Exam and Credential as listed in Appendix "A". Pg 109

20. Discussion and Possible Action Regarding the Applications for Hygiene Licenses by Exam and Credential as listed in Appendix "A". Pg 110

21. Discussion and Possible Action Regarding Dentist requesting to Reinstate Dental Licenses listed in Appendix "A". Pg 110

22. Discussion and Possible Action Regarding Dentist Requesting to Retire and Request for Volunteer License as listed in Appendix "A". Pg 110

23. Discussion and Possible Action Regarding Dentists and Dental Hygienists Requesting to Not Renew License as listed in Appendix "A". Pg 110

24. Discussion and Possible Action Regarding requests for Advanced Procedures and Allied Dental Education Committee Recommendations as listed in Appendix "A". Pg 111

25. Potential setting of 2026 Board Meeting, hearing and study session dates.

26. The Board will be conducting a Board member training and study session after item #25 on the agenda. NO VOTES WILL BE TAKEN DURING THE TRAINING AND STUDY SESSION portion of the meeting; A training session for the Board will include a review of the Open Meetings Laws, State Purchasing Laws, the Administrative Procedures Act, the Americans with Disabilities Act, HIPAA and other protocols required of Board members pursuant to Oklahoma laws. Throughout the year, questions and issues arise that are compiled for review and discussion by the Board. This can include presentations and information provided by different organizations or individuals. This study session is open to the public and encouraged by licensees. Input and discussion are welcomed from licensees and interested parties during this training. A summary of the discussion will be available in the minutes to be approved at the November meeting.

A. Rules Updates

I. Dental Hygiene Correction / Additions

i. Make Phlebotomy and Venipuncture One Advanced Procedure – update if it needs to be a specific course. *(See Statutes 328.21 I Page 16, 195:151-6.1 (6) Rules).*

ii. Vaccinations (people have paid for Advanced Procedure but not listed as one) – Take off licenses? *(195:151-6.1 (6) Rules, Statutes 328.57 Page 51).*

iii. Add number of injections back to the local anesthesia requirements for courses. 10 blocks and 5 infiltrations. *(195:15-1-6.1(2) Rules).*

II. Dental Assistants Corrections / Additions

i. Review Vaccinations section of statutes to rules. May need to update rules. *(Chapter 15 195:15-1-4 (6)(iv) Rules*

ii. Review Phlebotomy and Venipuncture As One Expanded Function – update if it needs to be a specific course. Statutes and rules to be reviewed to sync. *(Page 21 of the Statutes 328.24 D, 195:15-1-4 (6) Rules).*

iii. BLS Continuing Education Requirement for Dental Assistants- This is required in the rules to obtain the nitrous expanded function. *(195:15-1-4(4) Rules, Add to 328.41 D-2 Statutes). Currently in the nitrous requirements, but not in the Continuing Education Requirements.*

III. Dispensing Permits – Clean up language

i. Rules need to be consistent with OBN and DEA laws.

ii. Review fee, who is required to have dispensing permits (dispensers and drug lockers), is it one per person, or per location- need clarification. No fees for this permit currently exist. *(195:30-1-6(d) Rules).*

iii. Correction on spelling: "labelling" to "labeling" *(195:30-1-4(b) Rules)*

iv. Review the difference between storage in a drug locker vs. dispensing from a drug locker. Do we want separate permits?

IV. Anesthesia Pg 113-152

i. Course approval by Board if it is outside of a dental school.

ii. Review of anesthesia issues this past year.

iii. Patient Records Statute

iv. CRNA Collaborative Agreement

B. Statute Updates and Other Items for Review

I. Change the reporting of an arrest or board action to within 48 hours, not just at renewal time. *(Add under 328.41).*

II. Falsified patient records. *(Add to either 328.31b or 328.32).*

III. Review continuing education statute regarding national meetings - needs to state only hours related to dentistry should count towards CE credit. Other general CE needs to state dentistry related (*Statutes 328.41(6) Page 40).*

IV. Discussion regarding adding Curadont to the can't do list for Dental Assistants *(195:15-1-5 Rules).*

V. Discussion regarding clarifying gray areas of supervision during educational training for dental assistant expanded functions. Also, update "or as approved by the Board." *(195:15-1-4 Rules, Definitions)*

VI. Discussion regarding clarifying and giving exemption for the Oklahoma State Health Department to complete their tri-yearly 3rd grade dental health survey.

VII. Discussion of the use of high-speed hand pieces for hygienists to remove a fixed prosthetic *(195:15-1-6 Rules).*

VIII. Discussion of the use of Peptide Therapy in a dental office Pg 153-232

IX. Review of basic health standards in a dental office - No water in dental office, lice, mold, bed bugs and other hazards. *(Chapter 35 195:35-1-1 Rules).*

X. Foreign trained D.D.S. to R.D.H. if they do INBDE do they need to do INDHE? *(328.21a 7 Statutes). Statute currently requires INDHE however the Board is receiving questions.*

XI. Entities –Managing Dentist for offices in excess of 2 dentists. *(328.31 Statutes).*

C. Shortages of Licensees/New Dental School Programs and New Laws from Other States

a. Discussion regarding school programs for Dental Assisting. Dental Assistant Intern Permit, with expanded functions then change to dental assistant with Dental Assisting upon course completion or graduation. *(Add a subsection to 328.26 Statutes).*

b. New compact bill – discussion and update of compact.

c. Alabama Dental Hygiene Program discussion, Virginia New Law Pg 233-258

d. Review of DANB Dental Assistant Level I, II, III – Lists. (328.17-C-2-b and 328.24 *Statutes)* Pg 259-270

e. New Laws Dental Assistant OPA and EFDA Programs Pg 271-372

D. Discussion- New licensees required to attend board meetings (can use 1-2 hours for ethics).

E. Discussion – AI and New Technology Pg 373-390

a. Define AI – independent, dentist/physician manipulated, other.

b. Robots being built for teeth cleaning. Ie: Yomi robot – article printed.

c. New Technology

F. Discussion regarding a Dental Assistant doing GBT biofilm therapy and use of erythritol powder in a pressure and water setting like EMS airflow.

a. Discussion – Dental Assistants and Impressions – Adding temporary crowns to duties (328.24 *Statutes).*

b. Discussion – Dental Assistants Coronal Polishing General Supervision. (328.24 I *Statutes).*

G. General Legal Issues Happening in Other States.

   a. Anesthesia cases in other states;

   b. FTC and accreditation;

   c. Other state law updates

H. General Rules discussion and possible updates for next session.

I. Other suggestions or ideas

J. Statute Updates and Other Items for Review

   a. Legislative Review

   b. State Dental Bill

   c. OBN Opioid Language Update. Pg 391-416

K. Letter Requests from the Oklahoma Dental Hygienists' Association. Pg 417-418

27. New business

28. Adjournment.

(The Board will be taking short breaks during the meeting including lunch; During these breaks, no business will be discussed until the meeting officially resumes.)

Regular Board Meeting Minutes
August 21, 2026
2920 N Lincoln Blvd., Board Room, Oklahoma City, OK 73105

1. **Meeting called to Order.** Meeting called to order at 8:59 a.m., members in attendance are Dr. Bobby Carmen, Dr. Erin Roberts, Dr. Krista Jones, Dr. Shawn Scott, Dr. Lisa Nowlin, Dr. Mark Folks, Mrs. Rachel Ostberg, Chief J.R. Kidney, and Sheriff Andy Simmons. Members absent are Dr. Shawn Scott and Dr. Brant Rouse.

2. **Swearing in of new Board Member, Scott Breland, District 2.** Board President, Dr. Bobby Carmen swears in Dr. Scott Breland.

3. **Approval of minutes from June 5, 2026, Regular Board Meeting.** Motion to approve the meeting minutes as submitted made by Dr. Folks and seconded by Dr. Roberts. All members vote yes, Dr. Breland, Dr. Jones, and Mrs. Ostberg are abstained, motion passes.

4. **Executive Director's Report**
   a. **Budget information;** The most recent copy of the current budget to actuals is in the meeting book. Tyler Technologies and OMES are asking for more money on our online credit card fees. More to come on that after meetings with OMES. The Board won't be able to continue to cover the excess fees and will need to look at upping our credit card fees.
   b. **Update Legislative Session and dental related bills;** Nothing to update on this, no action.
   c. **Study Session Ideas:** We have a list started and are taking ideas for the study session. Please send the ideas to Susan for them to be added to the agenda.
   d. **Case Evaluations**- Topic not visited, no action.

5. **President's Report to include AADB Report.** – Dr. Bobby Carmen. The next meeting in conjunction with ADEX will be October 17-18, 2026, in Maryland. There are upcoming elections for the board for the Secretary/Treasurer seat and it is a two-year term. The Board was polled on who is attending.

6. **ADEX Report - Dr. Krista Jones.** The next ADEX meeting is October 15-18 in Maryland in conjunction with the AADB meeting. No other news.

7. **CODA Report - Dr. Lisa Nowlin.** CODA just had our meeting in Chicago, and a presentation from CDAC (Canadian CODA) shared their experience with separating from the Canadian Dental Association. Most of the problem is funding.

8. **Dental Hygiene Advisory Committee Report** – Rachel Ostberg, R.D.H. Nothing to report, other than if you have something for the committee to work on, send the information to Mrs. Ostberg and she will take it to the committee to work on. Dr. Jones would like the Committee to revisit for the Allied Committee to put the number of injections for local anesthesia back in the rules.

9. **Deputy Director Puckett's report.** The open records requests have slowed down some this year. An update on cases worked and assigned, 2021- 118 cases, 2022 - 162 cases with 5 pending, 2023 - 137 cases, 2024, 146 cases, 2025 - 149 cases, 16 pending, 2026 - 125 cases 33 assigned and worked, 2 suspensions this year. The current numbers for licensees are in the books. Looking at asking the Anesthesia Committee to approve anesthesia courses that are taken.

10. **Paul Mullasseril, Dean of Oklahoma University College of Dentistry – Update on the Dental Hygiene Program and other upcoming programs.** Dean Mullasseril gave a short slide show on the anticipated expansion to the hygiene program pending CODA approval and local office participation eventually adding the Tulsa area. Oklahoma is currently still at 48.5 dentists per 100,000 people with the goal of reaching 50.

To do that, we have increased the class size this year. Second year students will be sent to local offices and graded by seasoned hygienists and dentists two days per week in the fall and spring semester. This will start with 2027 admittance. 2024 Students may do externships. Class size will be increasing to 68 students. With the three hygiene programs in the state there are only 52 graduates per year, OU is looking to double to 48, and the Enid campus adds 6 next year; Tulsa Community College to 20, and Rose State to 16 or 18. These will be internship/preceptor licenses and won't count toward the number of hygienists to dentists ratio. The international dentist to hygienist program likely ready by October 1st.

11. **Discussion and clarification of statute 328.21a regarding two years of lawful practice of dentistry in a foreign country.** The intended meaning was having worked two years in their home country and we are able to verify it; it doesn't have to be in the immediate last two years. No action, information only until the Study Session.

12. **Discussion and Possible Action Regarding the reappointment of Advisory Committee Members:** Motion to approve both Dr. Tewis and Dr Byrne made by Chief Kidney and seconded by Dr. Jones. All members vote yes, motion passes.

    Shane Tewis, DDS – Open Dental Practice Committee Board Appointment

    Mathew Byrne, DDS, Open Dental Practice Committee Board Appointment

13. **Discussion and Possible Action Regarding Possible Statement of Complaint and Request for an Emergency Suspension and Possible Agreed Order for Emergency Suspension for Jennifer Till, R.D.H., License #2785.** (*Possible Executive Session as authorized by 25 O.S. §307(B)(8) regarding the above matter in order to engage in deliberations or rendering a final or intermediate decision in an individual proceeding pursuant to Article II of the Administrative Procedures Act.)* Motion to go into executive session made by Chief Kidney seconded by Dr. Jones. All members vote yes, motion passes. Motion to come out of executive session made by Dr. Jones and seconded by Dr. Folks. All members vote yes, motion passes. Motion to approve the Statement of Complaint and Agreed Order made by Dr. Jones and seconded by Chief Kidney. All members vote yes, Dr. Folks recused, motion passes.

14. **Discussion and Possible Action Regarding Order for Reinstatement for Shane Fehrenbach, D.D.S., License # 7632.** (*Possible Executive Session as authorized by 25 O.S. §307(B)(7)(8) regarding the above matter in order to discuss any matter where discloser of information would violate confidentiality requirements of state or federal law and engage in deliberations or rendering a final or intermediate decision in an individual proceeding pursuant to Article II of the Administrative Procedures Act.)* Motion to approve Full Reinstatement of Dental License made by Dr. Folks and seconded by Chief Kidney. All members vote yes, motion passes.

15. **Discussion and Possible Action Regarding Possible Statement of Complaint and Possible Agreed Order for the Board of Dentistry v. Neeral Patel D.D.S., License #7432.** (*Possible Executive Session as authorized by 25 O.S. §307(B)(8) regarding the above matter in order to engage in deliberations or rendering a final or intermediate decision in an individual proceeding pursuant to Article II of the Administrative Procedures Act.)* Motion to approve the Statement of Complaint Chief Kidney and seconded by Dr. Roberts. All members vote yes, recused members are Dr. Folks and Dr. Jones, and motion passes. Motion to approve the Agreed Order made by Chief Kidney and seconded by Dr. Roberts. All members vote yes, recused members are Dr. Folks and Dr. Jones and motions passes.

16. **Discussion and Possible Action Regarding Possible Statement of Complaint and Possible Agreed Order for The Board of Dentistry v. Alexander Quante, D.D.S., License #7597.**

Canadian applications for both dentists and dental hygienists. Dr. Nowlin, Dr. Jones, and Dr. Roberts have been appointed.

23. **Discussion and Possible Action Regarding the current and future requirements and utilizations of Dental, Dental Hygiene and Dental Assisting Intern Permits for Preceptorships/Externships.** Statutory changes are needed here to utilize an intern permit for all three.

24. **Discussion and Possible Action Regarding forming a Panel to review and update the outdated jurisprudence exam.** Dr. Folks, Dr. Breland and Mrs. Ostberg have generously volunteered to help.

25. **Discussion and Possible Action Regarding the Applications for Dental Licenses by Exam as listed in Appendix "A".** Motion to approve made by Dr. Folks and seconded by Chief Kidney. All members vote yes, motion passes.

26. **Discussion and Possible Action Regarding the Applications for Dental Licenses by Credential as listed in Appendix "A".** Motion to approve made by Dr. Roberts and seconded by Dr. Folks. All members vote yes, motion passes.

27. **Discussion and Possible Action Regarding the Applications for Specialty Dental Licenses by Exam and Credential as listed in Appendix "A".** Motion to approve made by Dr. Jones and seconded by Chief Kidney. All members vote yes, motion passes.

28. **Discussion and Possible Action Regarding the Applications for Hygiene Licenses by Exam and Credential as listed in Appendix "A".** Motion to approve made by Dr. Folks and seconded by Dr. Jones. All members vote yes, motion passes.

29. **Discussion and Possible Action Regarding the Applications to Reinstate Dentist License as listed ins Appendix "A'.** Motion to approve made by Dr. Jones and seconded by Chief Kidney. All members vote yes, motion passes.

30. **Discussion and Possible Action Regarding Dentists Requesting to Not Renew Licenses or Permits listed in Appendix "A".** Motion to approve made by Dr. Folks and seconded by Chief Kidney. All members vote yes, motion passes.

31. **Discussion and Possible Action Regarding Dentists requesting to Retire and Request for Volunteer License and Permit as listed in Appendix "A".** Motion to approve made by Dr. Roberts and seconded by Dr. Folks. All members vote yes, motion passes.

32. **Discussion and Possible Action Regarding requests for Advanced Procedures and Allied Dental Education Committee Recommendations as listed in Appendix "A".** Motion to approve made by Dr. Jones and seconded by Chief Kidney. All members vote yes, motion passes.

33. **Official Notice of Deceased Dentist as listed in Appendix "A".** Information only, no action taken.

34. **New business.** No new business.

35. **Adjournment.** Motion to adjourn made by Dr. Jones and seconded by Chief Kidney. All members vote yes, motion passes. Meeting adjourned.

(The Board will be taking short breaks during the meeting including lunch; During these breaks, no business will be discussed until the meeting officially resumes.)

(Possible Executive Session as authorized by 25 O.S. §307(B)(8) regarding the above matter in order to engage in deliberations or rendering a final or intermediate decision in an individual proceeding pursuant to Article II of the Administrative Procedures Act.) Motion to go into executive session made by Mrs. Ostberg and seconded by Dr. Folks. All members vote yes, motion passes. Motion to come out of executive session made by Chief Kidney and seconded by Dr. Jones. All members vote yes motion passes. Motion to approve Statement of Complaint made by Dr. Roberts and seconded by Mrs. Ostberg. All members vote yes, Dr. Folks and Dr. Breland are recused. Motion to approve the Agreed Order, as a part of the order, if license is not renewed then license is revoked, made by Dr. Roberts and seconded by Mrs. Ostberg. All members vote yes, Dr. Folks and Dr. Breland are recused.

17. **Discussion and Possible Action Regarding Possible Statement of Complaint and Agreed Order or Set for Hearing Date for the Board of Dentistry v. Evelyn Sadoval, D.A, Permit # DA15716.** *(Possible Executive Session as authorized by 25 O.S. §307(B)(8) regarding the above matter in order to engage in deliberations or rendering a final or intermediate decision in an individual proceeding pursuant to Article II of the Administrative Procedures Act.)* Motion to approve the Statement of Complaint made by Dr. Roberts and seconded Chief Kidney. All members vote yes, motion passes. Agreed Order will be set for hearing, November 20, 2026, 9am.

18. **Discussion and Possible Action Regarding Possible Statement of Complaint and Possible Agreed Order for the Board of Dentistry v. Tara Stanford, D.D.S., License #7211.** *(Possible Executive Session as authorized by 25 O.S. §307(B)(8) regarding the above matter in order to engage in deliberations or rendering a final or intermediate decision in an individual proceeding pursuant to Article II of the Administrative Procedures Act.)* Motion to approve the Statement of Complaint and Agreed Order made by Dr. Roberts and seconded by Dr. Roberts. All members vote yes, Dr. Folks, Dr. Nowlin, and Dr, Jones are recused, motion passes

19. **Discussion and Possible Action Regarding Possible Statement of Complaint and Possible Agreed Order for the Board of Dentistry v. Blas Gaytan, D.D.S., License #8032.** *(Possible Executive Session as authorized by 25 O.S. §307(B)(8) regarding the above matter in order to engage in deliberations or rendering a final or intermediate decision in an individual proceeding pursuant to Article II of the Administrative Procedures Act.)* Motion to approve the Statement of Complaint and Agreed Order made by Dr. Roberts and seconded by Dr. Roberts. All members vote yes, Dr. Folks, Dr. Nowlin, and Dr, Jones are recused, motion passes.

20. **Discussion and Possible Action Regarding Possible Statement of Complaint and Possible Agreed Order for the Board of Dentistry v. Jordan Wright, R.D.H., License #4349.** *(Possible Executive Session as authorized by 25 O.S. §307(B)(8) regarding the above matter in order to engage in deliberations or rendering a final or intermediate decision in an individual proceeding pursuant to Article II of the Administrative Procedures Act.)* Motion to approve the Statement of Complaint and Agreed Order made by Mrs. Ostberg and seconded by Dr. Roberts. All members vote yes, Dr. Folks, Dr. Nowlin, and Dr, Jones are recused, motion passes.

21. **Discussion and Possible Action Regarding Possible Amended Statement of Complaint and Possible Agreed Order for the Board of Dentistry v. Kenneth Garner, D.D.S., License #8032.** *(Possible Executive Session as authorized by 25 O.S. §307(B)(8) regarding the above matter in order to engage in deliberations or rendering a final or intermediate decision in an individual proceeding pursuant to Article II of the Administrative Procedures Act.)* No agreement was reached with Dr. Garner or his attorney, formally setting for hearing November 20, 2026, 9am, and the Statement of Complaint will be amended back to the original.

22. **Discussion and Possible Action Regarding forming an Ad hoc committee for evaluations of**

Board of Dentistry
Business Unit - 21500 - Detail Account
FY-2027 Operating Budget Comparison Summary by Business Unit/Account
as of September 29, 2026

OCPGL341
29-SEP-2026
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21500 - Board of Dentistry
Department: 1000001 - 8800001

Account	Description	Annual Budget	YTD Budget	Expenses	Encumbrance	Pre-Encumbrance	Total Exp, Enc,Pre-Enc	Annual Variance	YTD Variance	Annual %	YTD %
511110	Sals-Regular Pay	740,868	185,217	158,696.71	0.00	0.00	158,696.71	582,171.29	26,520.29	21.42	85.68
511210	Longevity Pay-State Employees	14,970	3,743	0.00	0.00	0.00	0.00	14,970.00	3,742.50	0.00	0.00
511270	Overtime Wages	8,424	2,106	1,674.48	0.00	0.00	1,674.48	6,749.52	431.52	19.88	79.51
511280	Holiday Pay - Payroll Only	0	0	783.06	0.00	0.00	783.06	-783.06	-783.06	-	-
511310	Terminal Leave	219,996	54,999	25,307.69	0.00	0.00	25,307.69	194,688.31	29,691.31	11.50	46.01
511420	Excess Benefit Allowance	0	0	9,083.76	0.00	0.00	9,083.76	-9,083.76	-9,083.76	-	-
512110	Insur.Prem-Hlth-Life-State Pln	104,844	26,211	16,917.76	0.00	0.00	16,917.76	87,926.24	9,293.24	16.14	64.54
512210	Unemployment Compen.-Payroll	2,112	528	99.94	0.00	0.00	99.94	2,012.06	428.06	4.73	18.93
512310	Insur.Prem-Workers Comp.	1,752	438	0.00	770.00	0.00	770.00	982.00	-332.00	43.95	175.80
513110	Employer Share-FICA	58,276	14,569	12,078.77	0.00	0.00	12,078.77	46,197.23	2,490.22	20.73	82.91
513120	Employer Share-MQFE/FICA	13,644	3,411	2,824.86	0.00	0.00	2,824.86	10,819.14	586.14	20.70	82.82
513230	Employer Share OPERS	49,456	12,364	4,811.00	0.00	0.00	4,811.00	44,645.00	7,552.98	9.73	38.91
513260	Employer Match-AdFeeSt.Annuity	720	180	135.80	0.00	0.00	135.80	584.20	44.20	18.86	75.44
513290	St.Match-Ad Fee-Def Contr	31,868	7,967	7,568.87	0.00	0.00	7,568.87	24,299.13	398.11	23.75	95.00
513300	Ret.Savings-Def Contr Plan	11,380	2,845	2,703.17	0.00	0.00	2,703.17	8,676.83	141.82	23.75	95.02
515010	Offices Of Lawyers	290,000	72,500	0.00	0.00	0.00	0.00	290,000.00	72,499.98	0.00	0.00
515030	Other Legal Services	30,000	7,500	0.00	0.00	0.00	0.00	30,000.00	7,500.00	0.00	0.00
515050	Acctg,Tax,Books,Payroll Svc	24,000	6,000	671.00	2,334.00	0.00	3,005.00	20,995.00	2,995.00	12.52	50.08
515350	Custom Computer Program Svc	150,000	37,500	0.00	0.00	0.00	0.00	150,000.00	37,500.00	0.00	0.00
515380	Other Computer Related Svc	35,000	8,750	0.00	0.00	0.00	0.00	35,000.00	8,749.98	0.00	0.00
515400	Admin Mgmt-Gen.Mgmt Consulting	2,500	625	0.00	0.00	0.00	0.00	2,500.00	624.99	0.00	0.00
515560	Office Administrative Services	1,500	375	0.00	500.00	0.00	500.00	1,000.00	-125.00	33.33	133.33
515580	Business Support Services	29,000	7,250	3,605.00	18,850.20	0.00	22,455.20	6,544.80	-15,205.22	77.43	309.73
515610	Business Service Centers	500	125	0.00	0.00	0.00	0.00	500.00	124.98	0.00	0.00
515800	Outpat.Men.Hlth-Subst.Ab.Ctrs	20,000	5,000	0.00	20,000.00	0.00	20,000.00	0.00	-15,000.02	100.00	400.00
519130	Flexible Benefits-Adminis.	950	237	60.16	548.84	0.00	609.00	341.00	-371.52	64.11	256.44
521110	In-State Mileage-Motor Vehicle	10,000	2,500	1,183.92	0.00	0.00	1,183.92	8,816.08	1,316.07	11.84	47.36
521120	In-State Meals-Subsistence Exp	3,000	750	756.00	0.00	0.00	756.00	2,244.00	-6.00	25.20	100.80
521140	In-State Miscellaneous Charges	24	6	0.00	0.00	0.00	0.00	24.00	6.00	0.00	0.00
521150	In-State Lodging	4,000	1,000	0.00	4,000.00	0.00	4,000.00	0.00	-3,000.01	100.00	400.00
521210	Out of State Mileage-Priv.Veh.	500	125	0.00	0.00	0.00	0.00	500.00	124.98	0.00	0.00
521220	Out-of-State Transp.Charges	600	150	0.00	0.00	0.00	0.00	600.00	150.00	0.00	0.00
521230	Out-of-State Meals-Subsistence	4,000	1,000	0.00	0.00	0.00	0.00	4,000.00	999.99	0.00	0.00
521240	Out-of-State Local Transp.	600	150	0.00	0.00	0.00	0.00	600.00	150.00	0.00	0.00
521250	Out-of-State Misc.Charges	1,200	300	0.00	0.00	0.00	0.00	1,200.00	300.00	0.00	0.00
521260	Out-of-State Lodging	3,000	750	0.00	0.00	0.00	0.00	3,000.00	750.00	0.00	0.00
521310	Travel Reimb.-Non-State Empls.	13,040	3,260	0.00	0.00	0.00	0.00	13,040.00	3,259.98	0.00	0.00
522110	OutofSt Pur Trans Cst Agcy Dir	12,000	3,000	2,280.40	0.00	0.00	2,280.40	9,719.60	719.60	19.00	76.01
522112	OutofSt PurTollCollFeesAgDir	0	0	0.00	500.00	0.00	500.00	-500.00	-500.00	-	-
522113	InStPurPikePassCollFeesAgcyDir	1,000	250	0.00	1,000.00	0.00	1,000.00	0.00	-750.01	100.00	400.02
522130	OutofSt Pur Food Ldg Agcy Dir	7,200	1,800	0.00	0.00	0.00	0.00	7,200.00	1,800.00	0.00	0.00
522131	In-State Pur Food Ldg Agcy Dir	1,000	250	1,202.04	0.00	0.00	1,202.04	-202.04	-952.05	120.20	480.84
522150	Registration - Agency Direct	15,800	3,950	768.75	14,870.00	0.00	15,638.75	161.25	-11,688.77	98.98	395.92
531120	Postage	20,000	5,000	10,000.00	15,000.00	0.00	25,000.00	-5,000.00	-20,000.02	125.00	500.00
531130	Telecommunication Services	3,000	750	238.40	2,761.60	0.00	3,000.00	0.00	-2,250.00	100.00	400.00
531150	Printing & Binding Contrs	7,000	1,750	1,648.04	13,351.96	0.00	15,000.00	-8,000.00	-13,250.01	214.29	857.15
531170	Informational Service	13,722	3,430	1,492.38	14,658.26	0.00	16,150.64	-2,428.64	-12,720.17	117.70	470.80
531180	Bank Service Charges	19,000	4,750	0.00	17,000.00	0.00	17,000.00	2,000.00	-12,250.01	89.47	357.90
531230	ERP System Services	1,008	252	0.00	0.00	0.00	0.00	1,008.00	252.00	0.00	0.00
531260	Membership in Organizations	18,535	4,634	5,700.00	3,150.00	375.00	9,225.00	9,310.00	-4,591.26	49.77	199.08
531310	Prem-Property or Liab.Insur.	3,296	824	0.00	6,679.01	0.00	6,679.01	-3,383.01	-5,855.03	202.64	810.58
532110	Rent of Office Space	21,606	5,402	4,801.50	14,404.50	0.00	19,206.00	2,400.00	-13,804.50	88.89	355.57
532130	Rent of Other Building Space	5,000	1,250	921.80	5,197.29	0.00	6,119.09	-1,119.09	-4,869.11	122.38	489.54
532141	Rent of Motor Vehicles	0	0	0.00	272.30	0.00	272.30	-272.30	-272.30	-	-
532142	Lease of Motor Vehicles	18,100	4,525	0.00	18,000.00	0.00	18,000.00	100.00	-13,475.01	99.45	397.79
532160	Rent-Elec Data Processing Eq.	3,568	892	255.81	4,291.43	0.00	4,547.24	-979.24	-3,655.25	127.45	509.79
532170	Rent-Data Processing Software	0	0	0.00	2,029.76	0.00	2,029.76	-2,029.76	-2,029.76	-	-
533110	Mtce-Rep.-Bldgs-grnds-Vendor	5,000	1,250	0.00	0.00	0.00	0.00	5,000.00	1,249.98	0.00	0.00
533140	Mtce-Rep.-DP Equip-Vendor	2,000	500	0.00	1,710.00	0.00	1,710.00	290.00	-1,210.02	85.50	342.01
534110	Food,Other Kitchen Sup.,Mat'ls	500	125	0.00	0.00	0.00	0.00	500.00	124.98	0.00	0.00
534290	Motor Fuels-Common	5,000	1,250	0.00	6,000.00	0.00	6,000.00	-1,000.00	-4,750.02	120.00	480.01
535120	Uniform,Clothing,Accessories	3,000	750	0.00	0.00	0.00	0.00	3,000.00	750.00	0.00	0.00
535180	Safety and Security Supplies	1,500	375	0.00	900.00	0.00	900.00	600.00	-525.00	60.00	240.00
536110	Meeting Refreshments	1,400	350	242.91	0.00	0.00	242.91	1,157.09	107.07	17.35	69.41
536130	Office Supplies Non-Expendable	3,200	800	372.96	0.00	0.00	372.96	2,827.04	427.02	11.66	46.62
536140	Office Supplies (Expendable)	4,000	1,000	804.99	0.00	0.00	804.99	3,195.01	195.00	20.12	80.50
536150	Data Processing Supplies	1,000	250	0.00	0.00	0.00	0.00	1,000.00	249.99	0.00	0.00
536170	Food and Catering Service	3,000	750	325.00	0.00	0.00	325.00	2,675.00	425.00	10.83	43.33
537310	Motor Veh.Parts,Supp.-Non-Exp	2,000	500	0.00	0.00	0.00	0.00	2,000.00	499.98	0.00	0.00
541120	Data Processing Equipment	0	0	1,812.00	565.73	0.00	2,377.73	-2,377.73	-2,377.73	-	-
541130	Data Processing Software	1,420	355	0.00	0.00	0.00	0.00	1,420.00	354.99	0.00	0.00
542120	Library Resources-Textbooks	1,845	461	0.00	1,863.40	0.00	1,863.40	-18.40	-1,402.15	101.00	403.99
552140	Incentive Awards	2,000	500	240.00	0.00	0.00	240.00	1,760.00	259.98	12.00	48.00
553150	Indemnities,Restitn.,Settlmts	150,000	37,500	0.00	0.00	0.00	0.00	150,000.00	37,500.00	0.00	0.00

P5

P6

Board of Dentistry
Business Unit - 21500 - Detail Account
FY-2027 Operating Budget Comparison Summary by Business Unit/Account
as of September 29, 2026

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21500 - Board of Dentistry
Department: 1000001 - 8800001

Account Description	Annual Budget	YTD Budget	Expenses	Encumbrance	Pre-Encumbrance	Total Exp, Enc, Pre-Enc	Annual Variance	YTD Variance	Annual %	YTD %
554230 Reimbursement & Repayment -Oth	4,000	1,000	0.00	0.00	0.00	0.00	4,000.00	999.99	0.00	0.00
601100 APP Encumbrances	0	0	0.00	79,762.95	0.00	79,762.95	-79,762.95	-79,762.95	~	~
Totals	2,243,424	560,855	282,068.93	270,971.23	375.00	553,415.16	1,690,008.84	7,440.21	24.67	98.67

Class Funding	Annual Budget	YTD Budget	Expenses	Encumbrance	Pre-Encumbrance	Total Exp, Enc, Pre-Enc	Annual Variance	YTD Variance	Annual %	YTD %
20000 State Dental Fund	2,243,424	560,855	282,068.93	270,971.23	375.00	553,415.16	1,690,008.84	7,440.21	24.67	98.67
Totals	2,243,424	560,855	282,068.93	270,971.23	375.00	553,415.16	1,690,008.84	7,440.21	24.67	98.67

Dentist By County	Total Number 2023/2024 (10.23.23)	Total Number 2025 (9.22.25)	Total Number 2026 (9.22.26)
1. Adair County, Stilwell	2	2	2
2. Alfalfa County, Cherokee	3	3	2
3. Atoka County, Atoka	2	3	2
4. Beaver County, Beaver	0	1	1
5. Beckham County, Sayre	11	7	6
6. Blaine County, Watonga	4	2	2
7. Bryan County, Durant	12	13	13
8. Caddo County, Anadarko	4	2	2
9. Canadian County, El Reno	59	67	59
10. Carter County, Ardmore	32	31	33
11. Cherokee County, Tahlequah	23	23	25
12. Choctaw County, Hugo	3	2	1
13. Cimarron County, Boise City	0	0	0
14. Cleveland County, Norman	161	167	183
15. Coal County, Coalgate	0	0	0
16. Comanche County, Lawton	51	53	53
17. Cotton County, Walters	0	0	0
18. Craig County, Vinita	5	6	6
19. Creek County, Sapulpa	22	22	25
20. Custer County, Arapaho	11	15	15
21. Delaware County, Jay	13	13	16
22. Dewey County, Taloga	1	0	1
23. Ellis County, Arnett	1	1	0
24. Garfield County, Enid	24	23	22
25. Garvin County, Pauls Valley	8	8	7
26. Grady County, Chickasha	13	14	12
27. Grant County, Medford	0	0	0
28. Greer County, Mangum	3	3	2
29. Harmon County, Hollis	1	0	0
30. Harper County, Buffalo	1	1	1
31. Haskell County, Stigler	3	4	3
32. Hughes County, Holdenville	1	1	1
33. Jackson County, Altus	7	5	5
34. Jefferson County, Waurika	0	0	0
35. Johnston County, Tishomingo	3	6	6
36. Kay County, Newkirk	18	22	21
37. Kingfisher County, Kingfisher	7	11	11
38. Kiowa County, Hobart	1	2	3
39. Latimer County, Wilburton	3	2	2
40. Le Flore County, Poteau	10	10	9
41. Lincoln County, Chandler	6	5	4
42. Logan County, Guthrie	11	15	15
43. Love County, Marietta	0	0	0
44. Major County, Fairview	1	1	1
45. Marshall County, Madill	3	3	3
46. Mayes County, Pryor	7	7	7
47. McClain County, Purcell	17	19	22
48. McCurtain County, Idabel	9	9	9

49. McIntosh County, Eufaula	8	8	9
50. Murray County, Sulphur	3	3	3
51. Muskogee County, Muskogee	29	23	21
52. Noble County, Perry	5	2	2
53. Nowata County, Nowata	1	1	0
54. Okfuskee County, Okemah	1	2	2
55. Oklahoma County, Oklahoma City	743	777	807
56. Okmulgee County, Okmulgee	8	9	9
57. Osage County, Pawhuska	12	13	13
58. Ottawa County, Miami	6	7	7
59. Pawnee County, Pawnee	1	1	1
60. Payne County, Stillwater	33	38	37
61. Pittsburg County, McAlester	17	18	22
62. Pontotoc County, Ada	25	22	22
63. Pottawatomie County, Shawnee	31	28	23
64. Pushmataha County, Antlers	6	7	7
65. Roger Mills County, Cheyenne	1	0	0
66. Rogers County, Claremore	40	45	42
67. Seminole County, Wewoka	7	7	7
68. Sequoyah County, Sallisaw	14	12	12
69. Stephens County, Duncan	18	13	14
70. Texas County, Guymon	6	6	5
71. Tillman County, Frederick	1	1	1
72. Tulsa County, Tulsa	456	465	488
73. Wagoner County, Wagoner	14	20	19
74. Washington County, Bartlesville	20	19	22
75. Washita County, Cordell	1	0	0
76. Woods County, Alva	3	2	2
77. Woodward County, Woodward	9	9	9
Total:	**2096**	**2162**	2219
Out of State Licensees	316	347	325
Total Licensees:	**2412**	**2509**	**2544**

Hygienist By County	Total Number 2023/2024 (10.23.23)	Total Number 2025 (9.22.25)	Total Number 2026 (9.28.26)
1. Adair County, Stilwell	6	2	8
2. Alfalfa County, Cherokee	1	3	3
3. Atoka County, Atoka	5	3	4
4. Beaver County, Beaver	1	1	2
5. Beckham County, Sayre	8	7	10
6. Blaine County, Watonga	3	2	5
7. Bryan County, Durant	13	13	17
8. Caddo County, Anadarko	11	12	13
9. Canadian County, El Reno	119	139	144
10. Carter County, Ardmore	50	46	47
11. Cherokee County, Tahlequah	19	22	21
12. Choctaw County, Hugo	6	6	4
13. Cimarron County, Boise City	0	0	0
14. Cleveland County, Norman	193	189	194
15. Coal County, Coalgate	2	3	3
16. Comanche County, Lawton	55	48	48
17. Cotton County, Walters	5	6	6
18. Craig County, Vinita	7	8	7
19. Creek County, Sapulpa	35	38	39
20. Custer County, Arapaho	19	22	26
21. Delaware County, Jay	22	20	19
22. Dewey County, Taloga	3	2	1
23. Ellis County, Arnett	2	4	4
24. Garfield County, Enid	28	31	28
25. Garvin County, Pauls Valley	11	11	12
26. Grady County, Chickasha	44	49	54
27. Grant County, Medford	1	1	1
28. Greer County, Mangum	0	0	1
29. Harmon County, Hollis	0	0	1
30. Harper County, Buffalo	1	1	1
31. Haskell County, Stigler	7	6	7
32. Hughes County, Holdenville	3	4	4
33. Jackson County, Altus	9	10	8
34. Jefferson County, Waurika	2	4	3
35. Johnston County, Tishomingo	5	7	7
36. Kay County, Newkirk	18	18	19
37. Kingfisher County, Kingfisher	9	11	13
38. Kiowa County, Hobart	6	7	7
39. Latimer County, Wilburton	3	3	3
40. Le Flore County, Poteau	14	14	13
41. Lincoln County, Chandler	19	19	19
42. Logan County, Guthrie	31	28	32
43. Love County, Marietta	8	7	6
44. Major County, Fairview	2	3	3
45. Marshall County, Madill	9	10	10
46. Mayes County, Pryor	12	12	11
47. McClain County, Purcell	52	56	55
48. McCurtain County, Idabel	6	6	7
49. McIntosh County, Eufaula	5	8	11
50. Murray County, Sulphur	10	9	8
51. Muskogee County, Muskogee	37	38	38

52. Noble County, Perry	4	3	4
53. Nowata County, Nowata	5	5	5
54. Okfuskee County, Okemah	3	3	4
55. Oklahoma County, Oklahoma City	578	585	604
56. Okmulgee County, Okmulgee	16	16	18
57. Osage County, Pawhuska	19	21	22
58. Ottawa County, Miami	10	9	11
59. Pawnee County, Pawnee	7	9	10
60. Payne County, Stillwater	39	42	41
61. Pittsburg County, McAlester	25	26	27
62. Pontotoc County, Ada	12	15	15
63. Pottawatomie County, Shawnee	39	42	41
64. Pushmataha County, Antlers	5	6	6
65. Roger Mills County, Cheyenne	4	3	2
66. Rogers County, Claremore	74	75	78
67. Seminole County, Wewoka	3	2	3
68. Sequoyah County, Sallisaw	17	19	15
69. Stephens County, Duncan	33	35	34
70. Texas County, Guymon	5	5	7
71. Tillman County, Frederick	5	4	4
72. Tulsa County, Tulsa	493	503	507
73. Wagoner County, Wagoner	50	57	61
74. Washington County, Bartlesville	42	40	45
75. Washita County, Cordell	7	9	10
76. Woods County, Alva	4	5	3
77. Woodward County, Woodward	14	12	12
Total:	**2450**	**2520**	**2596**
Out of State Licensees:	**213**	**212**	**196**
Total Licensees:	**2663**	**2732**	**2792**

DENTAL STATUTES THAT WILL CHANGE AS OF JULY 1, 2026 FROM HB 3934

This year's legislation was developed collaboratively by several groups and is intended to help address workforce shortages in all areas of dentistry. Below are the changes included in this year's legislative request bill.

1. **Canadian dentists and hygienists** that graduated from a Canadian Accredited Dental School are eligible for licensure in Oklahoma.

2. **Dental Assistants** will be able to work under general supervision only to take radiograph/xrays with the appropriate expanded duty permit. [1] This is the only expanded function a dental assistant may perform under general supervision.

3. **59 O.S. § 328.23a and § 328.24,** also allows a dental assistant to "assist" a hygienist under the general supervision of a dentist. The intent of this is for the dental assistant to be able to assist with instruments and suction and DOES NOT allow the assistant to perform ANY expended functions except radiograph/xrays.

4. The **General Dental Practice Committee** will be changing from ten members to eighteen members. If you are interested in participating in this committee you may send an email with your resume and a letter explaining your interest in participating in the committee.

5. **59 O.S. § 328.19(C),** "Any auxillary health care provider, licensed or permitted by the state that is working UNDER THE SUPERVISION of a dentist, shall be limited to practicing within the scope of dentistry.[2]

6. **ADEX** – the American board of dental examiners now includes, WREB, CITA and CDCA as they have all merged. Yes, the Board still accepts all the prior exams as listed. All prior scores for those exams are now located at ADEX.

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[1] Please review the definitions of General Supervision (dentist not in the office but staff working under directions) and Direct Supervision (dentist in the office directly supervising). Please review 59 OS § 328.3 and 328.24 of the statutes.

[2] This does not apply to an allopathic or osteopathic physician as they are not required to be supervised and are providing care pursuant to their license.

7. **Please review the MINIMUM requirements for patient records at 59 O.S. § 328.31b.** The Board has had several actions in cases where basic required information was missing from patient records.

8. **59 O.S. § 328.24**, now allows a **hygienist** to administer **nitrous oxide**, perform **local anesthesia** and provide **THERAPUTIC use of lasers** under the general supervision of a dentist.

9. **59 O.S. § 328.24(B)** *New language* – "A patient of record may be established by teledentistry for the purposes of an emergency or hygiene treatment if the patient is physically located at the dental office or treatment facility and the dentist is not readily available."

10. **59 O.S. § 328.21a.** (New language) – The Oklahoma University College of Dentistry will be starting a program to evaluate foreign trained dentists for possible licensure as a Dental Hygienist. It is a comprehensive program with the same staff that supervises the regular Dental Hygiene program.

Study session October 2-3 at the Choctaw Resort in Durant

Each year the Board has a study session to review the statutes and discuss updates that are requested for the purpose of next years legislative request. This is an open meeting and all are welcome to attend. If you have a suggestion for changes or you would like to do a presentation you are asked to email susan.rogers@dentistry.ok.gov. Please put in the subject line, suggestion for legislation.

An Act

ENROLLED HOUSE
BILL NO. 3934

By: Smith of the House

and

Pederson of the Senate

An Act relating to professions and occupations; amending 59 O.S. 2021, Section 328.3, as last amended by Section 2, Chapter 273, O.S.L. 2025 (59 O.S. Supp. 2025, Section 328.3), which relates to the practice of dentistry definitions; updating certain definitions; amending 59 O.S. 2021, Section 328.17, as amended by Section 3, Chapter 273, O.S.L. 2025 (59 O.S. Supp. 2025, Section 328.17), which relates to standing committees; adding a reference to the Dental Practice Committee; amending 59 O.S. 2021, Section 328.19, as last amended by Section 4, Chapter 273, O.S.L. 2025 (59 O.S. Supp. 2025, Section 328.19), which relates to acts constituting practice of dentistry; requiring auxiliary health care providers to limit practice within scope of dentistry; amending 59 O.S. 2021, Section 328.21, as last amended by Section 5, Chapter 273, O.S.L. 2025 (59 O.S. Supp. 2025, Section 328.21), which relates to application of dental licensure; updating approved accredited programs; amending 59 O.S. 2021, Section 328.22, as amended by Section 3, Chapter 220, O.S.L. 2023 (59 O.S. Supp. 2025, Section 328.22), which relates to specialty licenses; specifying requirements to represent oneself as a dental specialist; amending 59 O.S. 2021, Section 328.23, which relates to temporary licensing of dentists and dental hygienists; updating the required examination; amending 59 O.S. 2021, Section 328.23a, as last amended by Section 4, Chapter 46, O.S.L. 2024 (59 O.S. Supp. 2025, Section 328.23a), which relates to special volunteer licenses for dentist and dental hygienist; allowing dental assistants to work under certain procedures; amending

59 O.S. 2021, Section 328.24, as last amended by Section 6, Chapter 273, O.S.L. 2025 (59 O.S. Supp. 2025, Section 328.24), which relates to dental assistant permits; allowing specific exemptions for dental assistants to work outside of the direct supervision of a dentist; amending 59 O.S. 2021, Section 328.29a, as last amended by Section 11, Chapter 273, O.S.L. 2025 (59 O.S. Supp. 2025, Section 328.29a), which relates to dental assistants; updating language; amending 59 O.S. 2021, Section 328.31, which relates to Board of Dentistry requirements; removing requirement to publish an annual summary of the registry; amending 59 O.S. 2021, Section 328.31b, as last amended by Section 13, Chapter 273, O.S.L. 2025 (59 O.S. Supp. 2025, Section 328.31b), which relates to maintenance and retention of written records; removing requirements of maintaining certain records; amending 59 O.S. 2021, Section 328.34, as amended by Section 6, Chapter 220, O.S.L. 2023 (59 O.S. Supp. 2025, Section 328.34), which relates to the scope of practice for dental hygienists; updating scope of practice; amending 59 O.S. 2021, Section 328.54, which relates to the practice of dentistry via Internet; allowing for a patient of record to be established under certain circumstances; creating procedures for foreign-trained dentist licensure; providing for codification; providing an effective date; and declaring an emergency.

SUBJECT: Professions and occupations

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 59 O.S. 2021, Section 328.3, as last amended by Section 2, Chapter 273, O.S.L. 2025 (59 O.S. Supp. 2025, Section 328.3), is amended to read as follows:

Section 328.3. As used in the State Dental Act, the following words, phrases, or terms, unless the context otherwise indicates, shall have the following meanings:

1. "Accredited dental college" means an institution whose dental educational program is accredited by the Commission on Dental Accreditation of the American Dental Association, or the Commission on Dental Accreditation of Canada (CADA) or another accrediting association recognized by the United States Department of Education;

2. "Accredited dental hygiene program" means a dental hygiene educational program which is accredited by the Commission on Dental Accreditation of the American Dental Association, or the Commission on Dental Accreditation of Canada (CADA) or another accrediting association recognized by the United States Department of Education;

3. "Accredited dental assisting program or class" means a dental assisting program which is accredited by the Commission on Dental Accreditation of the American Dental Association or another accrediting association recognized by the United States Department of Education or a class approved by the Board of Dentistry;

4. "Advanced procedure" means a dental procedure for which a dental hygienist has received special training in a course of study approved by the Board;

5. "Board" means the Board of Dentistry;

6. "Certified dental assistant" means a dental assistant who has earned and maintains current certified dental assistant certification from the Dental Assisting National Board (DANB);

7. "Coronal polishing" means a procedure limited to the removal of plaque and stain from exposed tooth surfaces, utilizing a slow speed hand piece with a prophy/polishing cup or brush and polishing agent and is not prophylaxis. To be considered prophylaxis, examination for calculus and scaling must be done by a dental hygienist or dentist;

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

9. "Dentistry" means the practice of dentistry in all of its branches;

10. "Dentist" means a graduate of an accredited dental college who has been issued a license by the Board to practice dentistry as defined in Section 328.19 of this title;

11. "Dental ambulatory surgical center (DASC)" means a facility that operates exclusively for the purpose of furnishing outpatient surgical services to patients. A DASC shall have the same privileges and requirements as a dental office and additionally must be an accredited facility by the appropriate entity;

12. "Dental appliance" means a dental appliance, prosthetic denture, bridge, restoration, or other device made for an individual patient for a purpose listed in Section 328.19 of this title;

13. "Dental office" means an establishment owned and operated by a dentist for the practice of dentistry, which may be composed of reception rooms, business offices, private offices, laboratories, and dental operating rooms where dental operations are performed;

14. "Dental hygiene" means the science and practice of the promotion of oral health and prevention and treatment of oral disease through the provision of educational, therapeutic, clinical, and preventive services;

15. "Dental hygienist" means an individual who has fulfilled the educational requirements and is a graduate of an accredited dental hygiene program and who has passed an examination and has been issued a license by the Board and who is authorized to practice dental hygiene as defined in this section;

16. "Dental assistant" means an individual working for a dentist, under the dentist's general, direct supervision or direct visual supervision, and performing duties in the dental office or a treatment facility including the limited treatment of patients in accordance with the provisions of the State Dental Act~~. A dental assistant may assist a dentist with the patient; provided, this shall be done only under the direct supervision or direct visual supervision and control of the dentist and only in accordance with the educational requirements~~ and rules promulgated by the Board;

17. "Dental laboratory" means a location, whether in a dental office or not, where a dentist or a dental laboratory technician performs dental laboratory technology;

18. "Dental laboratory technician" means an individual whose name is duly filed in the official records of the Board, which authorizes the technician, upon the laboratory prescription of a dentist, to perform dental laboratory technology, which services must be rendered only to the prescribing dentist and not to the public;

19. "Dental laboratory technology" means using materials and mechanical devices for the construction, reproduction or repair of dental restorations, appliances or other devices to be worn in a human mouth;

20. "Dental specialty" means a specialized practice of a branch of dentistry, recognized by the Board, where the dental college and specialty program are accredited by the Commission on Dental Accreditation (CODA), or a dental specialty recognized by the Board, requiring a minimum number of hours of approved education and training and/or recognition by a nationally recognized association or accreditation board;

21. "Direct supervision" means the supervisory dentist is in the dental office or treatment facility and, during the appointment, personally examines the patient, diagnoses any conditions to be treated, and authorizes the procedures to be performed by a dental hygienist or dental assistant. The supervising dentist is continuously on-site and physically present in the dental office or treatment facility while the procedures are being performed and, before dismissal of the patient, evaluates the results of the dental treatment;

22. "Direct visual supervision" means the supervisory dentist has direct ongoing visual oversight which shall be maintained at all times during any procedure authorized to be performed by a dental assistant;

23. "Expanded duty" means a dental procedure for which a dental assistant has received special training in a course of study approved by the Board;

24. "Fellowship" means a program designed for post-residency graduates to gain knowledge and experience in a specialized field;

25. "General anesthesia" means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain

ventilator function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired;

26. "General supervision" means the supervisory dentist has diagnosed any conditions to be treated within the past thirteen (13) months, has personally authorized the procedures to be performed by a dental hygienist, and will evaluate the results of the dental treatment within a reasonable time as determined by the nature of the procedures performed, the needs of the patient, and the professional judgment of the supervisory dentist. General supervision may only be used to supervise a dental hygienist and may not be used to supervise a dental assistant except as provided by subsection I of Section 328.24 and Section 328.58 of this title;

27. "Indirect supervision" means the supervisory dentist is in the dental office or treatment facility and has personally diagnosed any conditions to be treated, authorizes the procedures to be performed by a dental hygienist, remains in the dental office or treatment facility while the procedures are being performed, and will evaluate the results of the dental treatment within a reasonable time as determined by the nature of the procedures performed, the needs of the patient, and the professional judgment of the supervisory dentist. Indirect supervision may not be used for a dental assistant;

28. "Investigations" means an investigation proceeding, authorized under Sections 328.15A and 328.43a of this title, to investigate alleged violations of the State Dental Act or the rules of the Board;

29. "Laboratory prescription" means a written description, dated and signed by a dentist, of dental laboratory technology to be performed by a dental laboratory technician;

30. "Minimal sedation" means a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilator and cardiovascular functions are unaffected;

31. "Mobile dental anesthesia provider" means a licensed and anesthesia-permitted dentist, physician or Certified Registered Nurse Anesthetist (CRNA) that has a mobile dental unit and provides anesthesia in dental offices and facilities in the state;

32. "Mobile dental clinic" means a permitted motor vehicle or trailer utilized as a dental clinic, and/or that contains dental equipment and is used to provide dental services to patients on-site and shall not include a mobile dental anesthesia provider. A mobile dental clinic shall also mean and include a volunteer mobile dental facility that is directly affiliated with a church or religious organization as defined by Section 501(c)(3) or 501(d) of the United States Internal Revenue Code, the church or religious organization with which it is affiliated is clearly indicated on the exterior of the volunteer mobile dental facility, and such facility does not receive any form of payment either directly or indirectly for work provided to patients other than donations through the affiliated church or religious organization; provided, that the volunteer mobile dental facility shall be exempt from any registration fee required under the State Dental Act;

33. "Moderate sedation" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained;

34. "Prophylaxis" means the removal of any and all calcareous deposits, stains, accretions or concretions from the supragingival and subgingival surfaces of human teeth, utilizing instrumentation by scaler or periodontal curette on the crown and root surfaces of human teeth including rotary or power-driven instruments. This procedure may only be performed by a dentist or dental hygienist;

35. "Patient" or "patient of record" means an individual who has given a medical history and has been examined and accepted by a dentist for dental care;

36. "Residencies" are programs designed for advanced clinical and didactic training in general dentistry or other specialties or other specialists at the post-doctoral level recognized by the Commission on Dental Accreditation (CODA) or the Board;

37. "Supervision" means direct supervision, direct visual supervision, indirect supervision or general supervision;

38. "Teledentistry" means the remote delivery of dental patient care via telecommunications and other technology for the exchange of clinical information and images for dental consultation, preliminary treatment planning and patient monitoring; and

39. "Treatment facility" means:

a. a federal, tribal, state or local public health facility,

b. a Federally Qualified Health Center (FQHC),

c. a private health facility,

d. a group home or residential care facility serving the elderly, disabled or juveniles,

e. a hospital or dental ambulatory surgery center (DASC),

f. a nursing home,

g. a penal institution operated by or under contract with the federal or state government,

h. a public or private school,

i. a patient of record's private residence,

j. a mobile dental clinic,

k. a church with a nonprofit clinic,

l. a dental college, dental program, dental hygiene program or dental assisting program accredited by the Commission on Dental Accreditation, or

~~l.~~

m. such other places as are authorized by the Board.

SECTION 2. AMENDATORY 59 O.S. 2021, Section 328.17, as amended by Section 3, Chapter 273, O.S.L. 2025 (59 O.S. Supp. 2025, Section 328.17), is amended to read as follows:

Section 328.17. A. 1. The Board of Dentistry shall have the following standing committees that shall meet once per year and other times as needed to study issues affecting the practice of dentistry and the safety of the public and to make recommendations to the Board:

a. Dental Practice Committee,

b. Anesthesia Committee,

c. Specialty Practice Committee,

d. Historical and Retirement Committee, and

e. Assistants, Dental Labs and Other Auxiliary Personnel Committee.

2. Each committee shall be cochaired by a current or past Board member to be appointed by the Board President with approval by the Board and a member of a statewide organization representing dentists as recommended by such organization.

3. Each committee may have up to ten committee members with the exception of the Dental Practice and Anesthesia ~~Committee~~ Committees which may have up to eighteen members, exclusive of the cochairs.

4. The Board President, with approval of the Board, shall appoint all committee members. One-half (1/2 or 50%) of the committee members shall be recommended by the Board and one-half (1/2 or 50%) of the committee members shall be recommended to the Board President by a statewide organization representing dentists.

5. Committee members shall be on staggered three-year terms and shall serve at the pleasure of the Board.

B. There shall be a Dental Hygiene Advisory Committee to be composed of the following members:

1. One current dental hygiene member of the Board;

2. Two dental hygienists recommended by the Board and two dental hygienists recommended by a statewide organization representing dental hygienists;

3. The Committee shall have the following functions:

a. to develop and propose recommendations to the Board regarding the education, examination, licensure, and regulation of dental hygienists,

b. to advise the Board in rulemaking regarding dental hygiene,

c. to hold meetings at least annually, but not more than six (6) times a year, and

d. to work directly with the Allied Dental Education Committee in reviews and recommendations for equivalent dental hygiene programs; and

4. Members of the Committee shall be appointed by the Board and shall serve a term of three (3) years. Appointments shall be made so that approximately one-third (1/3 or 33%) of the Committee is reappointed at any given time. Members may be appointed for consecutive terms if recommended by the Board President and approved by the Board.

C. There shall be an Allied Dental Education Committee.

1. The Board President shall appoint all members of the Allied Dental Education Committee upon approval by the Board;

2. The Allied Dental Education Committee shall:

a. review the standards and equivalency of in-state and out-of-state dental and auxiliary program requirements and make recommendations to the Board,

b. evaluate individual credentials and programs for the purpose of issuing dental assistant expanded duty permits and dental hygiene advanced procedure permits from persons holding out-of-state licenses and permits based on CODA or DANB programs and criteria as defined by the State Dental Act and other statutes and shall make recommendations to the Board,

c. recommend standards and guidelines and review criteria for all expanded duty programs or courses for dental assistants from CODA approved programs and non-CODA approved providers and advanced procedures of dental hygienists from CODA approved programs or training and non-CODA approved programs or training to the Board, and

d. recommend and develop guidelines for classroom, electronic media and other forms of education and testing;

3. The Committee shall meet as deemed necessary by the Board President; and

4. The Committee may have up to ten (10) members of whom three shall have a background in dental education. The Committee shall be composed of:

a. the Board President or his or her designee who must be a current or past Board Member,

b. the hygiene member of the Board or their designee who must be a current or past Board Member,

c. the Dean of the University of Oklahoma College of Dentistry or his or her designee, and

d. up to seven at-large members, one of which must be an educator and one of which must have a current Certified Dental Assistant Permit.

D. The Board President shall have the authority to appoint other ad hoc committees as needed.

E. All Committee members of standing committees, the Hygiene Committee and the Allied Dental Education Committee shall serve staggered three-year terms and serve at the pleasure of the Board.

SECTION 3. AMENDATORY 59 O.S. 2021, Section 328.19, as last amended by Section 4, Chapter 273, O.S.L. 2025 (59 O.S. Supp. 2025, Section 328.19), is amended to read as follows:

Section 328.19. A. The following acts by any person shall be regarded as practicing dentistry within the meaning of the State Dental Act:

1. Representing oneself to the public as being a dentist or as one authorized to practice dentistry;

2. Representing oneself to the public as being able to diagnose or examine clinical material or contract for the treating thereof;

3. Representing oneself as treating or professing to treat by professional instructions or by advertised use of professional equipment or products;

4. Representing oneself to the public as treating any of the diseases or disorders or lesions of the oral cavity, teeth, gums, maxillary bones, and associate structures;

5. Removing human teeth;

6. Repairing or filling cavities in human teeth;

7. Correcting or attempting to correct malposed teeth;

8. Administering anesthetics, general or local;

9. Treating deformities of the jaws and adjacent structures;

10. Using x-ray and interpreting dental x-ray film;

11. Offering, undertaking or assisting, by any means or methods, to remove stains, discolorations, or concretions from the teeth; provided, that this paragraph shall not preclude or prohibit the sale of any teeth whitening kit designed for self-administration as approved by the United States Food and Drug Administration;

12. Operating or prescribing for any disease, pain, injury, deficiency, deformity, or any physical condition connected with the human mouth;

13. Taking impressions of the teeth and jaws;

14. Furnishing, supplying, constructing, reproducing, or repairing, or offering to furnish, supply, construct, reproduce, or repair, prosthetic dentures, sometimes known as plates, bridges, or

other substitutes for natural teeth for the user or prospective user thereof;

15. Adjusting or attempting to adjust any prosthetic denture, bridge, appliance, or any other structure to be worn in the human mouth;

16. Diagnosing, making, and adjusting appliances to artificial casts of malposed teeth for treatment of the malposed teeth in the human mouth, without instructions;

17. Writing a laboratory prescription to a dental laboratory or dental laboratory technician for the construction, reproduction or repair of any appliance or structure to be worn in the human mouth;

18. Owning, maintaining, or operating an office or offices by holding a financial interest in same for the practice of dentistry; or

19. Any other procedure otherwise defined in the State Dental Act requiring a valid license or permit to perform while the person does not hold such valid license or permit issued by the Board.

B. The fact that a person uses any dental degree, or designation, or any card, device, directory, poster, sign or other media representing oneself to be a dentist shall be prima facie evidence that the person is engaged in the practice of dentistry; provided that nothing in this section shall be so construed as to prevent the following:

1. Physicians or surgeons, who are licensed under the laws of this state, from administering any kind of treatment coming within the province of medicine or surgery;

2. The practice of dentistry in the discharge of the person's official duties by dentists in the United States Army, the United States Navy, the United States Air Force, the United States Marine Corps, the United States Coast Guard, the United States Public Health Service, or the United States Veterans Administration;

3. Dental schools or colleges, as now conducted and approved, or as may be approved, and the practice of dentistry by students in dental schools, colleges or hospitals, approved by the Board, when acting under the direction and supervision of licensed dentists or dentists holding properly issued permits acting as instructors;

4. Acts of a dental clinician or other participant at a dental educational meeting or at an accredited dental college, when no fee is charged to or paid by a patient;

5. The practice of dental hygiene, as defined herein, by a person granted a license by the Board;

6. The performing of acts by a dental assistant who performs the acts under the general, direct supervision or direct visual supervision of a dentist and in accordance with the provisions of the State Dental Act and the rules promulgated by the Board; or

7. The fabrication of dental appliances pursuant to a laboratory prescription of a dentist, by a dental laboratory technician in a dental laboratory using inert materials and mechanical devices for the fabrication of any restoration, appliance or thing to be worn in the human mouth.

C. Any auxiliary health care provider, licensed or permitted by the state that is working under the supervision of a dentist, shall be limited to practicing within the scope of dentistry.

SECTION 4. AMENDATORY 59 O.S. 2021, Section 328.21, as last amended by Section 5, Chapter 273, O.S.L. 2025 (59 O.S. Supp. 2025, Section 328.21), is amended to read as follows:

Section 328.21. A. No person shall practice dentistry, dental hygiene, or dental assisting without first applying for and obtaining a license from the Board of Dentistry.

B. Application shall be made to the Board in writing and shall be accompanied by the fee established by the rules of the Board, together with satisfactory proof that the applicant:

1. Is of good moral character;

2. Is twenty-one (21) years of age, or over, at the time of making application to practice dentistry or eighteen (18) years of age, or over, if the applicant is to practice dental hygiene;

3. Has passed a written theoretical examination and a clinical examination approved by the Board within the previous five (5) years; and

4. Has passed a written jurisprudence examination over the rules and laws affecting dentistry in this state.

C. An application from a candidate who desires to secure a license from the Board to practice dentistry or dental hygiene in this state shall be accompanied by satisfactory proof that the applicant:

1. Is a graduate of ~~an~~ a United States or Canadian accredited dental college, if the applicant is to practice dentistry;

2. Is a graduate of ~~an~~ a United States or Canadian accredited dental hygiene program, if the applicant is to practice dental hygiene; and

3. Has passed all portions of the National Board Dental Examination or the National Board Dental Hygiene Examination.

D. Pursuant to Section 328.15 of this title, the Board may affiliate as a member state, and accept regional exams from the ~~Commission on Dental Competency Assessments (CDCA-WREB-CITA)~~ American Board of Dental Examiners (ADEX) if the following requirements are included:

1. For dental licensing the following components on a live patient or manikin:

a. a fixed prosthetic component of the preparation of an anterior all porcelain crown and the preparation of a three-unit posterior bridge,

b. a periodontal component,

c. an endodontic component,

d. an anterior class III and posterior class II restorative component,

e. a diagnosis and treatment planning section as approved by the Board, as specified in Section 328.15 of this title, and

f. the Board may determine equivalencies based on components of other exams for the purpose of credentialing; or

2. For dental hygienists licensing the following components on a live patient or manikin:

a. clinical patient treatments with an evaluation of specific clinical skills, and

b. evaluation of the candidate's compliance with professional standards during the treatment as approved by the Board in Section 328.15 of this title and shall include:

(1) extra/intra oral assessment,

(2) periodontal probing, and

(3) scaling/subgingival calculus removal and supragingival deposit removal.

3. The Board President may authorize the approval of a regional or state exam, which includes the components listed in paragraphs 1 and 2 of this subsection, for any person holding a dental or dental hygiene license in excess of ten (10) years with no Board action.

E. When the applicant and the accompanying proof are found satisfactory, the Board shall notify the applicant to appear for the jurisprudence examination at the time and place to be fixed by the Board. A dental student or a dental hygiene student in the student's last semester of a dental or dental hygiene program, having met all other requirements, may make application and take the jurisprudence examination with a letter from the dean of the dental school or director of the hygiene program stating that the applicant is a candidate for graduation within the next six (6) months.

F. The Board shall require every applicant for a license to practice dentistry or dental hygiene to submit, for the files of the Board, a copy of a dental degree or dental hygiene degree, an official transcript, a recent photograph duly identified and attested, and any other information as required by the Board.

G. Any applicant who fails to pass the jurisprudence examination may apply for a second examination, in which case the applicant shall pay a reexamination fee as established by the statutes or rules of the State Dental Act.

H. A dentist or dental hygienist currently licensed in another state having met the qualifications in paragraphs 1 through 3 of subsections B and C of this section may apply for a license by credentials upon meeting the following:

1. A dentist holding a general dentist license in good standing and having practiced for at least five hundred (500) hours within the previous five (5) years immediately prior to application and having passed a regional examination substantially equivalent to the requirements for this state may apply for licensure by credentials;

2. A dental hygienist holding a dental hygiene license in good standing and having practiced for at least four hundred twenty (420) hours within the previous five (5) years immediately prior to application and having passed a regional examination substantially equivalent to the requirements for this state may apply for licensure by credentials. Applicants for credentialing must include:

a. a letter of good standing from all states in which the applicant has ever been licensed, and

b. any other requirements as set forth by the rules;

3. An applicant applying for a dental or dental hygiene license by credentials shall only be required to pass the jurisprudence portion of the examination requirements as set forth in paragraph 4 of subsection B of this section; and

4. The spouse of an active duty military member pursuant to a current permanent change of station order from the military who was actively licensed in another state for the previous two (2) years shall be eligible for a license or permit pursuant to the requirements listed in 50 U.S.C., Section 4025(a).

I. 1. There shall be seven types of advanced procedures available for dental hygienists upon completion of a ~~Commission on Dental Accreditation (CODA) approved~~ program, course, or certification program that has been approved by the Board:

a. administration of nitrous oxide,

b. administration of local anesthesia,

c. neuromodulator administration,

d. therapeutic use of lasers,

e. phlebotomy,

f. venipuncture, and

g. elder care and public health pursuant to Section 328.58 of this title.

2. A dental hygienist holding an advanced procedure permit or credential in any other state for two (2) years shall be eligible for the advanced procedure permit by credentials; provided, that application for the advanced procedure permit by credentials for administration of local anesthesia shall additionally require proof of passage of such advanced procedure in ~~a CDCA-WREB-CITA~~ an American Board of Dental Examiners (ADEX) exam or another program or certification authorized by the Board.

3. For all advanced procedures other than administration of local anesthesia, a dental hygienist may apply by filling out an application with required documentation of education, training ~~as required by state law and rules of the Board~~ or verification of active practice for the previous two (2) years of the advanced procedure in a dental office. A dental hygienist licensed by the Board prior to January 30, 2024, shall be eligible for the advanced procedure of therapeutic use of lasers upon submission of an affidavit attesting to two (2) years of practice using lasers.

4. All advanced procedures shall be added to the dental hygiene license upon ~~approval~~ verification of documentation as listed in paragraphs 2 and 3 of this subsection.

J. All licensees and permit holders shall display the current permit or license in a visible place within the dental office or treatment facility.

K. The Board shall have the authority to temporarily change requirements of an examination due to availability or changes in the examination format, not to exceed one (1) year.

L. During a year in which governmental officials have declared a health pandemic, a state or federal disaster, or other natural or man-made disaster, the Board shall have the authority through a resolution to change or make allowances in requirements of all

candidates for licensure and issue temporary licenses for extended periods of time or as needed until the event passes. The resolution shall have a beginning and an end date and shall automatically expire no less than thirty (30) days after the end of the disaster is declared by governmental officials.

M. Every licensee or permit holder shall have an official address and email address listed with the Board. Every licensee or permit holder shall update the address within thirty (30) calendar days of moving. Official notification of any action of the Board adverse to a licensee or permit holder including but not limited to notification of license or permit cancellation due to nonrenewal, notice of a formal complaint, or a decision of the hearing panel or board, shall be served to the licensee or permit holder by registered mail at the official address, in person, to the licensee's or permit holder's attorney, by agreement of the individual, by a process server, or by an investigator of the Board pursuant to Section 2004 of Title 12 of the Oklahoma Statutes.

SECTION 5. AMENDATORY 59 O.S. 2021, Section 328.22, as amended by Section 3, Chapter 220, O.S.L. 2023 (59 O.S. Supp. 2025, Section 328.22), is amended to read as follows:

Section 328.22. A. 1. The Board of Dentistry may issue a dental specialty license authorizing a dentist to represent himself or herself to the public as a specialist, and to practice as a specialist, in a dental specialty.

2. No dentist shall represent himself or herself to the public as a specialist or practice as a specialist as listed in this paragraph, unless the individual:

a. has successfully completed an advanced dental specialty educational program accredited by the Commission on Dental Accreditation, or has met the board certification requirements and is recognized as a current board-certified member of a dental specialty organization or association recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards,

b. has passed the jurisprudence examination covering the State Dental Act, rules and state laws, ~~and~~

c. has passed a regional examination as defined in subsection D of Section 328.21 of this title, or is board-certified in their specialty as described in subsection A of this section, and

d. has completed any additional requirements set forth in state law or rules and has been issued a dental specialty license by the Board.

3. Specialty licenses recognized by the Board shall include:

a. dental public health,

b. endodontics,

c. oral and maxillofacial surgery,

d. oral and maxillofacial radiology,

e. orthodontics and dentofacial orthopedics,

f. pediatric dentistry,

g. periodontics,

h. prosthodontics,

i. oral and maxillofacial pathology,

j. dental anesthesiology,

k. oral medicine, and

l. orofacial pain.

B. 1. At the time of application, if the dentist has ever been licensed in any other state, he or she shall provide a letter of good standing from such state before the Board may issue a specialty license.

2. In conducting an investigation of an applicant who has applied for a dental specialty license pursuant to this subsection, the Board shall require of the applicant disclosure of the same background information as is required of an applicant for a license to practice dentistry in this state.

C. Any person holding an Oklahoma specialty license that does not have an Oklahoma general dentistry license shall be limited to practicing that specialty for which ~~they hold~~ he or she holds a license.

D. The Board may use the American Dental Association National Commission on Recognition of Dental Specialties and Certifying Boards guidelines or the guidelines of another nationally recognized dental association or board for the purpose of defining a specialty practice area not otherwise defined herein.

SECTION 6. AMENDATORY 59 O.S. 2021, Section 328.23, is amended to read as follows:

Section 328.23. A. The President of the Board, upon verification that a person meets the requirements provided for in this section and any other requirements provided for in the State Dental Act, may issue an emergency temporary license to practice dentistry for thirty (30) days. A temporary license may be extended but shall not exceed ninety (90) days or the next available regularly scheduled Board meeting.

B. The President of the Board, upon verification that a person meets the requirements provided for in the State Dental Act, may issue an emergency temporary license to practice dental hygiene, which shall expire as of the date of the next dental hygiene clinical examination in Oklahoma, as required by the Board.

C. An active duty military spouse residing with the active duty member having met the requirements for licensure shall be eligible for a temporary license.

D. Any applicant requesting an emergency temporary license shall submit a letter explaining the exigent circumstances along with all application materials. The determination of whether or not to grant the emergency temporary license based upon the exigent circumstances shall be at the sole discretion of the President or acting President of the Board.

E. A holder of a temporary license to practice dentistry or dental hygiene shall have the same rights and privileges and be governed by the State Dental Act and the rules of the Board in the same manner as a holder of a permanent license to practice dentistry and dental hygiene.

F. The President of the Board may authorize patient treatment and care by individuals taking the ~~Commission on Dental Competency Assessments (CDCA) or the Western Regional Examining Board exam~~ American Board of Dental Examiners (ADEX), or other regional exams as approved by the Board, in order for such individuals to complete criteria related to Board examinations. The Board may authorize specialty examinations to be given throughout the year as needed.

SECTION 7. AMENDATORY 59 O.S. 2021, Section 328.23a, as last amended by Section 4, Chapter 46, O.S.L. 2024 (59 O.S. Supp. 2025, Section 328.23a), is amended to read as follows:

Section 328.23a. A. There is established a special volunteer license for dentists and a special volunteer license for dental hygienists who are retired from active practice or out-of-state licensees in active practice who are in the Oklahoma Medical Reserve Corps or assisting with emergency management, emergency operations or hazard mitigation in response to any emergency, man-made disaster or natural disaster, or participating in public health initiatives, disaster drills and community service events that are endorsed by a city or county health department or the State Department of Health and wish to donate their expertise for the dental care and treatment of indigent and needy persons of the state. A special volunteer license may also be issued for any live patient training approved by the Board of Dentistry. The special volunteer license shall be:

1. Issued by the Board of Dentistry to eligible persons;

2. Issued without the payment of an application fee, license fee or renewal fee;

3. Issued or renewed without any continuing education requirements for a period less than one (1) calendar year; and

4. Issued for one (1) calendar year or part thereof.

B. A special volunteer license may be issued for a dentist or dental hygienist who is on active duty military service. This license shall not be subject to paragraph 4 of subsection A of this section and may be issued for the time period of the tour of duty.

C. A dentist or dental hygienist must meet the following requirements to be eligible for a special volunteer license:

1. Completion of a special volunteer dental or dental hygiene license application including documentation of the dental or dental hygiene school graduation and practice history;

2. Documentation that the dentist or dental hygienist has been previously issued a full and unrestricted license to practice dentistry or dental hygiene in this state or in another state of the United States and that he or she has never been the subject of any reportable medical or dental disciplinary action in any jurisdiction. If the dentist or dental hygienist is licensed in more than one state and any license of the licensee is suspended, revoked, or subject to any agency order limiting or restricting practice privileges, or has been voluntarily terminated under threat of sanction, the dentist or dental hygienist shall be ineligible to receive a special volunteer license;

3. Acknowledgement and documentation that the dentist's or dental hygienist's practice under the special volunteer license will be exclusively and totally devoted to providing dental care to needy and indigent persons in this state;

4. Acknowledgement and documentation that the dentist or dental hygienist will not receive or have the expectation to receive any payment or compensation, either direct or indirect, for any dental services rendered under the special volunteer license; and

5. A listing of all locations and dates that the person will be completing volunteer work under the special volunteer license.

D. The Board of Dentistry shall have jurisdiction over dentists, dental hygienists, dental assistants and dental technicians who volunteer their professional services in the state. Dental assistants and dental technicians shall work under the direct supervision of a dentist. A dental assistant may work under general supervision of a dentist to assist a hygienist with a procedure that the hygienist is allowed to perform under general supervision as listed in Section 328.34 of this title.

E. Dental assistants may be issued a volunteer permit at the request of an entity that provides dental services to the needy. Volunteers in a volunteer initiative who are not dentists or dental hygienists shall be named and provided on a list to the Board by the entity hosting the volunteer initiative with any other requirements as set forth by the Board. The Board shall provide written documentation to the host entity designating all persons who may

participate in the volunteer initiative including authorization of the timetable requested by the host entity for granting licensure exemption. Any person working under a volunteer dental assistant permit shall not receive payment or compensation for any services rendered under the volunteer dental assistant permit. Volunteer dental assistant permits shall be limited to specific dates and locations of services to be provided.

F. All persons providing care shall do so under the provisions specified in Section 328.1 et seq. of this title or rules promulgated by the Board. Only those functions authorized by law or administrative rule shall be performed by the named person approved by the Board.

G. Volunteers shall not use sedation or general anesthesia during volunteer procedures.

H. Volunteers shall use a form to be provided by the Board for any patient with clear instructions for any and all follow-up care.

I. At any time, the Board shall revoke a volunteer license based on documentation of failure to participate according to state laws or administrative rules.

J. A special volunteer license shall be restricted to services provided at the locations listed on the application or for a specific not-for-profit treatment provider group as approved by the Board.

K. A special volunteer license may be issued to a dentist with an active license in good standing in another state for the purpose of participating in a continuing education class that includes live patient treatment as a part of the training program.

SECTION 8. AMENDATORY 59 O.S. 2021, Section 328.24, as last amended by Section 6, Chapter 273, O.S.L. 2025 (59 O.S. Supp. 2025, Section 328.24), is amended to read as follows:

Section 328.24. A. No person shall practice as a dental assistant without first applying for and obtaining a permit from the Board of Dentistry.

B. The application shall be made to the Board in writing and shall be accompanied by the fee established by the Board, together

with satisfactory proof that the applicant passes a background check with criteria established by the Board.

C. Every dental assistant receiving a permit shall complete a class on infection control as approved by the Board within one (1) year from the date of receipt of the permit. Failure to complete the class shall be grounds for discipline pursuant to Section 328.29a of this title.

D. There shall be eight types of expanded duty permits available for dental assistants upon completion of a program approved by the Commission on Dental Accreditation (CODA) or a course that has been approved by the Board:

1. Radiation safety;

2. Coronal polishing and topical fluoride;

3. Sealants;

4. Assisting in the administration of nitrous oxide;

5. Phlebotomy;

6. Venipuncture;

7. Elder care and public health; or

8. Oral maxillofacial surgery. An oral maxillofacial surgery expanded duty permit shall be available to a dental assistant who has met the requirements as listed in Section 328.25 of this title and assists a dentist, pediatric dentist, or oral maxillofacial surgeon who holds a parenteral or general anesthesia permit; provided, only the dentist, pediatric dentist, or oral maxillofacial surgeon, or an anesthesiologist or a Certified Registered Nurse Anesthetist, may administer anesthesia and assess the patient's level of sedation and only the dentist, pediatric dentist, or oral maxillofacial surgeon may perform surgery.

All expanded duties shall be added to the dental assistant permit upon approval by the Board.

E. The training requirements for all expanded duty permits shall be set forth by the Board. A program that is not CODA-

certified must meet the standards set forth and be approved by the Board.

F. An applicant for a dental assistant permit who has graduated from a dental assisting program accredited by CODA and has passed the jurisprudence examination shall receive all expanded duty permits provided for in subsection D of this section if the course materials approved by the Board are covered in the program.

G. A dental assistant who holds an out-of-state dental assistant permit with expanded duties may apply for credentialing and reciprocity for a dental assistant permit including any expanded duty by demonstrating the following:

1. The dental assistant has had a valid dental assistant permit in another state for a minimum of two (2) years and is in good standing;

2. The dental assistant has had a valid expanded duty in another state for a minimum of one (1) year; and

3. The dental assistant provides a certificate or proof of completion of an educational class for the expanded duty and that the dental assistant has been providing this treatment to dental patients while working as a dental assistant in a dental office for one (1) year.

H. Any person having served in the military as a dental assistant shall receive credentialing and reciprocity for expanded functions by demonstrating the following:

1. Proof of military service in excess of two (2) years with any certifications or training in the expanded function areas; and

2. Verification from the commanding officer of the medical program or the appropriate supervisor stating that the dental assistant provided the expanded functions on patients in the military dental facility for a minimum of one (1) year within the past five (5) years.

I. Dental assistants are required to work under the direct supervision of a dentist for all procedures with the following exceptions:

1. A dental assistant may complete radiation safety under the general supervision of a dentist; and

2. A dental assistant may work under general supervision of a dentist to assist a hygienist with a procedure that the hygienist is allowed to perform under general supervision.

SECTION 9. AMENDATORY 59 O.S. 2021, Section 328.29a, as last amended by Section 11, Chapter 273, O.S.L. 2025 (59 O.S. Supp. 2025, Section 328.29a), is amended to read as follows:

Section 328.29a. A. The following acts or occurrences by a dental assistant shall constitute grounds for which the penalties specified in Section 328.44a of this title may be imposed by the Board of Dentistry or be the basis for denying a new applicant any license or permit issued by the Board:

1. Any of the causes now existing in the laws of this state;

2. A violation of the provisions of the State Dental Act; or

3. A violation of the rules of the Board promulgated pursuant to the State Dental Act.

B. The Board shall also have the power to act upon a petition by a dental assistant for reinstatement to good standing. The Board shall keep a record of the evidence and proceedings in all matters involving the revocation or suspension of a permit, censure or probation of a dental assistant. The Board shall make findings of fact and a decision thereon. Notification of the licensee or permit holder shall occur pursuant to Section 328.21 of this title.

C. The decision shall be final unless the dental assistant appeals the decision as provided by the State Dental Act.

D. The Board shall have power to revoke or suspend the permit, censure, or place on probation a dental assistant for a violation of one or more of the following:

1. Pleading guilty or nolo contendere to, or being convicted of, a felony crime that substantially relates to the occupation of a dental assistant and poses a reasonable threat to public safety, or a violation of federal or state controlled dangerous substances laws;

2. Presenting to the Board a false application or documentation for a permit;

3. Being, by reason of persistent inebriety or addiction to drugs, incompetent to continue to function as a dental assistant;

4. Functioning outside the general, direct or direct visual supervision of a dentist for a procedure authorized by this act;

5. Performing any function prohibited by Chapter 15 of the Oklahoma Administrative Code or any violation that would be a violation for a dentist or hygienist under Section 328.32 or 328.33 of this title, or any other duty not assignable to a dental assistant; or

6. Failure to secure an annual registration as specified in Section 328.41 of this title.

E. The Board's review panel, as set forth in Section 328.43a of this title, upon concurrence with the president of the Board, may determine that an emergency exists to temporarily suspend the permit of a dental assistant if the panel finds that public health, safety or welfare imperatively requires emergency action. The panel may conduct a hearing pursuant to Section 314 of Title 75 of the Oklahoma Statutes for the temporary suspension.

F. As used in this section:

1. "Substantially relates" means the nature of criminal conduct for which the person was convicted has a direct bearing on the fitness or ability to perform one or more of the duties or responsibilities necessarily related to the occupation; and

2. "Poses a reasonable threat" means the nature of criminal conduct for which the person was convicted involved an act or threat of harm against another and has a bearing on the fitness or ability to serve the public or work with others in the occupation.

SECTION 10. AMENDATORY 59 O.S. 2021, Section 328.31, is amended to read as follows:

Section 328.31. A. Professional entities formed pursuant to the Professional Entity Act, for the purpose of rendering professional services by a dentist, shall be subject to all of the provisions of the State Dental Act, except that professional

entities shall not be required to obtain a license from the Board of Dentistry. Individuals who hold a license issued by the Board shall be responsible, pursuant to the State Dental Act, for their personal conduct without regard to the fact that they are acting as an owner, manager, agent or employee of, or the holder of an interest in, a professional entity.

B. Professional entities formed for the purpose of rendering professional services by a dentist must register with the Board before rendering such services and must update the registration during the renewal period of each year. The Board shall:

1. Provide the form and establish the fee for the registration and update; and

2. Maintain a registry of all such professional entities~~; and~~

~~3. Publish annually a summary of the registry~~.

C. The Board is authorized to issue certificates pursuant to Section 804 of Title 18 of the Oklahoma Statutes and shall maintain a record of each certificate issued.

D. Enforcement actions by the Board for violation of the State Dental Act or the rules of the Board may be brought against a professional entity as well as against any individual who is or has acted as an owner, manager, agent or employee of, or the holder of an interest in, the professional entity.

SECTION 11. AMENDATORY 59 O.S. 2021, Section 328.31b, as last amended by Section 13, Chapter 273, O.S.L. 2025 (59 O.S. Supp. 2025, Section 328.31b), is amended to read as follows:

Section 328.31b. A. Every dental office or treatment facility, whether individual, group or multi-doctor practice operating under a name, trade name or other professional entity shall maintain written records on each patient treated at the facility and shall make these records available to the Board of Dentistry and other regulatory entities or be subject to the penalties as set forth in Section 328.44a of this title.

B. Each licensed dentist shall maintain written records on each patient that shall contain, at a minimum, the following information about the patient:

1. A current health history listing known illnesses, other treating physicians and current medications prescribed;

2. Results of a clinical examination, including a physical intraoral examination and head and neck examination, tests conducted, and any lab results including the identification, or lack thereof, of any oral pathology or diseases;

3. Treatment plan proposed by the dentist; and

4. Treatment rendered to the patient. The patient record shall clearly identify the dentist and the dental hygienist or dental assistant providing the treatment with the dentist, specialty or dental hygienist license number. The patient record shall include documentation of any medications prescribed, administered or dispensed to the patient.

C. Prior to a dentist prescribing, diagnosing, or overseeing patient treatment for any dental appliance, the patient shall be a patient of record and the dentist shall conduct an in-person patient examination.

D. 1. The name of the dentist or dentists actually providing the dental services to the patient shall appear on all insurance claim forms~~, billing invoices, or statements sent to the patient and on all receipts if any are given to the patient~~.

2. Treatment records shall be maintained for each patient that clearly identify the dentist or dentists, hygienists or dental assistants who performed all dental services for the patient.

E. Whenever patient records are released or transferred, the dentist releasing or transferring the records shall maintain either the original records or copies thereof and a notation shall be made in the retained records indicating to whom the records were released or transferred.

F. All claims being submitted for insurance must be signed, stamped or have an electronic signature by the treating dentist.

G. Patient records may be kept in an electronic data format, provided that the dentist maintains a backup copy of information stored in the data processing system using disk, tape or other electronic back-up system and that backup is updated on a regular basis, at least weekly, to assure that data is not lost due to

system failure. Any electronic data system shall be capable of producing a hard copy on demand.

H. All patient records shall be maintained for seven (7) years from the date of treatment.

I. Each licensed dentist shall retain a copy of each entry in his or her patient appointment book, calendar, or such other log, calendar, book, file or computer data used in lieu of an appointment book for a period no less than seven (7) years from the date of each entry thereon.

J. A licensee closing an office shall notify the Board in writing and include the location of where the patient records will be maintained.

SECTION 12. AMENDATORY 59 O.S. 2021, Section 328.34, as amended by Section 6, Chapter 220, O.S.L. 2023 (59 O.S. Supp. 2025, Section 328.34), is amended to read as follows:

Section 328.34. A. A dental hygienist may practice dental hygiene under the supervision of a dentist in a dental office or treatment facility. A dentist may employ not more than the equivalent of three full-time dental hygienists for each dentist actively practicing in the same dental office. Employing the equivalent of three dental hygienists shall mean the employment or any combination of full- or part-time dental hygienists not to exceed one hundred twenty (120) hours per week per dentist.

B. 1. A dentist may delegate to a dental hygienist the following procedures:

a. the duties and expanded duties authorized for dental assistants by the State Dental Act or the rules of the Board of Dentistry,

b. health history assessment pertaining to dental hygiene,

c. dental hygiene examination and the charting of intra-oral and extra-oral conditions, which include periodontal charting, dental charting and classifying occlusion,

d. dental hygiene assessment and treatment planning for procedures authorized by the supervisory dentist,

e. prophylaxis, which means the removal of any and all calcareous deposits, stains, accretions, or concretions from the supragingival and subgingival surfaces of human teeth, utilizing instrumentation by scaler or periodontal curette on the crown and root surfaces of human teeth, including rotary or power-driven instruments. This paragraph shall not be construed to prohibit the use of a prophy/polishing cup or brush on the crowns of human teeth by a dental assistant who holds a current expanded duty permit for coronal polishing and topical fluoride issued by the Board,

f. periodontal scaling and root planing,

g. dental hygiene nutritional and dietary evaluation,

h. placement of subgingival prescription drugs for prevention and treatment of periodontal disease,

i. soft tissue curettage,

j. placement of temporary fillings,

k. removal of overhanging margins,

l. dental implant maintenance,

m. removal of periodontal packs,

n. polishing of amalgam restorations, and

o. other procedures authorized by the Board.

2. The procedures specified in subparagraphs b through o of paragraph 1 of this subsection may be performed only by a dentist or a dental hygienist.

3. Except as provided in subsections C and D of this section, the procedures specified in paragraph 1 of this subsection may be performed by a dental hygienist only on a patient of record and only under the supervision of a dentist. The advanced procedures of

administration of nitrous oxide, therapeutic use of lasers and administration of local anesthesia~~,~~ may be performed under general supervision and neuromodulator administration, ~~therapeutic use of lasers,~~ and phlebotomy and venipuncture shall be performed only under the direct or indirect supervision of a dentist. The level of supervision, whether direct, indirect, or general, for the advanced procedure of elder care and public health pursuant to Section ~~7~~ 328.24 of this ~~act~~ title shall be at the discretion of the supervisory dentist. Authorization for general supervision shall be limited to a maximum of thirteen (13) months following an examination by the supervisory dentist of a patient of record.

C. 1. A dentist may authorize procedures to be performed by a dental hygienist, without complying with the provisions of paragraph 3 of subsection B of this section, if:

a. the dental hygienist has at least two (2) years' experience in the practice of dental hygiene,

b. the authorization to perform the procedures is in writing and signed by the dentist, and

c. the procedures are performed during an initial visit to a person in a treatment facility, or pursuant to Section ~~7~~ 328.24 of this ~~act~~ title.

2. The person upon whom the procedures are performed must be referred to a dentist after completion of the procedures performed pursuant to paragraph 1 of this subsection.

3. A dental hygienist shall not perform a second set of procedures on a person pursuant to this subsection until the person has been examined and accepted for dental care by a dentist.

4. The treatment facility in which any procedure is performed by a dental hygienist pursuant to this subsection shall note each such procedure in the medical records of the person upon whom the procedure was performed and list the dentist that authorized the hygienist to perform the procedures signed by the hygienist.

D. A treatment facility may employ dental hygienists whose services shall be limited to the examination of teeth and the teaching of dental hygiene or as otherwise authorized by the Board.

E. The Board is authorized to prescribe, by rule, the educational requirements for advanced procedures that may be performed by a dental hygienist upon receipt of the advanced procedures designated on his or her license. The advanced procedures shall include the administration of local anesthesia, the administration of nitrous oxide analgesia, neuromodulator administration, therapeutic use of lasers, phlebotomy and venipuncture, and elder care and public health pursuant to Section ~~7~~ 328.24 of this ~~act~~ title.

F. A dental hygienist shall not own or operate an independent practice of dental hygiene.

G. Nothing in the State Dental Act shall be construed to prohibit a dentist from performing any of the procedures that may be performed by a dental hygienist.

H. Nothing in the State Dental Act shall be construed to allow a dental assistant to work under the supervision of a dental hygienist while acting under direct, indirect or general supervision, except as provided by subsection I of Section ~~7~~ 328.24 and Section 328.58 of this ~~act~~ title.

SECTION 13. AMENDATORY 59 O.S. 2021, Section 328.54, is amended to read as follows:

Section 328.54. A. Any person conducting a diagnosis for the purpose of prescribing medication or treatment or any other action determined to be a dental practice as defined by the State Dental Act, via the Internet or other telecommunications device on any patient that is physically located in this state shall hold a valid Oklahoma state dental license.

B. A patient of record may be established by teledentistry for the purposes of an emergency or hygiene treatment if the patient is physically located at the dental office or treatment facility and the dentist is not readily available.

C. A dentist holding a valid dental license in Oklahoma may consult, diagnose and treat a patient of record via synchronous or asynchronous telecommunication between the patient and dentist. The dentist must record all activities relating to teledentistry in the patient record and must have an office location in Oklahoma available for follow-up treatment and maintenance of records.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 328.21a of Title 59, unless there is created a duplication in numbering, reads as follows:

A. The University of Oklahoma College of Dentistry shall develop and implement a three-year pilot program to create a pathway for foreign-trained dentists to practice in the state under the conditions of this section.

B. A dentist, having received a dental degree or certificate in a foreign country that is a non-United States or Canadian accredited program, may apply for a dental hygiene license upon meeting the following requirements:

1. The applicant must provide proof of a valid dental education and degree, certificate or other proof acceptable by the Board and proof of lawful practice of dentistry for the past two (2) years in a foreign country. All documents shall be translated to English and verifiable by the Board;

2. Successful passage of the ADEX dental hygiene licensure exam;

3. Successful passage of the Test of English as a Foreign Language (TOEFL). The applicant can provide proof of passing the TOEFL exam within the past five (5) years;

4. Successful completion of an evaluation program to practice dental hygiene conducted by the University of Oklahoma College of Dentistry;

5. Demonstrated that the education and clinical training received abroad is substantially equivalent to the standards required of dental hygienists in the state, as determined by the Board, the University of Oklahoma College of Dentistry, and the University of Oklahoma Department of Diagnostic and Preventive Sciences Dental Hygiene program;

6. Successful completion of the Oklahoma Jurisprudence exam; and

7. Successful passage of the National Board of Dental Hygiene Examination (NBDHE).

SECTION 15. This act shall become effective July 1, 2026.

SECTION 16. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Passed the House of Representatives the 24th day of March, 2026.

_____
Presiding Officer of the House
of Representatives

Passed the Senate the 29th day of April, 2026.

_____
Presiding Officer of the Senate

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____

Approved by the Governor of the State of Oklahoma this _____

day of _____, 20_____, at _____ o'clock _____ M.

_____
Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____

2026 License Numbers as of September 29, 2026	
License Type	**2026**
Dentists	2544
Hygienists	2791
Dental Assistants	8063
Dental Labs	71
Professional Entity	1290
Dispensing Permits	733
Anesthesia Provider	196
Anesthesia Facility	249
Faculty	7
Residents	10
Fellowship	0
Retired Volunteer	77
Dental Student Interns	2
Mobile Dental Units	5

Myofunctional Therapy

Myofunctional therapy trains muscles in your mouth and face to move in ways that support eating, breathing, swallowing and more. A provider guides you through a series of exercises that strengthen muscles and increase your awareness of facial movements. Therapy may help with conditions like obstructive sleep apnea and TMJ disorders.

Overview

What is myofunctional therapy?

Myofunctional therapy (also called orofacial myofunctional therapy or OMT) trains muscles in your mouth and face to move as they should and rest in the proper positions. It involves doing certain exercises with your cheeks, tongue or lips. These exercises strengthen your muscles and finetune your awareness of facial movements (proprioception).

OMT treats orofacial myofunctional disorders (OMDs). OMDs are abnormal muscle movement patterns in your mouth and face that affect how you breathe, chew, swallow and/or speak.

Healthcare providers use myofunctional therapy to help people with OMDs, but it's a growing area of research. This means providers are still learning more about optimal techniques for different conditions and how long you should do this therapy to have the most benefits. Despite the need for more research, it's clear from existing studies that OMT is safe and has no known risks.

What can orofacial myofunctional therapy help me with?

OMT aims to help all the different parts of your mouth area — your jaws, lips, teeth and tongue — smoothly work together as a unit. Healthcare providers sometimes use OMT to manage:

- **Mouth breathing**. This means you can't take in enough air through your nose, despite adequate treatment for any nasal obstructions. Mouth breathing can lead to sleep disorders and affect your overall health.
- **Obstructive sleep apnea (OSA)**. This is a form of sleep-disordered breathing that involves soft tissues in your head and neck pressing on your windpipe. This prevents you from taking in enough air and disrupts your sleep, potentially leading to serious complications.
- **Open mouth posture**. Normally, your lips should come together to form a seal. But an open mouth posture means your mouth remains slightly open at rest, potentially leading to issues with your teeth, jaws and tongue. An open mouth posture can also result in your tongue resting on the floor of your mouth. Your tongue should be lightly suctioned to the roof of your mouth at rest.
- **Tongue thrust**. This issue typically affects children. It's when your child's tongue pushes against or between their teeth. This affects their ability to swallow normally or produce certain sounds accurately — like *s,z,t,d* and *n*. It can also affect how their teeth develop.
- **Clenching or grinding your teeth (bruxism)**. Keeping your teeth tightly closed too often can damage your teeth and cause headaches or jaw pain.

- **TMJ disorders**. These conditions affect your temporomandibular (TMJ) joints and the muscles and ligaments around them. Over time, TMJ disorders can lead to chronic pain, trouble chewing and other problems.
- **Recovery from jaw surgery**. Some research shows that OMT can help improve your ability to chew foods after having jaw surgery.
- **Recovery from surgery to release tongue ties (lingual frenectomy)**. OMT can be used to stretch the tongue muscles after surgery to get a better range of motion for eating and making sounds.

What age is OMT for?

OMT is designed for school-aged children (4 years old and up), adolescents and adults. It's not appropriate for babies and toddlers because it requires understanding and following specific directions. Your provider or your child's provider can tell you more about OMT and how it might help.

Treatment Details

What happens during a myofunctional therapy session?

OMT can involve a wide variety of exercises designed to strengthen your mouth and facial muscles. Your myofunctional therapist will create a plan specific to your needs. Things you might do during an OMT therapy session include:

- Sing
- Play a wind instrument
- Do breathing exercises
- Lift or extend your tongue in specific ways
- Hold a small object between your lips

How long will I need this treatment?

How long you need OMT depends on the condition it's treating. According to the Academy of Orofacial Myofunctional Therapy, treatment typically lasts six to 12 months. You may need more or less time depending on your situation.

Your provider will tell you how many days per week you should do therapy and how long each session will last. You may do some sessions with your provider and some on your own at home.

What type of provider does myofunctional therapy?

Healthcare providers with special training in orofacial myofunctional disorders (OMDs) perform myofunctional therapy. Speech-language pathologists, occupational therapists and dental hygienists are just some examples of the types of providers who complete such training.

Some providers earn certifications through professional societies like the Academy of Orofacial Myofunctional Therapy or the International Association of Orofacial Myology. Such certifications show your provider has completed rigorous training and stays current in the field by doing continuing education tasks. Specific credentials you might see after your provider's name include:

- Certified orofacial myofunctional therapist (COMT®).
- Certified orofacial myologist (COM®).

P54

Providers who do OMT typically work closely with other specialists, like oral surgeons, otolaryngologists and sleep medicine specialists. Together, these providers create a treatment plan that meets your unique needs.

Risks / Benefits

What are the potential benefits of orofacial myofunctional therapy?

OMT may help:

- Make it easier for you to breathe through your nose, chew foods and/or speak clearly.
- Improve your lip or tongue positioning to support your teeth alignment and oral health.
- Support your recovery from jaw surgery.
- Support the goals of orthodontic treatment.
- Reveal whether or not you need speech therapy (which, unlike OMT, focuses specifically on speaking and language skills).
- Boost your self-confidence.

Most research on OMT focuses on how it might help people with obstructive sleep apnea, particularly when used in addition to other sleep apnea treatments. According to a recent study, there's evidence that OMT may:

- Make your nighttime breathing problems less severe
- Help you feel less sleepy during the day
- Help you take in more oxygen while sleeping
- Reduce how often you snore
- Offer an alternative or supplement to CPAP use

What are the risks or complications of OMT?

OMT has no known risks. Your provider can tell you more about what to expect and if there are any drawbacks in your specific situation.

When To Call the Doctor

When should I call my healthcare provider?

Contact your healthcare provider if you want to learn more about OMT or how it might help you. If you're doing therapy, reach out any time you have questions or concerns about your treatment plan.

A note from Cleveland Clinic

Think fast: How many times do you swallow per day? Breathe in through your nose? Open your mouth to speak? It's hard to come up with a number because these processes are so automatic — and so frequent — that you barely think about them. Unless, of course, you have a condition that makes seemingly simple movements a lot harder than they should be.

Myofunctional therapy is one approach to treating facial muscle issues that might keep you from enjoying a full range of motion or taking in enough air while you sleep. Your provider can tell you more about whether this therapy is worth a try in your specific situation.

Experts You Can Trust

Medically Reviewed. Last updated on 12/30/2024.

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Cleveland Clinic's health articles are based on evidence-backed information and review by medical professionals to ensure accuracy, reliability and up-to-date clinical standards.

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Advisory Committees to the State Board of Dentistry

List for Appointment :

The Committees are advisory only to the Board. The committees will discuss issues, current dental practices and complete an ongoing review of practice in relationship to the Rules and Statutes and make recommendations to the Board.

Each of the following committees will have a co-chair, one appointed by the Board and one appointed by the ODA. The Board and the ODA shall have a list of recommendations for the committee members that must be approved by the Board.

*Not all positions are required to be filled with the exception of the co-chairs.

*Each committee group is on 3-year staggered terms for appointment purposes.

* Meetings are required once a year but may be called by the co-chairs at any time needed.

A. Historical and Retirement

Board co-chair Dr. Jim Gore (expires June 30th 2028)

Association co-chair Dr. Ron Winder (expires June 30th 2029)

1. Dr. James Farley (expires June 30th 2029) Board
2. Dr. Robert Miller (expires June 30th 2028) Board
3. Dr. Richard Corwin (expires June 30th 2029) Board
4. Dr. Linda LoScuito (expires June 30th 2027) Board
5. Dr. Steve Glenn (expires June 30th 2028) ODA
6. _____ (expires June 30th 2029) ODA
7. _____ (expires June 30th 2027) ODA
8. Dr. Greg Watkins (expires June 30th 2028) ODA

B. Dental Practice

Board co-chair Dr. Brant Rouse and Erin Roberts (expires June 30th 2027)

Association co-chair Dr. Jennifer Jenkins (expires June 30th 2028)

1. Dr. Loren Israelsen – Shawnee (expires June 30th 2027) Board
2. Dr. Audrey Crawford – Grove (expires June 30th 2028) Board
3. Dr. Eric Hopkins- Shawnee (expires June 30th 2029) Board
4. Dr. John Fullington- Yukon (expires June 30th 2027) Board
5. Dr. Roberta Bo Wright – Oklahoma City (expires June 30th 2028) ODA
6. Dr. Laura Ousley-Oklahoma City (expires June 30th 2029) ODA
7. Dr. Blake Cohlmia-Oklahoma City (expires June 30th 2027) ODA
8. Dr. Victoria Ball- Edmond (expires June 30th 2029) ODA
9. Dr. Ed Braly – Norman (expires June 30th 2028) Board

10. Shane Tewis, Tulsa (expires June 30th 2029) Board
11. Matthew Byrne, Norman (expires June 30th 2028) Board
12. _____ (expires June 30th 2027) Board
13. _____ (expires June 30th 2029) Board
14. _____ (expires June 30th 2029) ODA
15. _____ (expires June 30th 2028) ODA
16. _____ (expires June 30th 2027) ODA
17. _____ (expires June 30th 2029) ODA
18. _____ (expires June 30th 2028) ODA

C. Specialty Practice

Board co-chair Dr. Jeff Lunday (expires June 30th 2027)

Association co-chair _____ (expires June 30th 2028)

1. _____ (expires June 30th 2027) Board
2. Dr. Jeff Cohlmia (expires June 30th 2028) Board
3. _____ (expires June 30th 2029) Board
4. _____ (expires June 30th 2027) Board
5. Dr. Farah Masood (expires June 30th 2028) ODA
6. Dr. Tracey Whitley (expires June 30th 2029) ODA
7. Dr. Katie Higgins (expires June 30th 2027) ODA
8. Dr. Alejandro Romero (expires June 30th 2028) ODA

D. Dental Assistants, Dental Labs and Auxiliary Personnel

Board co-chair Dr. Stan Crawford and Dr. Erin Roberts (expires June 30th 2027)

Association co-chair Dr. Susan Davis-Lavern (expires June 30th 2028)

1. Robin Graham, RDH-Newcastle (expires June 30th 2027) Board
2. Tina Tuck, RDH-Weatherford (expires June 30th 2028) Board
3. Brant Rouse - Tahlequah (expires June 30th 2029) Board
4. Daryn Lu – OKC (expires June 30th 2027) Board
5. Ronald Faram, OKC (expires June 30th 2028) ODA
6. _____ (expires June 30th 2029) ODA
7. _____ (expires June 30th 2027) ODA
8. _____ (expires June 30th 2028) ODA

E. Anesthesia Committee

Board co-chair Dr. Ryan Roberts (expires June 30th 2027)

Association co-chair Dr. Tawana Duncan (Pedo) (expires June 30th 2028)

1. Dr. Roy Stevens (special needs children) (expires June 30th 2029) Board

2. Dr. Tate Montgomery (dentist anesthesiologist) (expires June 30th 2028) Board
3. Dr. David T. Evans (pediatric dentistry) (expires June 30th 2029) Board
4. Dr. Lauren Lunday (oral surgery) (expires June 30th 2027) Board
5. Dr. Carla Whitney Yeates (expires June 30th 2028) ODA
6. Dr. Ed Braly (oral surgery) (expires June 30th 2029) ODA
7. Dr. David Ciesla (Ped) (expires June 30th 2027) ODA
8. _____ (expires June 30th 2028) ODA
9. Dr. Daniel Cannon (expires June 30th 2027) Board
10. Dr. Rob Bryan (expires June 30th 2028) Board
11. Dr. JayCee Van Horn (expires June 30th 2029) Board
12. Dr. Bruce Horn (expires June 30th 2027) Board
13. Dr. Autumn Hurd (expires June 30th 2028) ODA
14. _____ (expires June 30th 2029) ODA
15. _____ (expires June 30th 2027) ODA
16. _____ (expires June 30th 2028) ODA
17. Dr. Thomas Rogers (expires June 30th 2027) Board
18. _____ (expires June 30th 2028) ODA

F. Hygiene Committee

1. Rachel Ostberg R.D.H. hygiene member of the Board
2. Julie Seward, R.D.H. (expires June 30th 2027) Board
3. Candice Davis, R.D.H. (expires June 30th 2028) ODHA
4. Monica McKee, R.D.H. (expires June 30th 2029) Board
5. Holly Abbott, R.D.H. (expires June 30th 2027) ODHA

G. Allied Dental Education Committee (all appointments are to be recommended by the President to the Board

1. Dr. Krista Jones (expires June 30th 2027)
   Board President or designee that is a current or past Board Member.

2. Rachel Ostberg, R.D.H. (expires June 30th 2028)
   Hygiene Member of the Board or a designee that is a past or current member of the Board.

3. Robin Graham, R.D.H. (expires June 30th 2029)
   Dean of the OU College of Dentistry or his/her designee.

4. Sherri Lewis, D.A. (expires June 30th 2027)
   Board appointment of certified dental assistant with current permit.

5. Tina Tuck, R.D.H. (expires June 30th 2028)
Board appointment of individual that is an educator.

6. Dr. James Sparks (expires June 30th 2029) Board at-large
7. DA (expires June 30th 2027) Board at-large
8. Michaela Hall, BS, RDH (expires June 30th 2028) Board at-large
9. _____ (expires June 30th 2027) Board at-large
10. _____ (expires June 30th 2028) Board at-large

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The UNIVERSITY *of* OKLAHOMA
Health Sciences Center

College of Dentistry
Office of the Dean

September 24, 2026

Ms. Susan Rogers Executive Director
Oklahoma Board of Dentistry
2920 North Lincoln Boulevard, Suite B Oklahoma
City, Oklahoma 73105

Dear Ms. Rogers:

This letter is provided to support the limited faculty license application for Mohammed Zahedul Islam Nizami, PhD, GDCSc, BDS.

Dr. Nizami, received his BDS degree in 2003 from Dhaka University in Dhaka, Bangladesh. Following graduation, he went on to get his Graduate Diploma in Clinical Science (GDCSc) from the Mahidol University in Salaya, Nakhon Pathom, Thailand and a PhD in Dental Science from the Okayama University of Okayama City, Japan.

Dr. Nizami will be a great addition and asset to the Division of Prosthodontics, Department of Restorative Sciences. He comes with a wealth of experience over the last twenty years. I appreciate the Board's consideration. If I can provide any additional information or clarification, please do not hesitate to contact me.

Sincerely,

Paul Mullasseril, DDS, MS
Dean and Connie and Herbert Shillingburg, DDS,
Professorship of Prosthodontics

1201 North Stonewall Avenue, Oklahoma City, OK 73117-1214
PHONE: (405) 271-5444 FAX: (405) 271-7775

CURRICULUM & EDUCATIONAL LEADERSHIP

- **Curriculum Design:** Led development and evaluation of under/postgraduate courses.
- **External Education:** Delivered invited lectures and workshops internationally (USA, Hong Kong, Japan, Malaysia, Bangladesh, and Thailand).
- **Course Coordinator:** BDS I & IV, Pioneer Dental College; BDS IV, City Dental College
- **Exam Coordinator & Clinical Tutor:** Pioneer Dental College, City Dental College, AIMST University, Okayama University, and Hong Kong University
- **Innovation in Education:** Implemented didactic, clinical, digital simulation, problem-based learning, challenge-based learning, and serious games in dental education.
- **Accreditation and Quality Assurance:** Committee member for curriculum accreditation (MQA Malaysia).

MENTORSHIP

- Supervised BDS, BDT, MS, MPhil, and PhD students
- Mentored postdoctoral fellows and junior faculty
- Grant and manuscript mentorship

RESEARCH PROFILE

Primary research focuses on cariology, minimally invasive dentistry, dental biomaterials, graphene oxide nanocomposites, hydrogel-based drug delivery systems, and implant surface functionalization.

RESEARCH FUNDING

- **NIH R90 Grant** (2023–present) – Principal Investigator.
- **Health and Medical Research Fund** (2022-present) – Principal Investigator.
- **Seed Fund for Basic Research** (2022) – Co-Investigator.

SCHOLARLY PROFILE

Research profile- "Mohammed Zahedul Islam Nizami,"

- Google Scholar,
- LinkedIn,
- ResearchGate,
- ORCID (0000000260411907),
- Scopus (57213165905),
- WoS (HHZ-2582-2022).

PUBLICATIONS

Authored over **38 peer-reviewed publications, 2 book chapters, and 2 encyclopedias**

Citations: 607; h-index: 12; i10-index: 13 as of 1/16/2026).

HONORS AND AWARDS

Recipient of major awards:

- R90 NIH Grant Award (2023),
- IADR William J. Gies Award (2021),
- Ocean Plaque Award (2020),
- IADR Kulzer Travel Award (2020),
- Morita Foundation Scholarship (2017),
- JASSO Scholarship (2017).

PROFESSIONAL SERVICE

- **Editorial Board Member:** SciBase Dentistry and Oral Sciences, Journal of Dentistry and Oral Health, International Journal of Dental Medicine.
- **Guest Editor:** Journal of Functional Biomaterials, Journal of Applied Biomaterials & Functional Materials
- **Peer Reviewer:** Journals from Elsevier, Springer Nature, MDPI, Wiley, Frontiers, Taylor & Francis, SAGE, J-STAGE, and others.
- **International invited speaker-** Oral and poster presentation, Committee of conference, symposium, seminar.

PROFESSIONAL MEMBERSHIPS

- International Association for Dental Research (IADR),
- American Association for Dental, Oral, and Craniofacial Research (AADOCR),
- Southeast Asian Division of the IADR (IADR-SEA),
- Hong Kong Society of Preventive Dentistry,
- Japanese Association for Dental Research (JADR),
- Japanese Society of Conservative Dentistry,
- Okayama Dental Society,
- Bangladesh Medical and Dental Council (BM&DC),
- Bangladesh Dental Society,
- Bangladesh Prosthodontics Society,
- Bangladesh Research Health Foundation,
- Bangladesh Oral Health Research Foundation,
- Bangladesh Academy of Dentistry International

CONCLUSION

An academic clinician-scientist integrating excellence in restorative dentistry, including prosthodontics, operative dentistry, and dental materials, with funded translational research, education, and mentorship to advance oral health within academic dentistry.

FULL PUBLICATION LIST

Journal Articles

1. **Nizami MZI**, Yin IX, Niu JY, Yu OY, Chu CH. Antibiotic Resistance in Dentistry: A Review. Antibiotics. 2025 Dec.
2. **Nizami MZI**, Jindarojanakul A, Ma Q, Lee SJ, Sun J. Advances in Bioactive Dental Adhesives for Caries Prevention: A State-of-the-Art Review. J. Funct. Biomater. 2025; 16(11):418.
3. **Nizami MZI**, Chu S, Chu S, Chu CH. Probiotics for caries prevention: A narrative review. J Appl Biomater Funct Mater. 2025; 23:22808000251376427.
4. WK Alomran, **MZI Nizami**, HHK Xu, J Sun. Evolution of Dental Resin Adhesives—A Comprehensive Review. J. Funct. Biomater. 2025; 16, 104
5. Xu VW, Yin IX, Niu JY, Yu OY, **Nizami MZI***, Chu CH. Antimicrobial properties of copper tetraamine fluoride. J Appl Biomater Funct Mater. 2024; 22: 22808000241307803.
6. Xu VW, Yin IX, Niu JY, Yu OY, **Nizami MZI***, Chu CH. The anti-caries effects of copper tetraamine fluoride on enamel: an in vitro study. J Dent. 2024; 1:105446.
7. Xu VW, Yin IX, Niu JY, Yu OY, **Nizami MZI***, Chu CH. Antibacterial and mineralising properties of copper tetraamine fluoride on dentine caries: A laboratory study. J Dent. 2024; 105444.
8. Sultana N, **Nizami MZI**, Obata S, Nishina Y. pH-responsive nanosized metal organic framework-graphene oxide composite for a controlled drug release. Carbon Reports. 2024; 040104.
9. Xu VW, **Nizami MZI**, Yin IX, Niu JY, Yu OY, Chu CH. Research Interest in Copper Materials for Caries Management: A Bibliometric Analysis. *J. Funct. Biomater.* 2024; 15(9): 274.
10. Xu VW, Yin IX, Niu JY, Yu OY, **Nizami MZI***, Chu CH. Developing a Novel Antibacterial Copper Tetraamine Fluoride. *J Dent.* 2024; 105320.
11. Dhanapal R, Parasuraman S, **Nizami MZI**, Lin GS, Dutta K. Ginger's Bite: A Systematic Review on the Effectiveness of *Zingiber officinale* in Reducing Dental Caries. *Intell. Pharm.* 2024.
12. Abdalla MM, **Nizami MZI**, Rajasekar V, Basabrain M, Lung CYK, Yiu CKY. Enhancing the Physical, Antimicrobial, and Osteo/Odontogenic Properties of Sol–Gel-Derived Tricalcium Silicate by Graphene Oxide for Vital Pulp Therapies. *J. Funct. Biomater.* 2024; 15(7): 193.
13. Sultana N, Nishina Y, **Nizami MZI***. Surface Modifications of Medical-Grade Stainless Steel. *Coatings.* 2024; 14(3): 248.
14. Xu VW, **Nizami MZI**, Yin IX, Niu JY, Yu OY, Chu CH. Copper Materials for Caries Management: A Scoping Review. *J. Funct. Biomater.* 2024; 15(1): 10.
15. Arias Z, **Nizami MZI**, Chen X, Chai X, Xu B, Kuang C, Omori K, Takashiba S. Recent Advances in Apical Periodontitis Treatment: A Narrative Review. *Bioengineering.* 2023; 10(4): 488.
16. **Nizami MZI**, Xue VW, Wong AWY, Yu OY, Yeung C, Chu CH. Challenge-Based Learning in Dental Education. *Dentistry Journal.* 2023; 11(1): 14.
17. **Nizami MZI**, Xu VW, Yin IX, Lung CYK, Niu JY, Chu CH. Ceramic Nanomaterials in Caries Prevention: A Narrative Review. *Nanomaterials.* 2022; 12(24): 4416.
18. Xu VW, **Nizami MZI**, Yin IX, Lung CYK, Yu OY, Chu CH. Caries Management with Non-Metallic Nanomaterials: A Systematic Review. *Int J Nanomedicine.* 2022; 17: 5809–5824.
19. **Nizami MZI**, Yin IX, Lung CYK, Niu JY, Mei ML, Chu CH. In Vitro Studies of Graphene for Dental Caries and Periodontal Disease Management: A Concise Review. *Pharmaceutics.* 2022; 14(10): 1997.
20. **Nizami MZI**, Campéon BDL, Nishina Y. Electrodeposition of Hydroxyapatite and Graphene Oxide Improves Bioactivity of Medical-Grade Stainless Steel. *Materials Today Sustainability.* 2022; 19(100193): 100193.
21. **Nizami MZI**, Campéon BDL, Satoh A, Nishina Y. Graphene Oxide-Based Multi-Component Antimicrobial Hydrogels. *Bull Chem Soc Jpn.* 2022; 95(5): 713–720.
22. Xu VW, **Nizami MZI***, Yin IX, Yu OY, Lung CYK, Chu CH. Application of Copper Nanoparticles in Dentistry. *Nanomaterials (Basel).* 2022; 12(5): 805.
23. **Nizami MZI***, Melahat G, Nishina Y, Yamamoto T, Shinoda-Ito Y, Takashiba S, Zulema A. Graphene Oxide-Based Endodontic Sealer: An In Vitro Study. *Acta Med Okayama.* 2022; 76(6): 715–721.
24. Zulema A, Heber HL, Teran O, Yamamoto T, **Nizami MZI**, Takashiba S. Reattachment of a Fractured Tooth Fragment: A Multidisciplinary Treatment Approach. *Bull Tokyo Dent Coll.* 2023; 64(1): 13–22.
25. **Nizami MZI**, Yeung C, Yin IX, Wong AWY, Chu CH, Yu OY. Tunnel Restoration: A Minimally Invasive Dentistry Practice. *Clin Cosmet Investig Dent.* 2022; 14: 207–216.
26. **Nizami MZI**, Xu VW, Yin IX, Yu OY, Chu CH. Metal and Metal Oxide Nanoparticles in Caries Prevention: A Review. *Nánomaterials (Basel).* 2021; 11(12): 3446.
27. **Nizami MZI**, Takashiba S, Nishina Y. Graphene Oxide: A New Direction in Dentistry. *Appl Mater Today.* 2020; 19(100576): 100576.
28. **Nizami MZI**, Nishina Y, Yamamoto T, Shinoda-Ito Y, Takashiba S. Functionalized Graphene Oxide Shields Tooth Dentin from Decalcification. *J Dent Res.* 2020; 99(2): 182–188.
29. Mamun MA, Ahmad MS, **Nizami MZI**, et al. Knowledge and Practice About Oral Hygiene of School Children in Northern Bangladesh. *Rangpur Dent Coll J.* 2015; 3(1): 19–24.
30. Ahmed S, Solaiman F, Islam MR, **Nizami MZI**, et al. Attitudes on Oral Hygiene Among School Children in Dhaka. *City Dent Coll J.* 2013; 10(2): 41–46.

31. Islam MS, **Nizami MZI**, Begum A, et al. Rehabilitation of the Occlusal Vertical Dimension with an Overlay Removable Partial Denture: A Case Report. *City Dent Coll J*. 2012; 9(1): 28–31.
32. Islam MS, Srithavaj MLT, **Nizami MZI**. Prosthetic Rehabilitation After Partial Rhinectomy: A Clinical Report. *City Dent Coll J*. 2011; 8(2): 21–26.
33. **Nizami MZI**, Srithavaj MLT. Acrylic Definitive Partial Denture Obturator for a Compromised Patient: A Case Report. *City Dent Coll J*. 2010; 7(2): 31–35.
34. Shihab SF, **Nizami MZI**. Conservative Management of TMJ and Muscle Disorders. *City Dent Coll J*. 2010; 7(1): 11–14.
35. **Nizami MZI**, Srithavaj MLT, Bissas D, Tanzir K. Denture Support for Normal Maxillary Complete Denture Versus Completely Edentulous Maxillectomy. *City Dent Coll J*. 2009; 6(2): 26–35.
36. Shihab SF, **Nizami MZI**, et al. Speech Aid Prosthesis in Congenital Cleft Palate Defect: A Case Report. *City Dent Coll J*. 2009; 6(2): 49–51.
37. Biswas D, Hossain MR, Mian MAH, Tanzir K, **Nizami MZI**. Root Morphology of Maxillary First Premolars in a Bangladeshi Population. *City Dent Coll J*. 2009; 6(2): 7–12.
38. **Nizami MZI**. Rehabilitation of Ocular Defect with Ocular Prosthesis. *City Dent Coll J*. 2008; 5(1): 11–13.

Book Chapters

1. **Nizami MZI**, Nishina Y. Recent Advances in Stem Cells for Dental Tissue Engineering. In: *Engineering Materials for Stem Cell Regeneration*. Singapore: Springer; 2021. p. 281–324.
2. **Nizami MZI**. Materials in Maxillofacial Prosthetics. In: Kharade HT, *Prosthetic Rehabilitation of Head and Neck Cancer Patients*. Elsevier; 2024, p. 268 (e1–27).

Encyclopedias

1. **Nizami MZI**, Xu VW, Yin IX, Lung CYK, Niu JY, Chu CH. Ceramic Nanomaterials in Caries Prevention: *Dentistry, Oral Surgery & Medicine. Scholarly Community Encyclopedia*.
2. **Nizami MZI**, Xu VW, Yin IX, Lung CYK, Yu OY, Chu CH. Nanomaterials in Caries Management: Nanomaterials in Biomedical Science. Scholarly Community Encyclopedia.

SELECTED INTERNATIONAL PRESENTATIONS

Oral Presentation

- Annual Scientific Meeting 2022: Faculty of Dentistry, The University of Hong Kong
- 35th IADR-SEA Annual Scientific Meeting and 9th Annual Scientific Meeting: Faculty of Dentistry, The University of Hong Kong
- Zhejiang University International Workshop & Dentistry Talent Cultivation and Frontier Science: The School of Stomatology, Zhejiang University School of Medicine, China
- IADR 2020, Washington DC, USA: Presentation: Functionalized Graphene Oxide Nanocomposites Protect Decalcification of Hydroxyapatite and Dentin
- Okayama Dental Society Seminar, Okayama, Japan, 2019: Presentation: Functionalized Graphene Oxide Nanocomposites Prevent Tooth Dentin Decalcification
- 151st JSCD Meeting, Fukuoka, Japan, 2019: Presentation: Functionalized Graphene Oxide Nanoparticles Protect Tooth Dentin from Decalcification Besides Bactericidal Activity
- The 2nd OU-SKKU Bilateral Symposium on Photofunctional Materials and Catalysts, CAMPUS Asia, Okayama University, Japan, 2019: Presentation: Functionalized Graphene Oxide Nanoparticles Prevent Tooth Dentin Decalcification
- International Seminar on Current Concept of Modern Dentistry, Dhaka, Bangladesh, 2010: Presentation: Occluprosthesis: What It Is?

Poster Presentations

- 15th International Conference of the Asian Academy of Preventive Dentistry, Hong Kong, November 2023: Challenge-Based Learning in Dental Education
- International Dental Collaboration of the Mekong River Region (IDCMR), Vietnam, April 2005: Presentation: Problems in Restoring the Eye Prosthesis for Ocular Enucleated Patients and Their Esthetic Satisfaction

IN AND BEFORE THE OKLAHOMA STATE BOARD OF DENTISTRY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., THE OKLAHOMA BOARD OF DENTISTRY, Plaintiff	)
vs.	)Case No:24-14
	)Case No: 25-34
GEOFFREY SIMS, D.D.S., License #5179, Respondent	)Case No:21-109(B)

AGREED ORDER ACCEPTING VOLUNTARY SURRENDER OF DENTAL LICENSE

This cause comes before the Oklahoma State Board of Dentistry (the "Board") previously on October 2, 2026 at the meeting of the Oklahoma State Board of Dentistry, held at The Choctaw Resort, 4216 US-69, Durant, Oklahoma 74701 (Cedar Room), pursuant to notice given as required by law and rules of the Board.

Plaintiff, the State of Oklahoma, ex rel. the Oklahoma State Board of Dentistry by and through its Executive Director and attorney, Susan Rogers and the Respondent, **GEOFFREY SIMS, D.D.S., License #5179**, does not appear.

The Board en banc after hearing arguments of counsel, reviewing the exhibits admitted and the sworn testimony of witnesses, and being fully advised in the premises, found that there is clear and convincing evidence to support the following Findings of Fact, Conclusions of Law and Orders:

AGREEMENT AND ACKNOWLEDGMENT BY RESPONDENT

By voluntarily submitting to jurisdiction and entering into this Order, Respondent acknowledges and accepts the complaint and citation filed herein as recommended by the investigation and review panel and acknowledges that a hearing before the Board would result in an initiation of an individual action and some sanction under the Oklahoma State Dental Practices Act.

Respondent, **GEOFFREY SIMS, D.D.S.**, states that he is of sound mind and is not under the influence of, or impaired by, any medication or drug and that he fully recognizes his right to appear before the Board for a formal initiation of an action and an evidentiary hearing on the allegations made against him. Respondent hereby voluntarily waives his right to a full hearing, submits to the jurisdiction of the Board and agrees to abide by the terms and conditions of this Order. Respondent acknowledges that he has read and understands the terms and conditions stated herein.

Respondent and Attorneys for the Board stipulate to the following findings of fact; The Board heard statements of counsel, reviewed the exhibits presented, and being fully apprised in the premises, finds that there is clear and convincing evidence of the following Findings of Fact, Conclusions of Law and Orders:

STIPULATIONS AND AGREED FINDINGS OF FACT

1. **GEOFFREY SIMS, D.D.S.,** currently possesses Oklahoma Dentistry License #5179, originally issued June 20, 1994.

2. Respondent **GEOFFREY SIMS, D.D.S.,** is the subject of two pending complaints, Case No: 24-14 and 25-34.

3. Respondent **GEOFFREY SIMS, D.D.S.,** has three previous orders with the Board, 98-058, 03-45 and 21-109(B). Case 21-109(B) still has fines due to the Board.

4. The Board pursuant to the Oklahoma State Dental Practices Act 59 O.S. § 328.1 et. seq is a duly authorized State Agency empowered to license and oversee the activities of all persons practicing dentistry or hygiene pursuant to the act in the State of Oklahoma.

5. The Board has jurisdiction over the subject matter herein, and notice has been given in all respects as required by law and the rules of the Board.

6. Respondent acknowledges that this agreement is freely and voluntarily made, and the Respondent has not been subject to duress or coercion.

7. Respondent has been apprised of his right to seek counsel on this matter and is fully aware of the consequences of this agreement.

8. The Respondent submits himself to the jurisdiction of the Board and, waives all rights to a hearing appeal and any other claim in a court having jurisdiction over any part of this matter.

9. The Respondent, **GEOFFREY SIMS, D.D.S.,** requests to surrender Dental License #5179 at this time.

10. A copy of the statement of the three previous orders are attached as "Exhibit A" and are incorporated herein by reference;

11. The Respondent has taken full responsibility for his actions at this time and has asked to enter into this agreed order.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over the Respondent the subject matter herein pursuant to the Oklahoma State Dental Act 59 O.S. § 328.1 et. seq and the Board of Dentistry Rules and Regulations, Title 195 et. seq.

2. Based on the foregoing facts and admissions, the Board finds that Respondent requests to voluntarily surrender his license;

AGREED ORDER

IT IS THEREFORE ORDERED by the Oklahoma State Board of Dentistry as follows:

1. The Board accepts the voluntary surrender of the license of **GEOFFREY SIMS, D.D.S.**, Oklahoma License #5179.

2. The voluntary surrender of the license of **GEOFFREY SIMS, D.D.S.**, Oklahoma License #5179 is accepted by the Board with the conditions as listed in this Order.

3. The pending cases 24-14 and 25-34 shall be held in abeyance should the Respondent, **GEOFFREY SIMS, D.D.S.**, reapply for licensure.

4. The Voluntary Surrender of Dental License #5179 of **GEOFFREY SIMS, D.D.S.**, shall be effective immediately.

_____
Bobby Carmen, D.D.S., Board President,
OKLAHOMA STATE BOARD OF DENTISTRY

AGREED AND APPROVED:

_____
GEOFFREY SIMS, D.D.S.,
Respondent

_____
Susan Rogers, OBA# 15497
Executive Director and General Counsel
Oklahoma State Board of Dentistry
Attorney for the Oklahoma State Board of Dentistry

BEFORE THE BOARD OF DENTISTRY

STATE OF OKLAHOMA

IN RE: INVESTIGATION OF GEOFFREY MICHAEL SIMS, D.D.S.	)	CASE NO. 98-058
Respondent.	)	

AGREED ORDER OF PROBATION

This matter comes on for consideration before the Board of Dentistry, State of Oklahoma ("Board") on this 13th day of November, 1998.

I. AGREED FINDINGS OF FACT

The Board hereby finds and, as evidenced by his signature appearing below, Respondent GEOFFREY MICHAEL SIMS, D.D.S. ("Dentist") admits and agrees that the following facts are true and correct:

1. Dentist holds Oklahoma Dental License No. 5179, issued June 20, 1994, which authorizes Dentist to practice dentistry in the state of Oklahoma. Said license is currently in force and effect.

2. Dentist operates dental office at 2042 West Houston, Broken Arrow, Oklahoma.

3. Dentist admits by reason of persistent inebriety or addiction to drugs, he was incompetent to continue the practice of dentistry as provided for in Title 59 O.S. Section 328.32 (3).

4. Dentist admits he voluntarily obtained inpatient treatment for chemical dependency from Talbot Marsh Treatment

Center, Atlanta, Georgia, in 1998..

II. CONCLUSION OF LAW

The Board hereby finds and, as evidence by his signature appearing below, Dentist admits and agrees, that the following conclusions of law are true and correct:

1. The Board has jurisdiction of this matter by virtue of the provisions of the State Dental Act, 59 O.S. 1996, § 328.1 et seq., as amended.

2. By virtue of the provisions of 59 O.S. Supp. 1996, § 328.15, the Board has the power and authority to promulgate rules to carry out the provisions of the State Dental Act as the Board deems necessary and proper to protect the dental health of the public.

3. By virtue of the provisions of 59 O.S. Supp. 1996, § 328.15 (7), the Board is charged with enforcement of the provisions of the State Dental Act.

III. GROUNDS FOR ACTION

The Board has the power to revoke the license of a dentist, suspend a dentist from practice, reprimand a dentist, or order a period of probation for a dentist, upon the ground that a dentist has violated the Dental Act. 59 O.S. 1996, § 328.32. Violations: Section 328.32 (3).

IV. AGREED ORDER OF PROBATION AND SUSPENSION

As evidenced by his signature on this order, Respondent dentist agrees to a four (4) consecutive year probation to commence immediately following adoption by the Board of

Dentistry. The following are terms and conditions:

1. During the period of probation, Respondent dentist will abstain from consuming any substance, licit or illicit, specifically including controlled dangerous substances unless authorized by a recognized treating physician. Any legitimate medication prescribed or dispensed by a treating physician will be reported to the Board in writing within ten (10) days.

2. Respondent will report the name of a treating physician, psychiatrist, or counselor to the Board. The Recognized treating physician, psychiatrist, or counselor will provide written progress reports to the Board every ninety days until the Board orders reports to cease.

3. Respondent will actively participate in the caduceus group of "Physician's Recovery, Inc." once per week. Written confirmation of attendance will be provided to the Board. Authorization for release of medical records will be provided to "Physician's Recovery, Inc." to allow reports of all drug screenings to be transmitted direct to the Board office. Further, Respondent will immediately authorize the group to contact this Board in writing should attendance or participation decline or cease. Written confirmation of attendance shall be received on or before the 10th of each month.

4. Respondent will immediately surrender his ability to prescribe, dispense, and administer Class II thru V registrations issued by the Drug Enforcement Administration and the Oklahoma Bureau of Narcotics and Dangerous Drugs Control. After two years, Respondent may re-apply for Class IV and V

registrations when specifically authorized by the Board. After probation, Respondent shall not re-apply to prescribe, dispense or administer Class II and III unless specifically authorized by the Board.

5. During the period of probation, Respondent dentist will randomly submit biological fluid specimens, specifically saliva, urine, and blood for analysis upon request by the Board or the Board's agent. Respondent dentist agrees to pay the cost of collection, testing and analysis of the specimens. Respondent dentist will sign a release authorizing a laboratory to submit findings of testing direct to Board member or Board agent.

6. During the period of probation, Respondent dentist agrees to random inspections of his office and review of any and all records in his possession relating to the practice of dentistry. The Board members or their agents will ensure the doctor/patient confidentiality is maintained regarding all records inspected.

7. During the period of probation, Respondent dentist will keep the Board informed in writing of his business and residential addresses. Respondent will report any change in practice if it should occur.

8. Respondent dentist will comply with all provisions of the Oklahoma State Dental Act and Rules and Regulations during probation.

9. If it comes to the Board's attention that Respondent dentist may have violated any material condition of his

probation, the Board shall give Respondent dentist at least twenty (20) days notice, by certified mail, to the most recent business and residential addresses that Respondent dentist has provided to the Board to appear and show cause why he should not be found in violation of the conditions of his probation. Said notice shall specify which material condition of probation Respondent dentist may have violated. If Respondent dentist fails to appear or fails to show good cause why he should not be found in violation of the conditions of his probation, the Board may take any action regarding Respondent's dental license that is set forth in 59 O.S. Section 328.32 (34), including revocation, suspension, further probation or reprimand.

10. During the period of probation, Respondent dentist will appear before the Board when requested to do so, provided the Board submits a written notice in advance of the designated time and place.

It is therefore ordered that **GEOFFREY MICHAEL SIMS** is placed on probation for four (4) consecutive years.

BOARD OF DENTISTRY

Geoffrey Michael Sims

GEOFFREY MICHAEL SIMS, D.D.S.

Ronald L. Winder, DDS

RONALD L. WINDER, D.D.S.
PRESIDENT, BOARD OF DENTISTRY

IV. ACKNOWLEDGEMENT AND WAIVER OF RIGHT OF HEARING

I, GEOFFREY MICHAEL SIMS, D.D.S., hereby acknowledges that I have read in its entirety the foregoing AGREED ORDER OF PROBATION (herein referred to as the "Order"), that I understand its content; and that I executed the Order freely, voluntarily, and with no mental reservation whatsoever.

While acknowledging my rights to a hearing as provided in the State Dental Act, specifically 59 O.S. 1996, §§ 328.15(7), 328.43a, 328.44a and provisions in the Administrative Procedures Act, the Rules of the Board, or any other applicable law, I HEREBY WAIVE MY RIGHT TO A HEARING in this matter.

FURTHERMORE:

1. I swear and attest that the facts and conclusions of law as set forth in this Order are true and correct.

2. I acknowledge that I have had ample opportunity to consult with my attorney about this matter prior to executing this Order.

3. I understand that this Order is a record of a public body and is therefore subject to inspection and copying by members of the public.

4. I understand that the Board will consider and adopt this Order at a meeting open to the public.

5. I understand that I may request permission to appear before the Board at the time the Board considers this Order.

6. I acknowledge and attest that no member of the Board, nor any employee, nor attorney of the Board, has coerced, intimidated, or pressured me, in any way whatsoever, to execute

this Order.

7. I understand that this Order will be reported to the National Practitioner Data Bank and the Clearinghouse of the American Association of Dental Examiners.

8. I understand that this Order is not in force and effect and is not binding on the Board unless and until adopted by the Board and executed by the Board's president.

Dated this 27 day of Oct, 1998.

GEOFFREY MICHAEL SIMS, D.D.S.

BEFORE THE BOARD OF DENTISTRY
STATE OF OKLAHOMA

IN RE: INVESTIGATION OF GEOFFREY MICHAEL SIMS, D.D.S	)	CASE NO. 98-058
Respondent.	)	

ORDER

This matter comes before the Oklahoma Board of Dentistry ("Board") upon the application of Geoffrey Michael Sims, D.D.S. ("Dr. Sims") for modification of the Agreed Order of Probation ("Agreed Order") entered by this Board, in the above styled case, on November 13, 1998. For good cause shown, this application of Dr. Sims is **GRANTED**. The period of **PROBATION** entered in the Agreed Order is **RESCINDED**. Furthermore, the other terms and conditions of the Agreed Order also are **RESCINDED**. The Agreed Order, however, remains a matter of public record and is subject to disclosure under the Oklahoma Open Records Act.

IT IS SO ORDERED, ADJUDGED AND DECREED.

Dated this 13th day of August, 1999.

BOARD OF DENTISTRY

Ronald L. Winder DDS

RONALD L. WINDER, D.D.S
PRESIDENT, BOARD OF DENTISTRY

BEFORE THE OKLAHOMA BOARD OF DENTISTRY
STATE OF OKLAHOMA

IN THE MATTER OF THE COMPLAINT AGAINST GEOFFREY MICHAEL SIMS, D.D.S.	)))	CASE NO. 03-045

AGREED ORDER OF SUSPENSION AND PROBATION

This matter comes on for consideration before the Board of Dentistry, State of Oklahoma ("Board"), on August 1, 2003.

I
FINDINGS OF FACT

Respondent Geoffrey Michael Sims, D.D.S. ("Respondent"), hereby agrees with the Board of Dentistry, State of Oklahoma, as follows:

1. Respondent holds Oklahoma Dental License No. 5179 issued June 20, 1994.

2. Respondent presently practices as a general dentist, at 2042 West Houston, Broken Arrow, Oklahoma.

3. Respondent agrees that if evidence was presented, there is clear and convincing evidence the Respondent is incompetent to continue the practice of dentistry by reason of persistent inebriety or addiction to drugs.

4. Respondent agrees that if evidence was presented, there is clear and convincing evidence the Respondent wrote false, unnecessary, or excessive prescriptions for drugs which are controlled dangerous substances under either federal or state law to patients A, B and C.

5. Respondent agrees that he has previously been disciplined by the Board for the same or similar violations of law on November 13, 1998. That Order was rescinded following a motion to rescind probation on August 13, 1999.

II
CONCLUSIONS OF LAW

The Board hereby finds and as evidenced by his signature appearing below, Respondent agrees and admits the following conclusions of law are true and correct:

1. The Board has jurisdiction of this matter by virtue of the provisions of the State Dental Act, 59 O.S. Supp 2000, Sec. 328.1 et seq.

2. By virtue of the provisions of 59 O.S. Supp 2000, Sec. 328.15, the Board has the power and authority to promulgate rules to carry out the provisions of the State Dental Act as the Board deems necessary and proper to protect the dental health of the public.

3. By virtue of the provisions of 59 O.S. Supp 2000, Sec. 328.15(3), the Board is charged with enforcement of the provisions of the State Dental Act.

4. That the facts above and Board Findings constitute violations of 59 O.S. Supp 2000, Sec. 328.32(3) and (27).

III
AGREED ORDER OF SUSPENSION AND PROBATION

Respondent will agree to voluntarily surrender his license to practice dentistry for a period of six (6) months followed by a probation of four (4) years. The suspension shall commence on the date of the Respondent's admission to an approved inpatient treatment facility. Respondent must provide written confirmation of successful completion of an approved inpatient treatment program prior to reissue of his license to practice dentistry. Probation will commence immediately upon completion of suspension. Respondent will further agree to the following terms and conditions, to wit:

1. Respondent will provide an authorization to release any and all records from the MAR Treatment Center. Further, the authorization shall include regular communication with staff and MAR Treatment Center. The MAR Treatment Center shall be selected prior to execution of this AGREED ORDER.

2. During the period of suspension and probation, Respondent will be prohibited from the administration and dispensing of controlled dangerous drugs in his dental office. Respondent will immediately surrender Class II through Class V registrations to prescribe, dispense and administer to both the Oklahoma Bureau of Narcotics and the Drug Enforcement Administration.

3. During the period of probation, Respondent will randomly submit biological fluid specimens, specifically saliva, urine, hair, and blood for analysis upon request by the Board of the Board's agent. Respondent agrees to pay the costs of collection, testing and analysis of the specimens. Respondent will sign a release authorizing a medical laboratory to submit findings of all drug screens or testing direct to the Board office. Failure to pay for a screening or decline a screening shall be a direct violation of the agreed probation.

4. During the period of probation, Respondent will abstain from consuming any substances, licit or illicit, specifically including controlled dangerous substances unless authorized by a recognized treating physician. Any legitimate medication prescribed or dispensed by a treating physician will be reported to the Board in writing within ten (10) days. Respondent will immediately provide and executed release of medical records to the Oklahoma Board of Dentistry. Respondent agrees all his medical records shall be reviewed by the Board or its agents at any time during the probation period.

5. During the probation period, Respondent will actively participate in the caduceus group of the **Oklahoma Health Professionals Recovery Program (OHPRP)** once per week. Written confirmation of attendance will be provided to the Board every thirty (30) days. Authorization for

release of all medical records or reporting will be provided to OHPRP. Aftercare contracts and/or all records will be provided including results of drug screenings. Further, Respondent will immediately authorize OHPRP to contact this Board in writing should attendance or participation decline or cease. Failure to comply with, or any other terms of this Agreed Order, will result in additional action by the Board.

6. During the probation period, Respondent will permit the Board of Dentistry, or its agents or assigns, to conduct unannounced inspections of Respondent's dental practice, to insure compliance with the State Dental Act, the Rules and Regulations promulgated thereunder, and the terms of this probation.

7. During the period of probation, Respondent will appear before the Board when requested to do so after twenty (20) days notice. All written notices shall include date, time, and location.

8. During the period of probation and thereafter, for as long as his dental license and registration remain effective, Respondent will adhere strictly to all provisions of the State Dental Act of Oklahoma and all Rules and Regulations promulgated by the Board.

IT IS FURTHER ORDERED AND AGREED that GEOFFREY MICHAEL SIMS, D.D.S., be suspended for six (6) months, to be followed by a four-year probation with terms and conditions as outlined above. This is a permanent Order and shall not be rescinded. Any future violations will result in additional action by the Board.

GEOFFREY MICHAEL SIMS, D.D.S.

James A. Sparks, D.D.S., PRESIDENT
BOARD OF DENTISTRY,
STATE OF OKLAHOMA

ACKNOWLEDGEMENT AND WAIVER OF RIGHTS TO HEARING

GEOFFREY MICHAEL SIMS, D.D.S., hereby acknowledges that I have read in its entirety the foregoing AGREED ORDER OF SUSPENSION AND PROBATION (herein referred to as the "Order"), that I understand its content; and that I executed the Order freely, voluntarily and with no mental reservation whatsoever. While acknowledging my rights to a hearing as provided in the State Dental Act, specifically 59 O.S. Supp 2000, Administrative Procedures Act, the Rules and Regulations of the Board, or any other applicable law,

1. I HEREBY WAIVE MY RIGHT TO A HEARING in this matter. Futhermore:

2. I agree and admit to the facts and conclusions of law as set forth in this Order.

3. I acknowledge that I have had ample opportunity to consult with my attorney about this matter prior to executing this Order.

4. I understand that this Order is a record of a public body and is therefore subject to inspection and copying by members of the public.

5. I understand that the Board will consider and adopt this Order at a meeting open to the public.

6. I understand that the Board will report this order to the National Practitioner Data Bank in compliance with Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, otherwise known as the National Practitioner Data Bank.

7. I understand that I may request permission to appear before the Board at the time the Board considers this Order.

8. I acknowledge and attest that no member of the Board, nor any employee, nor attorney of the Board, has coerced, intimidated, or pressured me, in any way whatsoever, to execute this Order.

9. I understand this Order is not in force and effect and is not binding on the Board unless and until adopted by the Board and executed by the Board's President.

10. I understand that this Order shall not be amended or changed unless specifically authorized by the Board of Dentistry in an open meeting.

DATED this 19 day of MAY, 2003.

GEOFFREY MICHAEL SIMS, D.D.S.

P82

VOLUNTARY SURRENDER OF CONTROLLED DANGEROUS SUBSTANCES PRIVILEGES

After being fully advised of my rights, and/or pursuant to my understanding of the Oklahoma Bureau of Narcotics and Dangerous Drugs Control Rules and Regulations with regard to registrants, I am aware that I am not required to surrender my controlled substances privileges. I freely execute this document and choose to take the actions described herein.

X In view of my alleged failure to comply with the State and/or Federal requirements pertaining to controlled substances, and as an indication of my good faith in desiring to remedy any incorrect or unlawful practices on my part;

____ In view of my desire to terminate handling of controlled substances listed in Schedules _____;

I hereby voluntarily surrender my Oklahoma Bureau of Narcotics and Dangerous Drugs Control Certificate of Registration, and all my controlled substances listed in Schedules 2 2N 3 3N 4 5 as evidence of my agreement to relinquish my privilege to handle controlled substances in Schedules All 2 2N 3 3N 4 5. Further, I agree and consent that this document shall be authority for the Director of the Oklahoma Bureau of Narcotics and Dangerous Drugs Control to terminate and revoke my registration without an order to show cause, a hearing, or any other proceedings and, if not all controlled substances privileges are surrendered, be issued a new registration certificate limited to Schedules None.

I waive refund of any payments made by me in connection with my registration.

I understand that I will not be permitted to order, manufacture, distribute, possess, dispense, administer, prescribe or engage in any other controlled substance activities whatsoever, until such time as I am again properly registered.

Name of Registrant (Print)	Address of Registrant	
Geoffrey Michael Sims	2042 W. Houston Broken Arrow OK 74012	
Signature of Registrant or Authorized Individual	Date	OBN Registration Number
Geoffrey Sims		17544

WITNESSES:

Name and Date	Title
5/19/03	Investigator State Board of Dentistry
Name and Date	Title

INFORMATION	SUBSTANCES PRIVILEGES	FILE NO.

After being fully advised of my rights, and understanding that I am not required to surrender my controlled substances privileges, I freely execute this document and choose to take the actions described herein.

[X] In view of my alleged failure to comply with the Federal requirements pertaining to controlled substances, and as an indication of my good faith in desiring to remedy any incorrect or unlawful practices on my part;

[ ] In view of my desire to terminate handling of controlled substances listed in schedule(s) _____;

I hereby voluntarily surrender my Drug Enforcement Administration Certificate of Registration, unused order forms, and all my controlled substances listed in schedule(s) 2,2N,3,3N,4,5 as evidence of my agreement to relinquish my privilege to handle controlled substances listed in schedule(s) 2,2N,3,3N,4,5. Further, I agree and consent that this document shall be authority for the Administrator of the Drug Enforcement Administration to terminate and revoke my registration without an order to show cause, a hearing, or any other proceedings, (and if not all controlled substances privileges are surrendered, be issued a new registration certificate limited to schedule(s) NONE).

I waive refund of any payments made by me in connection with my registration.

I understand that I will not be permitted to order, manufacture, distribute, possess, dispense, administer, prescribe, or engage in any other controlled substance activities whatever, until such time as I am again properly registered.

____ I do not have any DEA-222 Order Forms.
____ I have surrendered my DEA-222 Order Forms.
__X__ I do not have any controlled substances.
____ I have surrendered my controlled substances to: _____

NAME OF REGISTRANT (Print)	ADDRESS OF REGISTRANT	
Geoffrey Michael Sims	2042 W. Houston Broken Arrow OK 74012	
SIGNATURE OF REGISTRANT OR AUTHORIZED INDIVIDUAL	DATE	DEA REGISTRATION NO.
Geoffrey Sims	5-19-03	BS7427936

WITNESSES:

NAME AND DATE	TITLE
James L Lilly 5/19/03	Investigator State Bureau of Narcotics
NAME AND DATE	TITLE

DEA Form 104 (Sept. 1976) — Previous edition dated 1/74 is OBSOLETE.

IN AND BEFORE THE OKLAHOMA STATE BOARD OF DENTISTRY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., THE OKLAHOMA BOARD OF DENTISTRY, Plaintiff	)	
vs.	)	Case No: 21-109(B)
GEOFFREY SIMS, D.D.S., License #5179, Respondent	)	

CORRECTED
AGREED ORDER ACCEPTING VOLUNTARY
SUBMITTAL TO JURISDICTION

This cause comes before the Oklahoma State Board of Dentistry (the "Board") previously on November 3, 2023 at the meeting of the Oklahoma State Board of Dentistry, held at 2920 N. Lincoln Blvd., Oklahoma City, Oklahoma 73105, pursuant to notice given as required by law and rules of the Board. A mistake in the dates was discovered and the corrected agreed order came before the Board on August 23, 2024.

Plaintiff, the State of Oklahoma, ex rel. the Oklahoma State Board of Dentistry by and through its Executive Director and attorney, Susan Rogers and the Respondent, GEOFFREY SIMS, D.D.S., License #5179, who appears through his attorney, Brandon Witworth, does not appear.

The Board en banc after hearing arguments of counsel, reviewing the exhibits admitted and the sworn testimony of witnesses, and being fully advised in the premises, found that there is clear and convincing evidence to support the following Findings of Fact, Conclusions of Law and Orders:

AGREEMENT AND ACKNOWLEDGMENT BY RESPONDENT

By voluntarily submitting to jurisdiction and entering into this Order, Respondent acknowledges and accepts the complaint and citation filed herein as recommended by the investigation and review panel and acknowledges that a hearing before the Board would result in an initiation of an individual action and some sanction under the Oklahoma State Dental Practices Act.

Respondent, GEOFFREY SIMS, D.D.S., states that he is of sound mind and is not under the influence of, or impaired by, any medication or drug and that he fully recognizes his right to appear before the Board for a formal initiation of an action and an evidentiary hearing on the allegations made against him. Respondent hereby voluntarily waives his right to a full hearing, submits to the

jurisdiction of the Board and agrees to abide by the terms and conditions of this Order. Respondent acknowledges that he has read and understands the terms and conditions stated herein.

Respondent and Attorneys for the Board stipulate to the following findings of fact; The Board heard statements of counsel, reviewed the exhibits presented, and being fully apprised in the premises, finds that there is clear and convincing evidence of the following Findings of Fact, Conclusions of Law and Orders:

STIPULATIONS AND AGREED FINDINGS OF FACT

1. GEOFFREY SIMS, D.D.S., License currently possesses Oklahoma Dentistry License #5179, originally issued September 04, 1994.

2. Respondent GEOFFREY SIMS, D.D.S., is the subject of a complaint, Case No: 21-109(B).

3. The Board pursuant to the Oklahoma State Dental Practices Act 59 O.S. § 328.1 et. seq is a duly authorized State Agency empowered to license and oversee the activities of all persons practicing dentistry or hygiene pursuant to the act in the State of Oklahoma.

4. The Board has jurisdiction over the subject matter herein, and notice has been given in all respects as required by law and the rules of the Board.

5. GEOFFREY SIMS, D.D.S., has had two prior complaints, Case # 98-058 and 2003-045, both relating to substance abuse, before this Board on complaints prior to this.

6. Respondent acknowledges that this agreement is freely and voluntarily made, and the Respondent has not been subject to duress or coercion.

7. Respondent has been apprised of his right to seek counsel on this matter and is fully aware of the consequences of this agreement.

8. The Respondent submits himself to the jurisdiction of the Board and, waives all rights to a hearing appeal and any other claim in a court having jurisdiction over any part of this matter.

9. A complaint was received on or about December 10, 2021 regarding unlicensed persons providing patient care at DDS.Dentures and Implant Solutions in Ponca City, Oklahoma. The name of one individual was given by the complainant, Henry "Hank" Miller, alleging that he was doing coronal polishing, x-rays/radiographs and assisting in the administration of nitrous oxide without valid training or expanded duty permits as required by Oklahoma statute.

10. Dr. Howl assigned Dr. Carmen and Dr. Jones as the review panel and Investigator Steve Lowe was assigned to the case.

11. A copy of the statement of complaint is attached as "Exhibit A" and is incorporated herein by reference;

12. The Respondent has taken full responsibility for his actions at this time and has asked to enter into this agreed order.

13. Respondent acknowledges and admits violations of the following rules and laws:

    CT. 1 - AUTHORIZING OR AIDING AN UNLICENSED PERSON TO PRACTICE DENTISTRY, TO PRACTICE DENTAL HYGIENE OR TO PERFORM A FUNCTION FOR WHICH A PERMIT FROM THE BOARD IS REQUIRED; 59 O.S. § 328.32 (5); Specially for allowing Henry "Hank" Miller to provide patient treatment to patients on patient MM on February 23, 2022 with no valid permit or license issues by the Oklahoma Board of Dentistry as required by state law.

    CTS. 2 -12 – FAILURE TO CHECK THE PRESCRIPTION MONITORING PROGRAM (PMP) BEFORE PRESCRIBING; 63 O.S. §2-309D (G)(2). Specifically for patients TR, DL, VP, CS, KR, JS, KM, JD, JS and TD;

CONCLUSIONS OF LAW

1. The Board has jurisdiction over the Respondent the subject matter herein pursuant to the Oklahoma State Dental Act 59 O.S. § 328.1 et. seq and the Board of Dentistry Rules and Regulations, Title 195 et. seq.

2. Based on the foregoing facts and admissions, the Board finds that Respondent committed violations of

    CT. 1 - AUTHORIZING OR AIDING AN UNLICENSED PERSON TO PRACTICE DENTISTRY, TO PRACTICE DENTAL HYGIENE OR TO PERFORM A FUNCTION FOR WHICH A PERMIT FROM THE BOARD IS REQUIRED; 59 O.S. § 328.32 (5); Specially for allowing Henry "Hank" Miller to provide patient treatment to patients on patient MM on February 23, 2022 with no valid permit or license issues by the Oklahoma Board of Dentistry as required by state law.

    CTS. 2 -12 – FAILURE TO CHECK THE PRESCRIPTION MONITORING PROGRAM (PMP) BEFORE PRESCRIBING; 63 O.S. §2-309D (G)(2). Specifically for patients TR, DL, VP, CS, KR, JS, KM, JD, JS and TD;

The Board en banc, hereby adopts the agreement of the parties in this Voluntary Submittal to Jurisdiction.

AGREED ORDER

IT IS THEREFORE ORDERED by the Oklahoma State Board of Dentistry as follows:

1. There is NO ACTION against the license of Respondent, Geoffrey Sims, D.D.S. Oklahoma Dentistry License #5179 at this time.

2. Respondent is assessed a $1,500.00 fine for count 1 and $500 per count for violations 2-12 for a total of $6,500.00. The total fine is $8,000.00. The Board is suspending ½ of this fine pending no violations within two years from the date of this order. The Respondent is ordered to pay and administrative fine of $4,000.00 within 2 years of the date of this order. The first half of $2,000.00 will be due no later than August 21, 2025 and the second half due no later than August 21, 2026.

3. Respondent will conduct his practice in compliance with all other State Laws and Regulations under the Oklahoma Dental Practices Act;

4. Respondent will not violate any State or Federal law;

5. Respondent will keep the Oklahoma State Board of Dentistry informed of his current address.

6. This order may be reportable to the National Practitioner Data Bank.

7. Failure to meet any terms of the Board Order will constitute cause for the Board to initiate additional proceedings to suspend, revoke or modify Respondent's license after due notice and hearing.

Erin Roberts, D.D.S., Board Vice President,
OKLAHOMA STATE BOARD OF DENTISTRY

Panel Members
Dr. Bobby Carmen
Dr. Krista Jones

AGREED AND APPROVED:

Geoffrey Sims, D.D.S.
Respondant

Brandon Witworth, OBA#18874
Rodolf and Todd,
Attorney for the Respondent

Susan Rogers, OBA# 15497
Executive Director
Oklahoma State Board of Dentistry
Attorney for the Oklahoma State Board of Dentistry

Stephen McCaleb
OBA # 15649
Judicial Counsel, State Board of Dentistry

IN AND BEFORE THE OKLAHOMA STATE BOARD OF DENTISTRY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., THE OKLAHOMA BOARD OF DENTISTRY, Plaintiff	)	
vs.	)	Case No: 21-109(B)
GEOFFREY SIMS, D.D.S., License #5179, Respondent	)	

AGREED ORDER ACCEPTING VOLUNTARY SUBMITTAL TO JURISDICTION

This cause comes before the Oklahoma State Board of Dentistry (the "Board") on January 19, 2023 at the meeting of the Oklahoma State Board of Dentistry, held at 2920 N. Lincoln Blvd., Oklahoma City, Oklahoma 73105, pursuant to notice given as required by law and rules of the Board.

Plaintiff, the State of Oklahoma, ex rel. the Oklahoma State Board of Dentistry by and through its Executive Director and attorney, Susan Rogers and the Respondent, **GEOFFREY SIMS, D.D.S., License #5179**, who does not appear.

The Board en banc after hearing arguments of counsel, reviewing the exhibits admitted and the sworn testimony of witnesses, and being fully advised in the premises, found that there is clear and convincing evidence to support the following Findings of Fact, Conclusions of Law and Orders:

AGREEMENT AND ACKNOWLEDGMENT BY RESPONDENT

By voluntarily submitting to jurisdiction and entering into this Order, Respondent accepts and pleads guilty to the complaint and citation filed herein as recommended by the investigation and review panel and acknowledges that a hearing before the Board would result in an initiation of an individual action and some sanction under the Oklahoma State Dental Practices Act.

Respondent, GEOFFREY SIMS, D.D.S., states that he is of sound mind and is not under the influence of, or impaired by, any medication or drug and that he fully recognizes his right to appear before the Board for a formal initiation of an action and an evidentiary hearing on the allegations made against him. Respondent hereby voluntarily waives his right to a full hearing, submits to the jurisdiction of the Board and agrees to abide by the terms and conditions of this Order. Respondent acknowledges that he has read and understands the terms and conditions stated herein.

Respondent and Attorneys for the Board stipulate to the following findings of fact; The Board heard statements of counsel, reviewed the exhibits presented, and being fully apprised in the premises, finds that there is clear and convincing evidence of the following Findings of Fact, Conclusions of Law and Orders:

STIPULATIONS AND AGREED FINDINGS OF FACT

1. **GEOFFREY SIMS, D.D.S., License** currently possesses Oklahoma Dentistry License #5179, originally issued September 04, 1994.

2. Respondent GEOFFREY SIMS, D.D.S., is the subject of a complaint, Case No: 21-109(B).

3. The Board pursuant to the Oklahoma State Dental Practices Act 59 O.S. § 328.1 et. seq is a duly authorized State Agency empowered to license and oversee the activities of all persons practicing dentistry or hygiene pursuant to the act in the State of Oklahoma.

4. The Board has jurisdiction over the subject matter herein, and notice has been given in all respects as required by law and the rules of the Board.

5. GEOFFREY SIMS, D.D.S., has had two prior complaints, Case # 98-058 and 2003-045, both relating to substance abuse, before this Board on complaints prior to this.

6. Respondent acknowledges that this agreement is freely and voluntarily made, and the Respondent has not been subject to duress or coercion.

7. Respondent has been apprised of his right to seek counsel on this matter and is fully aware of the consequences of this agreement.

8. The Respondent submits himself to the jurisdiction of the Board and, waives all rights to a hearing appeal and any other claim in a court having jurisdiction over any part of this matter.

9. A complaint was received on or about December 10, 2021 regarding unlicensed persons providing patient care at DDS Dentures and Implant Solutions in Ponca City, Oklahoma. The name of one individual was given by the complainant, Henry "Hank" Miller, alleging that he was doing coronal polishing, x-rays/radiographs and assisting in the administration of nitrous oxide without valid training or expanded duty permits as required by Oklahoma statute.

10. Dr. Howl assigned Dr. Carmen and Dr. Jones as the review panel and Investigator Steve Lowe was assigned to the case.

11. A copy of the statement of complaint is attached as "Exhibit A" and is incorporated herein by reference;

12. The Respondent has taken full responsibility for his actions at this time and has asked to enter into this agreed order.

13. Respondent acknowledges and admits violations of the following rules and laws:

CT. 1 - AUTHORIZING OR AIDING AN UNLICENSED PERSON TO PRACTICE DENTISTRY, TO PRACTICE DENTAL HYGIENE OR TO PERFORM A FUNCTION FOR WHICH A PERMIT FROM THE BOARD IS REQUIRED; 59 O.S. § 328.32 (5); Specially for allowing Henry "Hank" Miller to provide patient treatment to patients on patient MM on February 23, 2022 with no valid permit or license issues by the Oklahoma Board of Dentistry as required by state law.

CTS. 2 -12 – FAILURE TO CHECK THE PRESCRIPTION MONITORING PROGRAM (PMP) BEFORE PRESCRIBING; 63 O.S. §2-309D (G)(2). Specifically for patients TR, DL, VP, CS, KR, JS, KM, JD, JS and TD;

CONCLUSIONS OF LAW

1. The Board has jurisdiction over the Respondent the subject matter herein pursuant to the Oklahoma State Dental Act 59 O.S. § 328.1 et. seq and the Board of Dentistry Rules and Regulations, Title 195 et. seq.

2. Based on the foregoing facts and admissions, the Board finds that Respondent committed violations of

CT. 1 - AUTHORIZING OR AIDING AN UNLICENSED PERSON TO PRACTICE DENTISTRY, TO PRACTICE DENTAL HYGIENE OR TO PERFORM A FUNCTION FOR WHICH A PERMIT FROM THE BOARD IS REQUIRED; 59 O.S. § 328.32 (5); Specially for allowing Henry "Hank" Miller to provide patient treatment to patients on patient MM on February 23, 2022 with no valid permit or license issues by the Oklahoma Board of Dentistry as required by state law.

CTS. 2 -12 – FAILURE TO CHECK THE PRESCRIPTION MONITORING PROGRAM (PMP) BEFORE PRESCRIBING; 63 O.S. §2-309D (G)(2). Specifically for patients TR, DL, VP, CS, KR, JS, KM, JD, JS and TD;

The Board en banc, hereby adopts the agreement of the parties in this Voluntary Submittal to Jurisdiction.

AGREED ORDER

IT IS THEREFORE ORDERED by the Oklahoma State Board of Dentistry as follows:

1. There is NO ACTION against the license of Respondent, Geoffrey Sims, D.D.S. Oklahoma Dentistry License #5179 at this time.

2. Respondent is assessed a $1,500.00 fine for count 1 and $500 per count for violations 2-12 for a total of $6,500.00. The Board is suspending half of the $6,500 fine pending no violations within two years from the date of this order. The Respondent is ordered to pay and administrative fine of $3,250 within 2 years of the date of this order. The first half of the fine in the amount of $1,650.00 will be due no later than January 19, 2024 and the second half in the amount of $1,650.00 due no later than January 19, 2025.

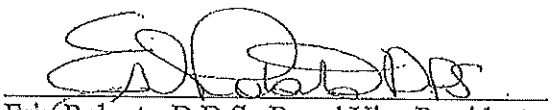
3. Respondent will conduct his practice in compliance with all other State Laws and Regulations under the Oklahoma Dental Practices Act;

4. Respondent will not violate any State or Federal law;

5. Respondent will keep the Oklahoma State Board of Dentistry informed of his current address.

6. This order may be reportable to the National Practitioner Data Bank.

7. Failure to meet any terms of the Board Order will constitute cause for the Board to initiate additional proceedings to suspend, revoke or modify Respondent's license after due notice and hearing.



Erin Roberts, D.D.S., Board Vice President,
OKLAHOMA STATE BOARD OF DENTISTRY

Panel Members
Dr. Bobby Carmen
Dr. Krista Jones

AGREED AND APPROVED:

Erin Roberts, D.D.S., Board Vice President,
OKLAHOMA STATE BOARD OF DENTISTRY

Panel Members
Dr. Bobby Carmen
Dr. Krista Jones

AGREED AND APPROVED:

Geoffrey Sims, D.D.S.
Respondent

Brandon Witworth, OBA #18874
Rodolf and Todd
Attorney for the Respondent

Susan Rogers, OBA #15497
Executive Director
Oklahoma State Board of Dentistry
Attorney for the Oklahoma State Board of Dentistry

Stephen McCaleb
OBA #15649
Judicial Counsel, State Board of Dentistry

Date_____

Panel Members
Dr. Bobby Carmen
Dr. Krista Jones

Investigators
Steve Lowe, BOD Investigator
Jeff Puckett, Deputy Director
Denise Warren, OBN Agent

[redacted]

[redacted]

TRANSCRIPT

Name [redacted]

Address [redacted]

Program End Date: [redacted]

Credential Type: Diploma

Student ID [redacted]

Program Start Date: May 03, 2021

Program Name: Dental Hygiene

Program Status: Graduated

Semester 1

Courses	Course Code	Final Mark Percentage	Pass/Fail	End Date
Anatomy and Physiology	HS131	[redacted]		Aug 30, 2021
College English	EN101			Sep 03, 2021
Computer Applications and Skills	IT110			Jun 04, 2021
Dental Anatomy	DH133			Aug 17, 2021
Dental Hygiene Clinic I	DH160		Complete	Sep 02, 2021
Dental Hygiene Theory I	DH150			Jun 25, 2021
Histology and Embryology	HS132			Sep 02, 2021
Infection Control	HS121			Jul 06, 2021
Introduction to Professionalism	DH110			Jul 29, 2021
Introduction to Psychology	GE120			Sep 01, 2021
Introduction to Statistics and Research	SR134			Aug 26, 2021
Microbiology	HS120			Aug 27, 2021

Semester 2

Courses	Course Code	Final Mark Percentage	Pass/Fail	End Date
Dental Hygiene Clinic II	DH260		Incomplete	Feb 04, 2022
Dental Hygiene Theory II	DH250	[redacted]		Feb 04, 2022
Dental Materials Theory	DH235			Jan 06, 2022
Dental Radiography Interpretation	DH238			Jan 26, 2022
Dental Radiography Lab	DH231		Complete	Dec 17, 2021
Dental Radiography Theory	DH230			Nov 30, 2021

[redacted]

[redacted]

TRANSCRIPT

Head and Neck Anatomy	DH233	[redacted]		Jan 28, 2022
Medical Emergencies	DH234			Feb 03, 2022
Oral Health Education	DH211			Nov 25, 2021
Pathophysiology	DH237			Jan 27, 2022
Periodontology I	DH232			Jan 21, 2022
Pharmacology	DH222			Jan 11, 2022

Semester 2

Courses	Course Code	Final Mark Percentage	Pass/Fail	End Date
Dental Hygiene Clinic II	DH260		Complete	Jun 24, 2022
Dental Hygiene Theory II	DH250	[redacted]		Jun 16, 2022
Dental Materials Theory	DH235			Apr 04, 2022
Dental Radiography Interpretation	DH238			Jun 23, 2022
Dental Radiography Lab	DH231		Complete	Jun 17, 2022
Dental Radiography Theory	DH230			May 24, 2022
Head and Neck Anatomy	DH233			Jun 15, 2022
Medical Emergencies	DH234			Jun 24, 2022
Oral Health Education	DH211			May 05, 2022
Pathophysiology	DH237			Jun 13, 2022
Periodontology I	DH232			Jun 16, 2022
Pharmacology	DH222			Jun 07, 2022

Semester 3

Courses	Course Code	Final Mark Percentage	Pass/Fail	End Date
Community Dental Health I	DH310	[redacted]		Nov 10, 2022
Dental Hygiene Clinic III	DH370		Incomplete	Nov 02, 2022
Dental Hygiene Theory III	DH350			Oct 20, 2022
Dental Materials Lab	DH336		Complete	Nov 11, 2022
Ethics and Jurisprudence	DH340			Nov 02, 2022

P100

[redacted]

[redacted]

TRANSCRIPT

Gerontology	DH312	[redacted]	Oct 26, 2022
Nutrition for Living	DH323		Oct 07, 2022
Oral Health Promotion	DH311		Oct 13, 2022
Oral Pathology	DH321		Oct 24, 2022
Periodontology II	DH332		Nov 04, 2022

Semester 3

Courses	Course Code	Final Mark Percentage	Pass/Fail	End Date
Dental Hygiene Clinic III	DH370		Complete	Sep 01, 2023

Semester 4

Courses	Course Code	Final Mark Percentage	Pass/Fail	End Date
Business Practice	DH420	[redacted]		Jan 24, 2024
Community Dental Health II	DH410			Dec 21, 2023
Consolidated Learning	DH460			Feb 02, 2024
Dental Hygiene Clinic IV	DH470		Complete	Jan 22, 2024
Dental Hygiene Theory IV	DH450			Jan 31, 2024
	Average			

Campus Official Signature [redacted]

Value	Description	Value	Description
A	Excellent (80.00-100%)	F	Failing (00.00 - 59.99%)
B	Good (60.00-69.99%)	TC	Transfer Credit
C	Average (70.00-79.99%)	Complete	Complete/Pass
D	Poor (60.00-59.99%)	Incomplete	Incomplete/Fail

[redacted]

Ashley Adkins

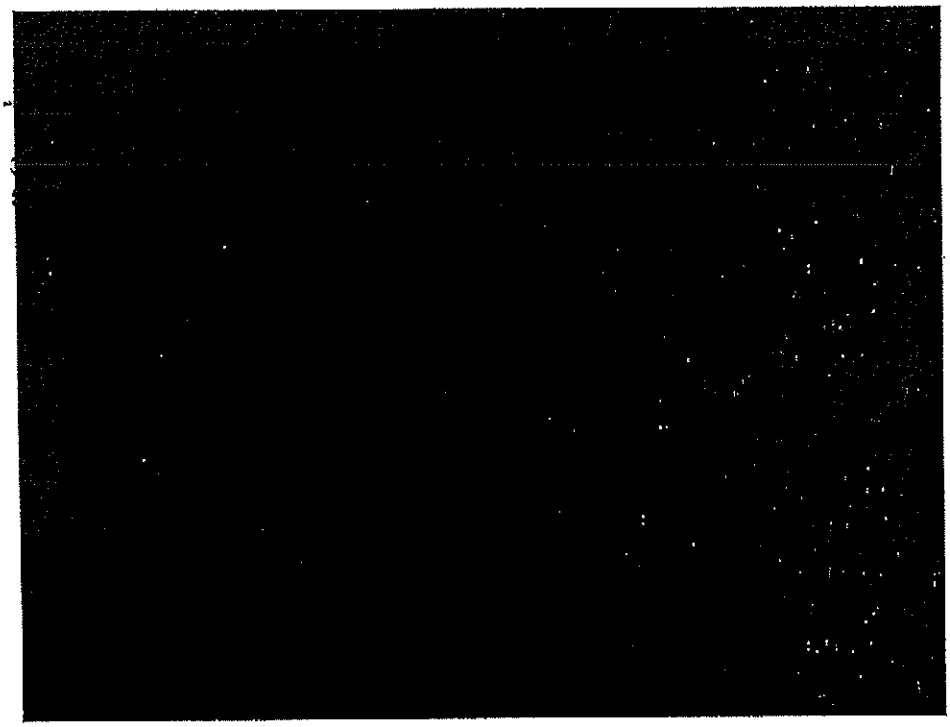
From: [redacted]
Sent: Wednesday, August 19, 2026 11:14 AM
To: OBOD BOARD
Cc: [redacted]
Subject: [EXTERNAL] Transcript - [redacted]
Attachments: [redacted]

Hello,

I hope this email finds you well. We are writing to fulfill a request for the transcript to be sent over to your organization by one of our former students, [redacted] who graduated from [redacted]

[redacted] pursued the Dental Hygiene [DH]program during their time with us. Please find their transcript attached to this email.

Should you require any additional information or have any questions regarding their documents, please don't hesitate to reach out to us.



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Explanatory Legend on Reverse Side

ECE Educational Credential Evaluators®

101 West Pleasant Street Suite 200
Milwaukee, WI 53212 USA
ECE.org

GENERAL EVALUATION REPORT

Name: [redacted]
Date of Birth:

Reference: [redacted]
Report Date: [redacted]

Purpose: Further Education
Evaluation report based on original and/or authenticated educational documents.

U.S. Equivalent Summary

Non-credit study

U.S. Equivalence: Non-credit study

Credential: Diploma in Dental Hygiene
Institution: [redacted]
Institution Status: This institution did not have official academic recognition at the time of enrollment.
Country: Canada
Date: [redacted]

- End of Report -

OKLAHOMA STATE BOARD OF DENTISTRY

AUG 06 2026

RECEIVED

[redacted] [redacted]

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The face of this document has a colored background — not a white background.

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Grades (marks) are converted to the A, B, C, D, F (4-point) grading scale used around the world. Plus (+) and minus (-) grading symbols are not used because they denote a level of grading precision that is not possible to achieve when one grading system is converted to another.

Grade	Points	Description
A	4	Excellent
B	3	Very good
C	2	Average
D	1	Below average
F	0	Failure

Grades not included in the grade average		
Absent	-	Absent from course or exam
Ex	-	Exempt
I	-	Incomplete
IP	-	In progress
P	-	Pass on a pass/fail basis
S	-	Satisfactory completion of academic work actual grades were not reported or where the grade was "S" on a satisfactory / unsatisfactory basis
Tr		Transfer credit granted
W		Withdrawn

Grade averages are calculated by dividing the total number of grade points earned by the total number of credits attempted. See example below.

8 credits with A (x 4) = 32 points
3 credits with B (x 3) = 24 points
5 credits with C (x 2) = 10 points
6 credits with D (x 1) = 6 points
Total 27 credits and 72 points

Divide points by credits to calculate grade average:
72 ÷ 27 = 2.67

Additional footnotes not identified on the report may be found at https://www.ece.org/footnotes.

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Ashley Adkins

From: evalml@ece.org
Sent: Wednesday, August 12, 2026 1:59 PM
To: Ashley Adkins
Subject: [EXTERNAL] ECE Reference Number [redacted]

Dear Ms. Adkins,

Thank you for your recent question regarding the report, Reference Number [redacted] for [redacted]

The phrase on the ECE report you referred to was included to confirm that it is our judgment that [redacted] has not been granted the power to award recognized academic degrees by the relevant educational authorities in Canada. In our judgment, any study completed at [redacted] has the U.S. equivalence of non-credit study.

Based on our research, [redacted] is a private (for-profit) career college operating in [redacted] In our judgment, the Canadian status of career college is not comparable to U.S. academic accreditation.

Career colleges in Canada are institutions that are privately owned and authorized to operate as commercial enterprises for the purpose of offering private training programs, for consumer protection purposes only. They must be registered or licensed under provincial or territorial legislation, but they do not have the power to award academic degrees.

In Canada, academic degree-granting universities would not consider this school recognized at the same level they are. In Canada, credit from a career college cannot be transferred to degree-granting universities.

For your reference, here is CICIC information on the college:

[redacted]

We hope this answers your question.

Best regards,
Harmony
Evaluator

Educational Credential Evaluators, Inc.
101 W Pleasant St, STE 200
Milwaukee WI 53212-3963

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A private, non-profit service organization

Oxford College of Arts, Business and Technology – Scarborough Campus

Program: [Dental Hygiene Education]
Province: [Ontario]

EDUCATION PROGRAM CONTACT INFORMATION

Inquiries on admission prerequisites should be directed to the admissions offices of the dental education program(s) you are interested in attending.

670 Progress Avenue
Scarborough , ON
M1H 3A4
Website: http://www.oxfordedu.ca

Search Again

October 2-3, 2026, BOARD MEETING APPENDIX
"A"

ABBREVIATIONS:
DC= DEAN'S CERTIFICATION, PD= PROGRAM DIRECTOR CERTIFICATION,
NB= NATIONAL BOARD SCORES, RE=REGIONAL EXAM SCORES, TR= TRANSCRIPTS, DP= DIPLOMA, BC= BIRTH CERTIFICATE, SC=SPECIALTY CERTIFICATE, AFF- AFFIDAVIT, WV=WORK VISA, JP=JURISPRUDENCE EXAM

Agenda Item #18 Dentist Application by Exam

APPLICANTS BELOW UPON RECEIPT OF TRANSCRIPTS, DIPLOMA, ALL REQUIRED DOCUMENTS AND PASSAGE OF THE JURISPRUDENCE EXAM, THEY ARE APPROVED FOR A DENTAL LICENSE.

Last	First	Type	Lic Number	Missing Documents	School
Archuleta	Lauren	DDS	8291	Complete	UT Health San Antonio 2024
Fisher	Mitchell	DMD	8288	Complete - JP	UNLV 2024
Ramos	Maritza	DDS	8292	Complete-JP	Texas A&M 2024
Tangella	Megana	DMD	8289	Complete-JP	Tufts 2025
Udall	William	DDS	8287	Complete- JP	Univ of Pacific 2023

Agenda Item # 19 Dentist Application by Credential

COMPLETE FILE – ISSUED TEMPORARY APPROVED DENTIST LICENSE.

Last	First	Type	Lic Number	Missing Documents	School
Cornish	Ricky	DDS	8286	Complete	Univ of Tenn 1992
Weaver	Ashley	DMD	8285	Complete	Univ of Alabama 2021

APPLICANTS BELOW UPON RECEIPT OF TRANSCRIPTS, DIPLOMA, ALL REQUIRED DOCUMENTS AND PASSAGE OF THE JURISPRUDENCE EXAM, THEY ARE APPROVED FOR A DENTAL LICENSE.

Last	First	Type	Lic Number	Missing Documents	School
Najafi	Gina	DMD	8290	Complete-JP	Nova SE 2018

Agenda Item # 20 Specialty by Exam and Credential

APPLICANTS BELOW ARE SCHEDULED FOR GRADUATION. UPON RECEIPT OF TRANSCRIPTS, DIPLOMA, ALL REQUIRED DOCUMENTS AND PASSAGE OF THE JURISPRUDENCE EXAM, THEY ARE APPROVED FOR A DENTAL LICENSE.

Last	First	Type	Spec Lic #	Specialty Type	Missing Documents	School
Cooper	Devon	DMD	26524	Pediatrics	Complete-JP	UAB 2015 / UCSF 2018
Namy	Mary	DMD	25623	Periodontics	Complete- JP	Boston Univ 2019 / Wilford Hall Med 2025
Nguyen	Dai	DMD	26522	Pediatrics	Complete	AT Still 24 / Nemours Childrens Hosp 26
Oh	Jae	DMD	26520	Endodontics	Complete-JP	Tufts 2018 / Naval Postgrad DS 2026

Agenda Item # 21 Hygienist Application by Exam and Credentials

APPLICANTS BELOW ARE SCHEDULED FOR GRADUATION. UPON RECEIPT OF TRANSCRIPTS, DIPLOMA, ALL REQUIRED DOCUMENTS AND PASSAGE OF THE JURISPRUDENCE EXAM, THEY ARE APPROVED FOR A HYGIENE LICENSE.

Last	First	Middle	Type	Lic	Missing Documents	School
Carr	Katie	Suzanne	RDH	5262	Complete-JP	Wallace State CC 2016
Flynt	Julia	Elizabeth	RDH	5254	Complete-JP	Houston Comm Coll 2020
Kleinfall	Dana	Lisette	RDH	5265	DC - JP	Sanford-Brown College 2015
Montgomery	Samirah		RDH	5260	Complete-JP	Texas A&M 2023
Palacios	Maira		RDH	5264	Complete-JP	Concorde Career College 2026
Salazar	Joselyn		RDH	5261	RE-JP	Amarillo College 2025
Stansell	Haylie	Alexis	RDH	5263	Complete-JP	UMKC 2024

Agenda Item #22 Request to Reinstate Dentist License.

Last	First	Middle	Type	Lic #	Issued	Expiration	Orders	Notes
Chaudhry	Manu		DDS	7412	7/8/2021	12/31/2024	No	Out of State – All CE good

Agenda Item #23 Retirement and Request for Volunteer License Dentists.

Last	First	Middle	Type	Lic #	Issued	Expiration	Volunteer Req
Hamra	Paul	William	DDS	5345	11/7/1997	12/31/2026	Yes
Willhoite	Laura	Lea	DDS	5117	6/12/1993	12/31/2026	No

Agenda Item #24 Requests to Not Renew License for Dentists and Dental Hygienists

Last	First	Type	Lic #	Issued	Expiration	Orders
Biehl	Amy	DDS	7351	7/9/2020	12/31/2026	No
Pakzad	Amin	DDS	6238	8/19/2010	12/31/2026	No

Last	First	Middle	Type	Lic #	Issue Date	Expires	Board Action
Humphrey	Laurie	Jo	RDH	4114	7/6/2017	RTNR	No

P110

Agenda Item #25 Requests for Advanced Procedures and Allied Dental Education Committee Recommendations

Last	First	Middle	Type	Lic	Nitrous	Local	Notes
[redacted]							
Palacios	Maira		RDH	5264	Pending	Pending	Pending Course Outline
Stansell	Haylie	Alexis	RDH	5263	Approved	Approved	

ADA GUIDELINES for the Use of Sedation and General Anesthesia by Dentists

Adopted by the ADA House of Delegates, October 2025

I. INTRODUCTION

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

Dentists must comply with their state laws, rules and/or regulations when providing sedation and anesthesia and will only be subject to Section III. Educational Requirements as required by those state laws, rules and/or regulations. Dental office-based sedation or general anesthesia may be administered by a qualified dentist or another independently qualified anesthesia healthcare provider, in accordance with state laws, rules and/or regulations for the benefit of patient safety.

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

TABLE OF CONTENTS

I. INTRODUCTION 1
II. DEFINITIONS 2
III. EDUCATIONAL REQUIREMENTS 6
IV. CLINICAL GUIDELINES 8
MINIMAL SEDATION 8
MODERATE SEDATION 10
DEEP SEDATION OR GENERAL ANESTHESIA 12
ENDNOTES 16

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

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

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

II. DEFINITIONS

METHODS OF ANXIETY AND PAIN CONTROL



MINIMAL SEDATION (PREVIOUSLY KNOWN AS ANXIOLYSIS) – a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's *normal response to verbal command.*[1]

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

The following definitions apply to administration of minimal sedation:

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

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

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

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

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

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

Note: In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

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

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

DEEP SEDATION AND GENERAL ANESTHESIA

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

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

ROUTES OF ADMINISTRATION

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

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

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

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

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

TERMS

analgesia – the diminution or elimination of pain.

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

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

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

operating dentist – dentist with primary responsibility for providing operative dental care while a qualified dentist or independently practicing qualified anesthesia healthcare provider administers minimal, moderate or deep sedation or general anesthesia.

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

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

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

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

continual – repeated regularly and frequently in a steady succession.

continuous – prolonged without any interruption at any time.

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

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

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

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

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

AMERICAN SOCIETY OF ANESTHESIOLOGISTS FASTING RECOMMENDATIONS*[3]

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

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

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

†The fasting periods noted above apply to all ages.

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

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

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

III. EDUCATIONAL REQUIREMENTS

A. Minimal Sedation

1. To administer minimal sedation, the dentist must be competent, as demonstrated by successful completion of:

   a. training in minimal sedation consistent with that prescribed in the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students,*

   or

   b. comprehensive training in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,

   or

   c. an advanced education program accredited by the Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage minimal sedation commensurate with these guidelines;

   and

   d. a current certification in Basic Life Support.

2. Administration of minimal sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and their clinical staff to maintain current certification in Basic Life Support.

B. Moderate Sedation

1. To administer moderate sedation, the dentist must be competent, as demonstrated by successful completion of:

   a. a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,

   or

   b. an advanced education program accredited by the Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage moderate sedation commensurate with these guidelines;

   and

   c. 1) A current certification in Basic Life Support and

      2) Current certification in Advanced Cardiac Life Support (ACLS). Current certification in Pediatric Advanced Life Support (PALS) is required for treating age-appropriate patients.

2. Administration of moderate sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and their clinical staff to maintain current certification in Basic Life Support.

C. Deep Sedation or General Anesthesia

1. To administer deep sedation or general anesthesia, the dentist must be competent, as demonstrated by successful completion of:
   a. An advanced education program accredited by the Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia, commensurate with Part IV.C of these guidelines;

      and

   b. 1) A current certification in Basic Life Support and
      2) Current certification in Advanced Cardiac Life Support (ACLS). Current certification in Pediatric Advanced Life Support (PALS) is required for treating age-appropriate patients.
2. Administration of deep sedation or general anesthesia by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and their clinical staff to maintain current certification in Basic Life Support (BLS).

IV. CLINICAL GUIDELINES



A. Minimal sedation

1. Patient History and Evaluation

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

2. Pre-Operative Evaluation and Preparation

   - The patient, parent, legal guardian and/or caregiver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
   - Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
   - An appropriate focused physical evaluation should be performed.
   - Baseline vital signs including body weight, height, BMI, blood pressure, pulse rate, and respiration rate must be obtained unless invalidated by the nature of the patient, procedure or equipment. Body temperature should be measured when clinically indicated.
   - Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
   - Pre-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian and/or caregiver.

3. Personnel and Equipment Requirements

   Personnel: At least one additional person trained in Basic Life Support must be present in addition to the dentist.

   Equipment:
   - A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available. At minimum, the following must be available: bag-valve-mask with multiple mask sizes, portable oxygen tank with regulator and key, and oral pharyngeal airways.
   - Documentation of compliance with manufacturers' recommended maintenance of monitors, anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A pre-procedural check of equipment for each administration of sedation must be performed.
   - When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
   - An appropriate scavenging system must be available if gases other than oxygen or air are used.

4. Monitoring and Documentation

Monitoring: A qualified dentist, or at the dentist's direction, an appropriately trained individual, must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment. Monitoring must include:

Consciousness: Level of sedation (e.g., responsiveness to verbal commands) must be continually assessed.

Oxygenation: Oxygen saturation by pulse oximetry.

Ventilation:

- The qualified dentist and/or appropriately trained individual must observe chest excursions.
- The qualified dentist and/or appropriately trained individual must verify respirations.

Circulation: Blood pressure and heart rate should be evaluated pre-operatively, post-operatively and intraoperatively as necessary (unless the patient is unable to tolerate such monitoring).

Documentation: An appropriate sedative record must be maintained, including the names of all drugs administered, time administered and route of administration, including local anesthetics, dosages, and monitored physiological parameters.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must monitor the patient during recovery until the patient is ready for discharge by the dentist.
- The qualified dentist must determine and document that level of consciousness, oxygenation, ventilation and circulation are satisfactory prior to discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian or caregiver.

6. Emergency Management

- If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.
- The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation and providing the equipment and protocols for patient rescue.
- All providers and offices must have written emergency protocols.
- Documented training sessions, including rehearsed emergency drills, must be developed and rehearsed, at minimum, every six months. It is the responsibility of the qualified dentist to ensure training occurs as presented.

B. Moderate Sedation

1. Patient History and Evaluation

   Patients considered for moderate sedation must undergo an evaluation prior to the administration of any sedative. This should consist of at least a review at an appropriate time of their medical history and medication use and NPO (nothing by mouth) status. In addition, patients with significant medical considerations (e.g., ASA III, IV) should also require consultation with their primary care physician or consulting medical specialist. Assessment of Body Mass Index (BMI)[4] should be considered part of a pre-procedural workup. Patients with elevated BMI may be at increased risk for airway associated morbidity, particularly if in association with other factors such as obstructive sleep apnea.

2. Pre-operative Evaluation and Preparation

   - The patient, parent, legal guardian and/or caregiver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
   - Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
   - An appropriate focused physical evaluation must be performed.
   - Baseline vital signs including body weight, height, BMI, blood pressure, pulse rate, respiration rate, and blood oxygen saturation by pulse oximetry must be obtained unless precluded by the nature of the patient, procedure or equipment. Body temperature should be measured when clinically indicated.
   - Pre-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian or caregiver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.[3]

3. Personnel and Equipment Requirements

   Personnel: At least one additional person trained in Basic Life Support must be present in addition to the dentist.

   Equipment:

   - A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available. At minimum, the following must be available: bag-valve-mask with multiple mask sizes, portable oxygen tank with regulator and key, oral pharyngeal airways, and supraglottic airways.
   - Documentation of compliance with manufacturers' recommended maintenance of monitors, anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A pre-procedural check of equipment for each administration of sedation must be performed.
   - When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.

- The equipment necessary for monitoring end-tidal CO_2 and auscultation of breath sounds must be immediately available.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravascular or intraosseous access should be available until the patient meets discharge criteria.
- The patient should be on supplemental oxygen throughout the procedure, as determined by the treating dentist, unless precluded by the nature of the patient, procedure (e.g., fire risk), or equipment.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level a qualified allied team member may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

Consciousness: Level of sedation (e.g., responsiveness to verbal command) must be continually assessed.

Oxygenation: Oxygen saturation must be evaluated by pulse oximetry continuously.

Ventilation:

- The dentist must observe chest excursions continually.
- The dentist must monitor ventilation and/or breathing by monitoring end-tidal CO_2 unless precluded or invalidated by the nature of the patient, procedure or equipment. In addition, ventilation should be monitored by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.
- Respiratory rate must be continually monitored and evaluated.

Circulation:

- The dentist must continually evaluate blood pressure and heart rate unless invalidated by the nature of the patient, procedure or equipment and this is noted in the time-oriented anesthesia record.
- Continuous ECG monitoring unless precluded or invalidated by the nature of the patient, procedure (e.g. fire risk), or equipment.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages (in weight, i.e., mg or mcg) and their administration times, including local anesthetics, dosages and monitored physiological parameters.
- Pulse oximetry, heart rate, respiratory rate, blood pressure and level of consciousness must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.



- The qualified dentist or appropriately trained clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The qualified dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian and/or caregiver.
- If a pharmacological reversal agent is administered before discharge criteria have been met, the patient must be monitored for a longer period than usual before discharge, since re-sedation may occur once the effects of the reversal agent have waned.

6. Emergency Management
   - If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.
   - The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.
   - All providers and offices must have written emergency protocols.
   - Documented training sessions, including rehearsed emergency drills, must be developed and rehearsed, at minimum, every six months. It is the responsibility of the qualified dentist to ensure training occurs as presented.



C. Deep Sedation or General Anesthesia

1. Patient History and Evaluation

   Patients considered for deep sedation or general anesthesia must undergo an evaluation prior to the administration of any sedative. This must consist of at least a review of their medical history and medication use and NPO (nothing by mouth) status. In addition, patients with significant medical considerations (e.g., ASA III, IV) must have consultation with their primary care physician or consulting medical specialist. Assessment of Body Mass Index (BMI)[4] should be considered part of a pre-procedural workup. Patients with elevated BMI may be at increased risk for airway associated morbidity, particularly if in association with other factors such as obstructive sleep apnea.

2. Pre-operative Evaluation and Preparation
   - The patient, parent, legal guardian and/or caregiver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained.
   - Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
   - An appropriate focused physical evaluation must be performed.

- Baseline vital signs including body weight, height, BMI, blood pressure, pulse rate, respiration rate, and blood oxygen saturation by pulse oximetry must be obtained unless invalidated by the patient, procedure or equipment. In addition, body temperature should be measured when clinically appropriate.
- Pre-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian and/or caregiver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.[3]
- An intravenous (IV) line should be established and secured for the duration of the procedure, as needed.
  - In certain cases, deep sedation or general anesthesia may be administered without first establishing an indwelling intravenous line. These exceptions may apply to very short procedures or situations where intravenous access is delayed until after sedation or anesthesia is initiated, such as with uncooperative patients.

3. Personnel and Equipment Requirements

Personnel: A minimum of three (3) individuals must be present.

- A dentist qualified in accordance with part III. C. of these *Guidelines* to administer the deep sedation or general anesthesia.
- Two additional individuals who have current certification in Basic Life Support (BLS).
- When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available. At minimum, the following must be available: bag-valve-mask with multiple mask sizes, portable oxygen tank with regulator and key, oral pharyngeal airways, and supraglottic airways.
- Documentation of compliance with manufacturers' recommended maintenance of monitors, anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A pre-procedural check of equipment for each administration must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.
- Equipment and drugs necessary to provide advanced airway management, and advanced cardiac life support must be immediately available.
- The equipment necessary for monitoring end-tidal CO_2 and auscultation of breath sounds must be immediately available.
- Resuscitation medications and an appropriate defibrillator must be immediately available.
- The patient must be on supplemental oxygen throughout the procedure, as determined by the treating dentist, unless precluded by the nature of the patient, procedure (e.g., fire risk), or equipment.



4. Monitoring and Documentation

Monitoring: A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

Oxygenation: Oxygenation saturation must be evaluated continuously by pulse oximetry.

Ventilation:

- Intubated patient: End-tidal CO2 must be continuously monitored and evaluated.
- Non-intubated patient: End-tidal CO2 must be continually monitored and evaluated unless precluded or invalidated by the nature of the patient, procedure, or equipment. In addition, ventilation should be monitored and evaluated by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.
- Respiratory rate must be continually monitored and evaluated.

Circulation:

- The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry.
- The dentist must continually evaluate blood pressure.

Temperature:

- A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.
- The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages (in weight, i.e., mg or mcg) and their administration times, including local anesthetics and monitored physiological parameters.
- Pulse oximetry and end-tidal CO2 measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The dentist or clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The dentist must determine and document that level of consciousness, oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, and parent, escort, guardian or caregiver.

6. Patients with Special Healthcare Needs

   Because many dental patients undergoing deep sedation or general anesthesia have mental and/or physical special healthcare needs, it is not always possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care. When these situations occur, the dentist responsible for administering the deep sedation or general anesthesia should document the reasons preventing the recommended preoperative management.

7. Emergency Management

   - The qualified dentist is responsible for sedative/anesthetic management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of deep sedation or general anesthesia and providing the equipment, drugs and protocols for patient rescue.
   - All providers and offices must have written emergency protocols.
   - Documented training sessions, including rehearsed emergency drills, must be developed and rehearsed, at minimum, every six months. It is the responsibility of the qualified dentist to ensure training occurs as presented.

ENDNOTES

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

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

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

4 Standardized BMI category definitions can be obtained from the Centers for Disease Control and Prevention or the American Society of Anesthesiologists.

INTRODUCTION

Criteria and parameters in this section refer specifically and exclusively to methods used by Oral and Maxillofacial Surgeons to control the pain and anxiety of patients treated in outpatient facilities (eg, dental school surgery units, ambulatory surgery centers, Oral and Maxillofacial Surgeons' offices, and other facilities where Oral and Maxillofacial Surgery is performed).

Pain and anxiety control, using various techniques of regional (local) anesthesia, all forms of sedation, and general anesthesia, have been an integral part of the practice of Oral and Maxillofacial Surgery since the inception of the specialty. Anxiety, fear, and pain are concerns because each is inherent in the patient's reaction to the proposed treatment. All three must be controlled satisfactorily during the perioperative period to permit safe and effective completion of the surgical procedure. These anesthesia criteria have been developed to maximize safety and minimize risk for patients.

The practitioner's selection of a particular technique for controlling pain and anxiety during a specific procedure has to be individually determined for each patient, considering the risks and benefits for each case.

Techniques seldom used or applicable to very few patients are not included in this section. This category includes hypnosis, acupuncture, transcutaneous electrical nerve stimulation, and specific medications and techniques for controlling acute or chronic pain. Behavior modification techniques (biofeedback) and psychiatric management also have been excluded from this section.

In the future, new indications or new anesthetic agents and techniques may lead to changes in equipment. As new pieces of equipment and their techniques for use are evaluated for safety and efficacy and accepted for patient care and treatment, their inclusion in this document will be considered. Consequently, the use of capnography for patients under moderate sedation, deep sedation, and general anesthesia should be instituted in OMS practice and used on these patients effective January 2014 unless precluded or invalidated by the nature of the patient, procedure, or equipment. It is anticipated that this implementation date will allow adequate time for the refinement of materials and methods so as to optimize the use of capnography in an open system.

DEFINITIONS OF SEDATION AND ANESTHESIA

American Society of Anesthesiologists (ASA) *Continuum of Depth of Sedation Definition of General Anesthesia and Levels of Sedation/Analgesia* (approved by the ASA House of Delegates on October 27, 2004, and amended on October 21, 2009)

Minimal Sedation (Anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes and ventilatory and cardiovascular functions are unaffected.

Moderate Sedation/Analgesia (Conscious Sedation) is a drug-induced depression of consciousness during which patients respond purposefully** to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

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

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

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue*** patients whose level of sedation becomes deeper than initially intended. Individuals administering moderate sedation/analgesia should be able to

**Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

***Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia, and hypotension) and returns the patient to the originally intended level of sedation.

These definitions are also published in the *AAOMS Office Anesthesia Evaluation Manual.*

rescue*** patients who enter a state of deep sedation/analgesia, whereas those administering deep sedation/analgesia should be able to rescue*** patients who enter a state of general anesthesia.

GENERAL CRITERIA, PARAMETERS, AND CONSIDERATIONS FOR ANESTHESIA IN OUTPATIENT FACILITIES

INFORMED CONSENT: All surgery must be preceded by the patient's or legal guardian's consent, unless an emergent situation dictates otherwise. These circumstances should be documented in the patient's record. Informed consent is obtained after the patient or the legal guardian has been informed of the indications for the procedure(s), the goals of treatment, the known benefits and risks of the procedure(s), the factors that may affect the risk, the treatment options, and the favorable outcomes.

DOCUMENTATION: The *AAOMS ParCare 2012* includes documentation of objective findings, diagnoses, and patient management interventions. *The ultimate judgment regarding the appropriateness of any specific procedure must be made by the individual surgeon in light of the circumstances presented by each patient. Understandably, there may be good clinical reasons to deviate from these parameters. When a surgeon chooses to deviate from an applicable parameter based on the circumstances of a particular patient, he/she is well advised to note in the patient's record the reason for the procedure followed. Moreover, it should be understood that adherence to the parameters does not guarantee a favorable outcome.*

FACILITIES: When anesthesia is administered in an office setting by or for an Oral and Maxillofacial Surgeon, that office shall have been evaluated according to the American Association of Oral and Maxillofacial Surgeons (AAOMS) bylaws, AAOMS Governing Rules and Regulations 2010-2011 (Chapter III, Component Societies and Counterparts, Section 30. Qualifications, B). Specific language applicable to the facility is as follows: "fulfillment of an on-site office anesthesia evaluation with re-evaluation every five (5) years based on the AAOMS office anesthesia evaluation program or required applicable state or federal regulations." The current edition of the *AAOMS Office Anesthesia Evaluation Manual* (8th edition) is applicable. State laws govern the necessity for inspection of facilities in which Oral and Maxillofacial Surgeons administer anesthesia. When Oral and Maxillofacial Surgeons administer anesthesia in multiple locations, the primary facility must be inspected. The surgeon should ensure that all facilities are held to the same standard of excellence, that facilities are comparably equipped with anesthetic emergency drugs and equipment, and that the staffs are comparably and adequately trained.

When nitrous oxide is used alone or as an adjunct to any of the anesthetic techniques included in this section, appropriate scavenging equipment must be used to reduce trace gas environmental contamination. It is suggested that all staff be educated in the risks of trace gas and exposure to nitrous oxide and techniques to minimize such risks.

The surgeon should successfully complete a course in Advanced Cardiac Life Support (ACLS) at 2-year intervals. The facility must also be equipped to provide ACLS care. When pediatric patients are treated, the completion of a Pediatric Advanced Life Support (PALS) course should be considered and the facility equipped with appropriate age-specific equipment to provide PALS level care.

PREANESTHETIC PHYSICAL AND LABORATORY ASSESSMENT: Preanesthetic physical assessment is described in the *Patient Assessment* chapter of *AAOMS ParCare 2012*. Routine laboratory testing is not indicated. The need for laboratory testing should be based on the history and physical examination of the patient and the nature of the surgical procedure. Laboratory testing should be performed only when the results may alter the management of the patient.

PERIOPERATIVE COMPLICATIONS AND EMERGENCIES: Because adverse outcomes related to anesthesia, though rare, may be catastrophic, the following must be available and/or provided:

A. Mobile auxiliary sources of light and suction that can be used during power failure. In addition to the central source of oxygen, there must be an auxiliary source capable of delivering oxygen under positive pressure for at least 1 hour.
B. Periodic scheduled practice sessions for all personnel to demonstrate knowledge and skillful management of potential emergency problems
C. ACLS guidelines and suggestions contained in the *AAOMS Office Anesthesia Evaluation Manual*, which are the recommendations for management of emergencies associated with anesthesia in the oral and maxillofacial surgery outpatient environment

D. Appropriate equipment and drugs, as recommended in the *AAOMS Office Anesthesia Evaluation Manual*

GENERAL THERAPEUTIC GOALS FOR ANESTHESIA IN OUTPATIENT FACILITIES:

A. Full recovery within a reasonable period
B. Appropriate understanding by patient (family) of treatment options and acceptance of treatment plan
C. Appropriate understanding and acceptance by patient (family) of favorable outcomes and known risks and complications

GENERAL FACTORS AFFECTING RISK DURING ANESTHESIA IN OUTPATIENT FACILITIES:

A. Degree of patient's and/or family's understanding of the origin and natural course of the condition and/or disorder and the knowledge of the patient's and/or family's medical history
B. Presence of coexisting systemic disease (eg, disease that increases a patient's ASA classification to II, III, or IV), as detailed in the *Patient Assessment* chapter
C. Age of patient
D. The use of prescribed or over-the-counter medications and/or herbal medications or vitamins
E. Current or past use of illicit drugs or alcohol
F. History of or present use of tobacco
G. Degree of patient's and/or family's understanding of the therapeutic goals and acceptance of the proposed treatment, resulting in the patient's and family's cooperation and compliance with perioperative anesthetic instructions
H. Documented airway assessment
I. Familial history of problems related to anesthesia
J. Diagnosed obstructive sleep apnea syndrome (OSAS) or Class II or Class III Body Mass Index (BMI)

GENERAL FAVORABLE THERAPEUTIC OUTCOMES FOR ANESTHESIA IN OUTPATIENT FACILITIES:

A. Recovery of the patient from the anesthetic effects, returning to his/her preanesthetic physiologic and psychologic state within an appropriate time after the cessation of the administration of the anesthetic drugs
B. Agreement that the anesthetic experience was satisfactory by both the surgeon and the patient
C. Recovery from the administration of sedatives, anesthetic agents, and other adjunctive medications
D. Patient (family) acceptance of procedure and understanding of outcomes

GENERAL KNOWN RISKS AND COMPLICATIONS FOR ANESTHESIA IN OUTPATIENT FACILITIES:

A. Syncope
B. Drug over dosage or reaction (allergy or sensitivity)
C. Adverse cardiovascular or pulmonary event
D. Vascular injury
E. Respiratory depression, obstruction, or arrest
F. Airway loss or obstruction requiring an emergent airway using endotracheal intubation, laryngeal mask airway (LMA) or other adjunct airway device placement, or surgical airway
G. Inability to intubate or ventilate
H. Prolonged hypoxia or hypercapnea
I. Vomiting and/or aspiration
J. Displacement of foreign body into upper airway or bronchi
K. Development of peripheral or central neurologic deficit
L. Anesthesia-related organ failure
M. Unplanned hospital admission
N. Dental injury related to anesthetic care (when likelihood of dental injury is possible, it should be noted in the patient's record before surgery)
O. Other oral and nasal injuries, such as laceration, hematoma, subcutaneous emphysema, hemorrhage, and edema, related to anesthetic administration
P. Ocular injuries
Q. Malignant hyperthermia
R. Death

SPECIAL CONSIDERATIONS FOR PEDIATRIC ANESTHESIA IN OUTPATIENT FACILITIES

Perhaps in no other patient group is the area of anxiety and pain control more pertinent than in the pediatric population. The goals of pediatric anesthesia are to provide efficient, safe, reversible and profound anesthesia, sedation, or analgesia as indicated. Moreover, the surgeon should make every effort to limit recall of the anesthetic surgical experience. The youngest child a surgeon will treat must be determined by each Oral and Maxillofacial Surgeon based on training, experience, appropriately sized equipment, and the availability of trained staff responsible for the welfare and safety of the patient.

Patient selection criteria may differ in subtle ways from those used to assess adults for sedation and anesthesia. Particular attention to evidence of recent upper respiratory tract infection (URI) is important when assessing children. A one to two-week postponement due to the runny nose may be appropriate. A runny nose or very mild form of URI must be differentiated from a more severe URI. The more severe URI should be allowed to clear and would require a 4- to 6-week period of delay to allow airway reactivity to resolve. Asthma is common in children, and when identified a thorough assessment of severity and current status is important. Endocrine disorders (diabetes), congenital cardiac defects, hematologic disease, and familial risk for susceptibility to malignant hyperthermia should all be assessed carefully in the presedation/anesthesia assessment of children. Recognizing that this may be the very first time that this young patient has ever been exposed to anesthetic drugs serves to highlight the need for a detailed family history.

Children have unique anatomical and physiologic characteristics that must be considered during anesthesia. Their airways provide little margin for error because of small mandibles, relatively large tongue and tonsillar/adenoidal tissues, smaller and more anteriorly superiorly placed glottises, and supple, pliable larynges that are easily compressed. The narrowest point of the child's airway is at the cricoid ring, and endotracheal tube size must be determined accurately to avoid mucosal compression or injury and subsequent postanesthesia airway edema. The child has a proportionately larger head and tongue than does the adult and may also have a long, floppy epiglottis. Laryngospasm is a fairly common complication that must be skillfully managed as quickly as possible. It is paramount to avoid periods of oxygen desaturation, which very quickly suppress cardiac function (eg, bradycardia) and reduce cardiac output. Most poor outcomes in pediatric anesthesia occur related to loss of the airway. Cardiac events that are not the result of hypoxemia and hypercarbia related to airway problems are uncommon in children.

Pharmacologic considerations demand a thorough knowledge of parenteral and oral anesthetic and analgesic agents. Most, if not all, agents should be administered and prescribed as units per kilogram of weight of the child, which is standard pediatric practice.

The availability of appropriate size pediatric anesthesia equipment and resuscitation supplies is an obvious requirement. Pediatric paddles are available for defibrillators.

PALS courses are recommended for practitioners providing anesthesia to children. PALS protocols may be useful in the resuscitation of children. Arrests are rare events, and in the anxiety of a pediatric resuscitation the calculation of quickly needed emergency drugs may be particularly challenging. One-page printouts of dosages in milliliters for the known concentrations of the commonly used drugs that would be required for the actual weight of the particular pediatric patient being anesthetized can facilitate a smooth, coordinated, and most likely successful resuscitation.

Finally, socioeconomic, psychological, emotional, and relational factors may affect a child's perception of anesthesia, subsequent induction of anesthetic, the postanesthetic recovery experience, and ultimate pain control. Many of these factors relate to the parent and the child. Accordingly, the Oral and Maxillofacial Surgeon must understand how to identify and how to modify, control, or eliminate these factors if they adversely affect the surgeon/anesthetist's management of the pediatric patient.

SPECIAL CONSIDERATIONS FOR ANESTHETIC MANAGEMENT OF THE PREGNANT PATIENT IN OUTPATIENT FACILITIES

Although elective surgery can usually be delayed until post partum, there are situations in which a pregnant female will present to the office requiring immediate surgery. The consequences of not providing essential care may present a greater risk than surgical intervention. The anesthetic goals in treating the pregnant patient include the ability to control the patient's pain and anxiety. In addition to maternal safety, anesthetic management must maintain fetal safety, which includes avoiding intrauterine fetal asphyxia and preterm labor.

A thorough knowledge of pharmacologic agents is required. Most local anesthetics are considered relatively safe during pregnancy. Single exposure to the commonly used sedatives benzodiazepines, opioids, and nitrous oxide have undetermined risk of teratogenicity. The Oral and Maxillofacial Surgeon should also counsel the patient about

MODERATE SEDATION

Moderate sedation may be achieved with parenteral agents, nitrous oxide, and/or oral, rectal, and intranasal medications.

I. Indications for Therapy

May include one or both of the following:

A. Need to depress the level of consciousness, anxiety, and/or pain minimally so that the patient can undergo a planned procedure
B. Need to retain the patient's ability to maintain an airway independently and continuously and respond appropriately to physical stimulation and verbal command

II. Specific Therapeutic Goals for Moderate Sedation

A. The presence of a general therapeutic goal, as listed in the section entitled General Criteria, Parameters, and Considerations for Anesthesia in Outpatient Facilities
B. Depressed level of consciousness
C. Reduced anxiety and improved patient cooperation during the surgical procedure
D. Anxiolysis to reduce cardiopulmonary morbidity
E. Ability to respond purposefully to physical stimulation and to spoken commands and ambulate normally without assistance shortly after completion of procedure(s)

III. Specific Factors Affecting Risk for Moderate Sedation

Severity of factors that increase risk and the potential for known complications:

A. The presence of a general factor affecting risk, as listed in the section entitled General Criteria, Parameters, and Considerations for Anesthesia in Outpatient Facilities
B. Noncompliance with eating and drinking (nothing by mouth [NPO]) requirements or physical conditions that could affect gastric emptying
C. Presence of systemic infection

IV. Indicated Therapeutic Parameters for Moderate Sedation

A. Completion of a medical history questionnaire, signed and dated by the patient or a responsible adult
B. Review of medical history by the Oral and Maxillofacial Surgeon on the day of surgery, with all significant responses evaluated and noted in the patient's record (dialogue history)
C. Determination and documentation of the patient's ASA classification and fitness for moderate sedation in the office
D. Documentation of airway assessment
E. Documentation of baseline vital signs
F. Completion of medical consultation or additional laboratory testing, if indicated, before initiation of treatment (except in extreme emergency)
G. Maintenance and completion of time-oriented anesthesia record (similar to that provided in the *AAOMS Office Anesthesia Evaluation Manual*) for each anesthetic administration
    1. Documentation of the anesthetic agents, including dosages, routes of administration, and times of administration
    2. Documentation of continuous monitoring including heart rate, blood pressure, ventilation, SpO_2 (arterial oxygen saturation), and temperature (when indicated) on at least a 5-minute interval
    3. Continuous electrocardiograph (ECG) monitoring
    4. Consider end-tidal carbon dioxide ($ETCO_2$) measurement and provide continuous $ETCO_2$ monitoring effective January 2014 (See page ANE-2 Introduction)
H. Determination and documentation that the patient has been NPO for an appropriate period of time
I. Documentation that contact lenses and complete/partial intraoral prosthesis have been removed
J. Documentation of maintenance (including calibration if appropriate) of the analgesic/anesthetic machine at appropriate intervals
K. Documentation of the presence and identity of each team member throughout the administration of moderate sedation. The team should consist of the surgeon who must be trained and currently competent in ACLS and one additional person trained and currently competent in Basic Life Support for Healthcare Providers.
L. The individual designated to monitor the patient's level of sedation and/or administer the sedation medications (if allowed by state or territory statute) may assist with minor, interruptible tasks within the procedure

MODERATE SEDATION (continued)

room once the patient's level of sedation/analgesia and vital signs have stabilized. Adequate monitoring of the patient's level of sedation/anesthesia can be done by another member of the anesthesia team who has appropriate education and training.

M. Use of supplemental oxygen: unless there are contraindications to the use of oxygen by the procedure, supplemental oxygen must be administered while the patient is sedated. The ability and equipment to provide positive pressure oxygen must be available.

N. Intravenous access for patients receiving intravenous medications for moderate sedation and maintenance of vascular access throughout the procedure until the patient is no longer at risk for cardiorespiratory depression

O. Intravenous access for patients who receive moderate sedation by nonintravenous routes; determination by the Oral and Maxillofacial Surgeon of the advisability of establishing or reestablishing intravenous access is on a case-by-case basis

P. Intravenous access using a new infusion set, including a new infusion line and new bag of fluid, for each patient

Q. Positioning of the patient to avoid injury to him/herself or others during the period of moderate sedation

R. Immediate availability of equipment to assess body temperature

S. Facility equipped with emergency drugs and equipment that allow appropriate management of untoward events

T. Adherence to recommendations for management of complications and emergencies, as described in the *AAOMS Office Anesthesia Evaluation Manual*

U. Determination and documentation that oxygenation, ventilation, circulation, and temperature (when indicated) are stable before discharge

V. Written postoperative instructions given to the patient and a responsible adult and explained to both the patient and a responsible adult at the time of discharge. These should include instructions not to operate any vehicle or machinery and/or be involved in any contractual or legal process for an appropriate period of time. In certain situations, the surgeon will not have written instructions in all languages.

W. Determination by the surgeon that the patient's vital signs are stable, the patient is mentally alert, and the patient is no longer at risk for cardiorespiratory depression. A notation should be made in the medical record that the patient has achieved predetermined discharge criteria.

X. Discharge of the patient in the care of a responsible adult. A responsible adult should be available to provide assisted care to the patient until the patient is fully recovered from anesthetic drugs.

V. Outcome Assessment Indices for Moderate Sedation

Indices are used by the specialty to assess aggregate outcomes of care. Outcomes are assessed through clinical evaluation.

A. Favorable therapeutic outcomes
   1. General favorable therapeutic outcomes, as listed in the section entitled General Criteria, Parameters, and Considerations for Anesthesia in Outpatient Facilities

B. Known risks and complications associated with therapy
   1. Presence of general known risks or complications, as listed in the section entitled General Criteria, Parameters, and Considerations for Anesthesia in Outpatient Facilities
   2. Unintended changes of the patient's level of consciousness (eg, to that of deep sedation or general anesthesia)
   3. Events related temporally to moderate sedation
      a. Aspiration
      b. Respiratory changes
      c. Dysphoria
      d. Psychogenic sequelae
      e. Unexpected changes in vital signs from baseline
      f. Cardiac dysrhythmia, other than arrest
   4. Failure to emerge from sedation sufficiently for discharge from facility within an appropriate time after completion of procedure

MODERATE SEDATION (continued)

5. Unplanned hospital admission after administration of moderate sedation

DEEP SEDATION/GENERAL ANESTHESIA

I. Indications for Therapy

A. Need to depress the patient's level of consciousness, anxiety, pain, and recall sufficiently during a planned procedure, recognizing that this may result in the partial or complete loss of protective reflexes and/or the patient's ability to maintain an airway independently, as well as possible changes in cardiovascular and pulmonary function.

II. Specific Therapeutic Goals for Deep Sedation/General Anesthesia

A. The presence of a general therapeutic goal, as listed in the section entitled General Criteria, Parameters, and Considerations for Anesthesia in Outpatient Facilities

B. In deep sedation/general anesthesia, a controlled state of depressed consciousness/loss of consciousness resulting in:

1. An inability to respond purposefully to physical stimulation or verbal command
2. Adequate control of pain and anxiety
3. Probable but not guaranteed inability to recall surgical experience

III. Specific Factors Affecting Risk for Deep Sedation/General Anesthesia

A. The presence of a general factor affecting risk, as listed in the section entitled General Criteria, Parameters, and Considerations for Anesthesia in Outpatient Facilities

B. Loss of the ability to respond purposefully to physical stimulation or verbal command and/or loss of protective cardiopulmonary reflexes and the ability to maintain an airway independently

C. Factors compromising airway patency

D. Factors compromising cardiovascular function

E. Noncompliance with or conditions affecting NPO requirements

F. Psychological aversion to intravenous or intramuscular injections and/or anesthetic mask

G. Presence of intraoral abscess or cellulitis

H. Presence of facial anomalies and anatomical variations that might prevent or impede adequate airway management

I. Presence of a recent or active upper respiratory infection

J. Regulatory and/or third-party decisions concerning access to care, indicated therapy, drugs, devices, and/or materials

K. Special needs patients

IV. Indicated Therapeutic Parameters for Deep Sedation/General Anesthesia

A. Completion of an appropriate medical history questionnaire, signed and dated by the patient or a responsible adult

B. Review of medical history by an Oral and Maxillofacial Surgeon, with all significant responses evaluated and noted in the patient's record (dialogue history) on the date of surgery

C. A brief physical evaluation, especially of heart and lungs, by the Oral and Maxillofacial Surgeon

D. Determination and documentation of the patient's ASA classification and fitness for general anesthesia in the office

E. Completion of medical consultation or additional laboratory testing, if indicated, before initiation of treatment

F. Maintenance and completion of a time-oriented (at least every 5 minutes) anesthesia record (similar to that provided in the *AAOMS Anesthesia Manual*) for each anesthetic administration

1. Documentation of the anesthetic agents, including dosages, routes of administration, and times of administration
2. Documentation of continuous monitoring, including heart rate, blood pressure, oxygen saturation, ventilation (and temperature, if monitored)

G. Determination and documentation that the patient has been NPO for an appropriate period of time

H. Documentation that the patient is currently not wearing contact lenses and/or complete or partial denture

I. Documentation of maintenance (including calibration if appropriate) of the anesthetic machine at appropriate intervals

DEEP SEDATION/GENERAL ANESTHESIA (continued)

J. Documentation of the presence and identity of each team member throughout administration of general anesthesia. The team should consist of the surgeon, trained and currently competent in ACLS, and two additional persons, trained and currently competent in Basic Life Support for Healthcare Providers.

K. The individual designated to monitor that patient's level of sedation should have no other responsibilities.

L. Use of supplemental oxygen throughout the anesthetic period and availability of supplemental oxygen throughout the postoperative period

M. Intravenous access for patients receiving intravenous medications for deep sedation/anesthesia and maintenance of vascular access throughout the procedure and until the patient is no longer at risk for cardiorespiratory depression

N. Intravenous access for patients who receive deep sedation/general anesthesia by nonintravenous routes and determination by the Oral and Maxillofacial Surgeon of the advisability of establishing or reestablishing intravenous access on a case-by-case basis

O. Intravenous access using a new infusion set, including a new infusion line and new bag of fluid, for each patient

P. Continuous supervision, monitoring, and documentation on at least a 5-minute interval in the anesthetic record of:

1. Ventilation and oxygenation during the administration of the anesthetic
    a. Continuous use of pulse oximetry during both the intraoperative and recovery period with the appropriate alarm settings established
    b. Documentation of data during the perioperative period
    c. Ventilatory monitoring should include all of the following:
        i. Auscultation of breath sounds when appropriate
        ii. Observations of the excursion of the chest wall
        iii. Use of a precordial or pretracheal stethoscope when appropriate
        iv. Observation of the reservoir bag when appropriate
        v. Monitoring color of skin, mucosa, nail beds, and surgical site
        vi. Monitoring of expiratory gases including $ETCO_2$ (capnometry or capnography) effective January 2014 (See page ANE-2 Introduction)
    d. When endotracheal intubation or an LMA is used:
        i. Monitoring of $ETCO_2$
        ii. Monitoring of inspired oxygen concentration
        iii. Use of the following when a ventilator is used:
            aa. Disconnect alarm
            bb. High and low respiratory pressure alarms
            cc. Supply pressure indicator
            dd. Respiratory rate and volume alarms
            ee. Adjustable expiratory and tidal volumes
2. The cardiovascular status of the patient
    a. Documentation of continuous monitoring, including heart rate, blood pressure, respiration (and temperature, if monitored)
    b. Use of the ECG, which must be continuously displayed and/or recorded until the patient leaves the operating room and documentation of its use in the anesthetic record. This documentation could be a notation of the rhythm present during the procedure or a sample of the rhythm strip.

Q. Positioning and protection of the patient to avoid injury to himself/herself or to others during the period of anesthesia
    1. Appropriately positioned and padded extremities to minimize peripheral nerve injuries
    2. Appropriately protected eyes to avoid injury

R. Equipment to assess body temperature that is immediately available

Body temperature must be continuously monitored in all patients who are being anesthetized with agents that can induce malignant hyperthermia, and a plan to treat malignant hyperthermia must be in place. It is recommended that all children have their temperature monitored.

S. Facility equipped with emergency drugs and equipment that allow appropriate ACLS intervention, including a device to confirm exhaled CO_2

DEEP SEDATION/GENERAL ANESTHESIA (continued)

T. Adherence to recommendations for management of complications and emergencies, as described in the current edition of the *AAOMS Office Anesthesia Evaluation Manual* and in the current *ACLS Manual*

U. Determination and documentation that oxygenation, ventilation, circulation, and temperature (when indicated) are stable before discharge

V. Written postoperative instructions given to the patient and a responsible adult and explained to both the patient and a responsible adult at the time of discharge. In certain situations the surgeon will not have written instructions available in all languages.

W. Determination by the surgeon that the patient's vital signs are stable, the patient is mentally alert, and the patient is no longer at risk for cardiorespiratory depression before discharge. A notation should be made in the medical record that the patient has achieved predetermined discharge criteria.

X. Discharge of the patient into the care of a responsible adult. A responsible adult should be available to provide assisted care to the patient until the patient is fully recovered from the anesthetic.

V. Outcome Assessment Indices for Deep Sedation/General Anesthesia

Indices are used by the specialty to assess aggregate outcomes of care. Outcomes are assessed through clinical evaluation.

A. Favorable therapeutic outcomes
   1. General favorable therapeutic outcomes, as listed in the section entitled General Criteria, Parameters, and Considerations for Anesthesia in Outpatient Facilities

B. Known risks and complications associated with therapy
   1. Presence of general risks or complications, as listed in the section entitled General Criteria, Parameters, and Considerations for Anesthesia in Outpatient Facilities
   2. Events related temporally to general anesthesia
      a. Aspiration
      b. Respiratory arrest, hypoventilation, or hyperventilation
      c. Hypoxia, hypercarbia, or hypocarbia
      d. Pulmonary edema
      e. Congestive heart failure
      f. Unanticipated need to intubate patient
      g. Dental, oral, or airway trauma secondary to intubation or placement of other adjunctive airway devices
      h. Prolonged intubation
      i. Prolonged emergence from anesthesia
      j. Postoperative dysphoria, excitation, or psychogenic sequelae
      k. Peripheral vascular injury
      l. Peripheral or central neurologic deficit
      m. Cardiovascular injury
      n. Organ damage
      o. Ocular injury
      p. Failure to emerge from anesthesia, requiring hospital admission for observation
      q. Malignant hyperthermia
      r. Adverse reaction to medication
      s. Death

SELECTED REFERENCES – ANESTHESIA IN OUTPATIENT FACILITIES

This list of selected references is intended only to acknowledge some of the sources of information drawn on in the preparation of this document. Citation of the reference material is not meant to imply endorsement of any statement contained in the reference material. The list is not an exhaustive compilation of information on the topic. Readers should consult other sources to obtain a complete bibliography.

SPECIAL CONSIDERATIONS FOR PEDIATRIC ANESTHESIA IN OUTPATIENT FACILITIES

1. American Academy of Pediatric Dentistry Ad Hoc Committee on Sedation and Anesthesia: Policy on the use of deep sedation and general anesthesia in the pediatric dental office. Adopted 1999. Revised 2004, 2007. Pediatr Dent 27(Suppl):51, 2005-2006 Available at: http://www.aapd.org/media/Policies_Guidelines/P_Sedation.pdf. Accessed July 8, 2011

Ashley Adkins

From: Jeff Puckett
Sent: Thursday, September 17, 2026 3:26 PM
To: Ashley Adkins
Subject: FW: [EXTERNAL] RDH's removing fixed prosthetics

Jeff Puckett
Deputy Director
Oklahoma Board of Dentistry
Direct 405-522-4617

From: Dr. John Fullington <redeemedsmiles@gmail.com>
Sent: Thursday, September 17, 2026 2:23 PM
To: Jeff Puckett <Jeff.Puckett@dentistry.ok.gov>
Cc: Dr. John Fullington <drfullington@redeemedsmiles.dentist>
Subject: [EXTERNAL] RDH's removing fixed prosthetics

Hello, Mr. Puckett!

I hope this message finds you doing well.

Thank you for taking my call last week. We had a question come up and were hoping you could provide us with some guidance.

Are Registered Dental Hygienists permitted to remove a fixed prosthetic in order to perform maintenance? Currently, we have our doctor remove the fixed arch, after which the hygienist completes the maintenance. The doctor then performs the examination and replaces the prosthetic.

We have been told that hygienists are permitted to remove the prosthetic screws. However, are they also permitted to use a high-speed handpiece to remove the composite material that is often placed over the screws? Over the screws there is teflon tape and composite.

Doctor, please feel free to add anything I may have missed or clarify any details.

Thank you for your time and guidance, Mr. Puckett. We greatly appreciate your assistance!

Thank you,

Anna

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Section 328.31b - Maintenance and Retention of Written Records - Minimum Information – Format

A. Every dental office or treatment facility, whether individual, group or multi-doctor practice operating under a name, trade name or other professional entity shall maintain written records on each patient treated at the facility and shall make these records available to the Board of Dentistry and other regulatory entities or be subject to the penalties as set forth in Section 328.44a of this title.

B. Each licensed dentist shall maintain written records on each patient that shall contain, at a minimum, the following information about the patient:

1. A current health history listing known illnesses, other treating physicians and current medications prescribed;

2. Results of a clinical examination, including a physical intraoral examination and head and neck examination, tests conducted, and any lab results including the identification, or lack thereof, of any oral pathology or diseases;

3. Treatment plan proposed by the dentist; and

4. Treatment rendered to the patient. The patient record shall clearly identify the dentist and the dental hygienist or dental assistant providing the treatment with the dentist, specialty or dental hygienist license number. The patient record shall include documentation of any medications prescribed, administered or dispensed to the patient.

C. Prior to a dentist prescribing, diagnosing, or overseeing patient treatment for any dental appliance, the patient shall be a patient of record and the dentist shall conduct an in-person patient examination.

D. 1. The name of the dentist or dentists actually providing the dental services to the patient shall appear on all insurance claim forms.

2. Treatment records shall be maintained for each patient that clearly identify the dentist or dentists, hygienists or dental assistants who performed all dental services for the patient.

E. Whenever patient records are released or transferred, the dentist releasing or transferring the records shall maintain either the original records or copies thereof and a notation shall be made in the retained records indicating to whom the records were released or transferred.

F. All claims being submitted for insurance must be signed, stamped or have an electronic signature by the treating dentist.

G. Patient records may be kept in an electronic data format, provided that the dentist maintains a backup copy of information stored in the data processing system using disk, tape or other electronic back-up system and that backup is updated on a regular basis, at least weekly, to

assure that data is not lost due to system failure. Any electronic data system shall be capable of producing a hard copy on demand.

H. All patient records shall be maintained for seven (7) years from the date of treatment.

I. Each licensed dentist shall retain a copy of each entry in his or her patient appointment book, calendar, or such other log, calendar, book, file or computer data used in lieu of an appointment book for a period no less than seven (7) years from the date of each entry thereon.

J. A licensee closing an office shall notify the Board in writing and include the location of where the patient records will be maintained.

Procedural Sedation Record

Patient Selection Criteria

Date: _____

Patient: _____ Birth Sex ☐ M ☐ F DOB ___/___/___ Weight: _____kg Height: _____

Physician name/phone number: _____ BMI: _____ BMI% for age: ____

Indication for sedation:
- ☐ Fearful/anxious patient for whom basic behavior guidance techniques have not been successful
- ☐ Patient unable to cooperate due to lack of psychological or emotional maturity and/or mental, physical, or medical disability
- ☐ To protect patient's developing psyche
- ☐ To reduce patient's medical risk

Medical history/review of systems (ROS)	NO	YES*	Describe positive findings:
Allergies &/or previous adverse drug reactions	☐	☐	
Current medications (including OTC, herbal)	☐	☐	
Relevant diseases (including COVID)	☐	☐	
Previous sedation/general anesthetics	☐	☐	
Physical/neurologic impairment	☐	☐	
Snoring, obstructive sleep apnea, mouth breathing	☐	☐	
Relevant birth, family, or social history	☐	☐	
For female: Post-menarchal	☐	☐	

Airway Assessment	NO	YES*
Limited neck mobility	☐	☐
Micro/retrognathia	☐	☐
Limited oral opening	☐	☐
Macroglossia	☐	☐

Brodsky grading scale: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Mallampati classification: ☐ I ☐ II ☐ III ☐ IV

ASA classification: ☐ I ☐ II ☐ III* ☐ IV* ☐ E If any *, is medical consultation indicated? ☐ NO ☐ YES Date requested: _____

Comments: _____

Is this patient a candidate for in-office sedation? ☐ YES ☐ NO Doctor's signature: _____ Date: _____

Plan

	Name/relation to patient	Initials	Date	By
Informed consent for sedation obtained from				
for protective stabilization obtained from				
for dental procedures obtained from				
Preoperative instructions reviewed with				
Postoperative precautions reviewed with				

Scheduled for: Date: _____ Time: _____ with Dr.: _____

Assessment on Day of Sedation

Date: _____

Accompanied by: _____ and _____ Relationships to patient: _____

Medical Hx & ROS update	NO	YES
Change in medical hx/ROS	☐	☐
Change in medications	☐	☐
Recent respiratory illness/COVID	☐	☐
Pregnancy test indicated	☐	☐
Date: _____ Test: _____ Results: _____		

NPO status
Clear liquids ____hrs
Milk, other liquids, &/or foods ____hrs
Medications ____hrs

Airway assessment	NO	YES
Upper airway clear	☐	☐
Lungs clear	☐	☐
Tonsillar obstruction	☐	☐ (___%)
Weight: ____kg Height: ____cm		
BMI: ____ BMI % for age: ____		

Vital Signs (if unable to obtain, ckeck ☐)
Pulse: ____/min
SpO_2: ____%
BP: ____/____ mmHg
Resp: ____/min
Temp: ____°F

Presedation cooperation level: ☐ Unable/unwilling to cooperate ☐ Rarely follows requests ☐ Cooperates with prompting ☐ Cooperates freely

Behavioral interaction: ☐ Definitively shy and withdrawn ☐ Somewhat shy ☐ Approachable

Guardian was provided an opportunity to ask questions, appeared to understand, and reaffirmed consent for sedation? ☐ YES ☐ NO

Comments: _____

Safety Checklist

- ☐ Monitors tested & functioning as intended
- ☐ Emergency kit, suction, & high-flow oxygen
- ☐ No contraindication to procedural sedation
- ☐ Two adults present or extended time for discharge accepted

Drug Dosage Calculations

Sedatives

Agent _____ Route _____ _____mg/kg X _____kg = _____mg ÷ _____mg/mL = _____mL

Agent _____ Route _____ _____mg/kg X _____kg = _____mg ÷ _____mg/mL = _____mL

Agent _____ Route _____ _____mg/kg X _____kg = _____mg ÷ _____mg/mL = _____mL

Emergency reversal agents

For narcotic: NALOXONE IV, IM, or subQ Dose: 0.1 mg/kg X _____ kg = _____mg (maximum dose: 2 mg; may repeat to maintain reversal)

For benzodiazepine: FLUMAZENIL IV (preferred), IM Dose: 0.01 mg/kg X _____ kg = _____mg (maximum dose: 0.2 mg; may repeat up to 4 times)

Local anesthetics (maximum dosage is based on weight; to calculate **maximum volume**, divide maximum dosage by agent concentration)

2% Lidocaine 4.4 mg/kg X _____ kg = _____ mg ÷ 20 mg/mL = _____ mL

4% Articaine 7 mg/kg X _____ kg = _____ mg ÷ 40 mg/mL = _____ mL

3% Mepivacaine 4.4 mg/kg X _____ kg = _____ mg ÷ 30 mg/mL = _____ mL

0.5% Bupivacaine 1.3 mg/kg X _____ kg = _____ mg ÷ 5 mg/mL = _____ mL

Patient: _____ DOB ____/____/____ Date: _____

Intra- and Postoperative Management

EMS telephone number: _____

Timeout: ☐ Caregiver present for timeout ☐ Pt ID ☐ Agreement on procedure ☐ Tooth/surgical site _____
Planned level of sedation: ☐ Minimal ☐ Moderate ☐ Deep ☐ General anesthesia
Monitors: ☐ Observation ☐ Pulse oximeter ☐ Precordial/pretracheal stethoscope ☐ Blood pressure cuff ☐ Capnograph ☐ EKG ☐ Thermometer
Protective stabilization/devices: ☐ Papoose ☐ Head positioner ☐ Manual hold ☐ Neck/shoulder roll ☐ Mouth prop ☐ Rubber dam ☐ _____

TIME	Baseline	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Sedatives[1]																	
N_2O/O_2 (%)																	
Local[2] (mg)																	
SpO_2																	
Pulse																	
Blood pressure																	
Respiration																	
CO_2																	
Procedure[3]																	
Comments[4]																	
Sedation level†																	
Behavior[5]																	

1. Agent _____ Route _____ Dose _____ Time _____ Administered by _____
   Agent _____ Route _____ Dose _____ Time _____ Administered by _____
   Agent _____ Route _____ Dose _____ Time _____ Administered by _____
2. Local anesthetic agent _____
3. Record dental procedure (e.g., Start, Completion, Recovery, Discharge)
4. Enter letter on chart and corresponding comments (e.g., complications/side effects, airway intervention, reversal agent, analgesic) below:
   A. _____ B. _____ C. _____
   D. _____ E. _____ F. _____

† Sedation level
- None (typical response/cooperation for this patient)
- Minimal (anxiolysis)
- Moderate (purposeful response to verbal commands ± light tactile sensation)
- Deep (purposeful response after repeated verbal or painful stimulation
- General Anesthesia (not arousable)

§ Behavior/responsiveness to treatment
- Excellent: quiet and cooperative
- Good: mild objections &/or whimpering but treatment not interrupted
- Fair: crying with minimal disruption to treatment
- Poor: struggling that interfered with operative procedures
- Prohibitive: active resistance and crying; treatment cannot be rendered

Overall effectiveness: ☐ Ineffective ☐ Effective ☐ Very effective ☐ Overly sedated Was all planned treatment completed? ☐ Yes ☐ No
Comments: _____

Discharge

Criteria for discharge
- ☐ Cardiovascular function is satisfactory and stable.
- ☐ Airway patency is satisfactory and stable.
- ☐ Patient is easily arousable.
- ☐ Responsiveness is at or very near presedation level (especially if very young or special needs child incapable of the usually expected responses)
- ☐ Protective reflexes are intact.
- ☐ Patient can talk (return to presedation level).
- ☐ Patient can sit up unaided (return to presedation level).
- ☐ State of hydration is adequate.

Discharge vital signs
Pulse: _____/ min
SpO_2: _____%
BP: _____/_____ mmHg
Resp: _____/ min
Temp: _____°F

Discharge process
- ☐ Postoperative instructions reviewed with _____ by _____
  - ☐ Transportation ☐ Airway protection/observation ☐ Activity ☐ Diet ☐ Nausea/vomiting ☐ Fever ☐ Rx ☐ Anesthetized tissues
  - ☐ Dental treatment rendered ☐ Pain ☐ Bleeding ☐ _____ ☐ Emergency contact
- ☐ Next appointment on: _____ for _____

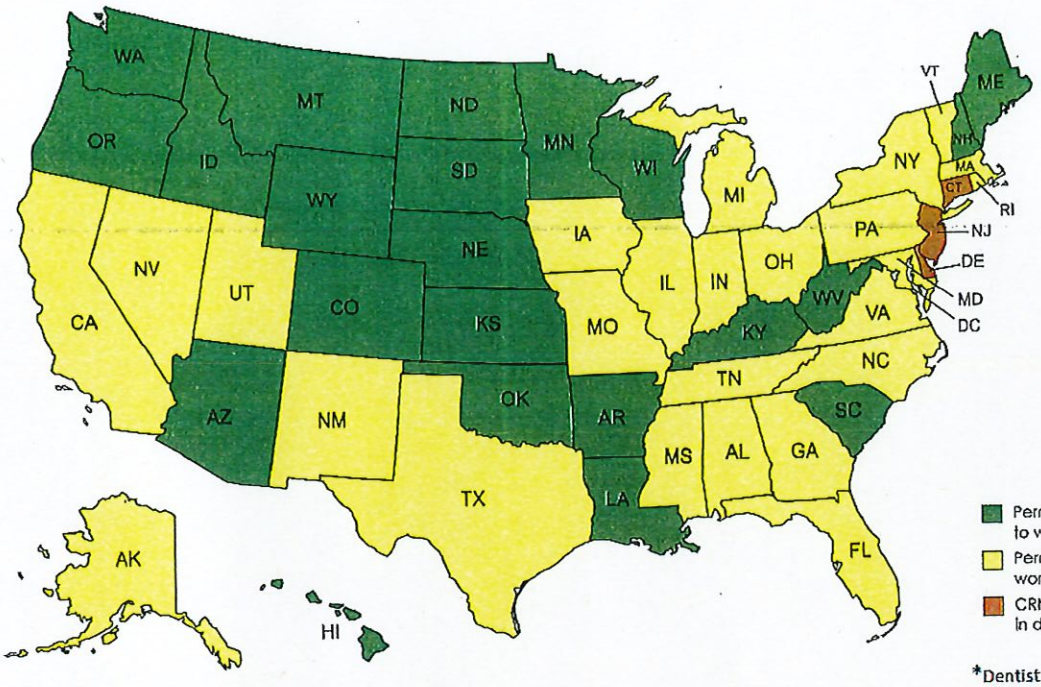
I have received and understand these discharge instructions. The patient is discharged into my care at _____ ☐ AM ☐ PM
Signature: _____ Relationship: _____ After hours number: _____

Operator/Dentist Signature: _____ Chairside Assistant: _____ Monitoring Personnel Signature: _____

Postoperative call

Date: _____ Time: _____ By: _____ Spoke to: _____ Comments: _____

State Dental Board Permit Status for CRNA Practice in Dental Offices



Created with mapchart.net

*Dentist administration permit status; does not concern facility permits

Virginia: Permit required for deep sedation/general anesthesia only

Indiana: Requires MD/DO direction and presence; an oral surgeon would need dual DDS/MD degree.

Source: AANA State Government Affairs Division

Do CRNAs have prescriptive authority? +

Do Anesthesiologist Assistants (AAs) have authority to practice? +

Has Texas opted out of the federal supervision requirement?

Are physician office settings regulated in my state?

State Licensure

Collaborative Practice Agreement between CRNA and Physician

This Collaborative Practice Agreement is being entered into between _____ ("CRNA"), and the physicians set forth on the signature pages hereto (each, a "Physician" and collectively, the "Physicians"). (the "Parties"). This Agreement shall guide the roles and responsibilities of the Parties in the collaborative care of patients requiring anesthetic services at Norman Regional Hospital ("Hospital"). This Agreement shall take affect when it has been signed by all Parties.

1. Recitals. CRNA is a Certified Registered Nurse Anesthetist licensed in the State of Oklahoma with privileges at the Hospital. Physician is a medical doctor, osteopathic physician, podiatric physician, or dentist licensed in Oklahoma and is a member of the Hospital's Medical Staff with clinical privileges at the Hospital. CRNA is permitted by law to administer anesthesia in collaboration with a medical doctor, osteopathic physician, podiatric physician, or dentist under conditions in which timely onsite consultation is available. This Agreement describes the terms under which the Parties will collaborate in the delivery of anesthesia to patients at the Hospital.

2. Collaboration Relationship. Prior to the administration of anesthesia to any Hospital patient, one of the Physicians listed below and CRNA shall agree that they are collaborating on the care of such patient, and such collaboration shall be reflected in the patient's medical record.

3. Physician Obligations. Physician agrees to provide the following services when serving as the collaborating physician with CRNA:

    a. actively work with CRNA to provide patient care, share responsibility, and make decisions regarding anesthesia;
    b. review and approve the medical treatment plan of the CRNA prior to treatment, as reflected in the patient's medical record;
    c. be available to provide timely onsite guidance to the CRNA, as warranted by the patient's medical conditions, from the time the patient is prepared for anesthesia service until the patient is placed under postoperative care; and
    d. timely review every patient medical record where treatment is provided by the CRNA and Physician is serving as the collaborating physician.

4. CRNA Obligations. CRNA agrees to provide the following services when providing collaborative care with Physician:

    a. CRNA shall actively work with Physician to provide patient care, share responsibility, and make decisions regarding anesthesia;
    b. CRNA may select, order and administer medications, including controlled substances, and apply appropriate medical devices for delivery of anesthesia services under the anesthesia plan agreed to by Physician.

5. Term. This Agreement shall remain in effect until the earlier of (i) written termination by a party with or without cause on not less than ten (10) day's notice; (ii) the date on which a party ceases to have clinical privileges at the Hospital; provided, however, termination

of this Agreement with respect to one of the Physicians listed below shall not affect the continuation of this Agreement with respect to the other Physicians listed below.

6. Alteration of Agreement. This Agreement may only be amended in writing in a document signed by both Parties.

Signature Page Follows

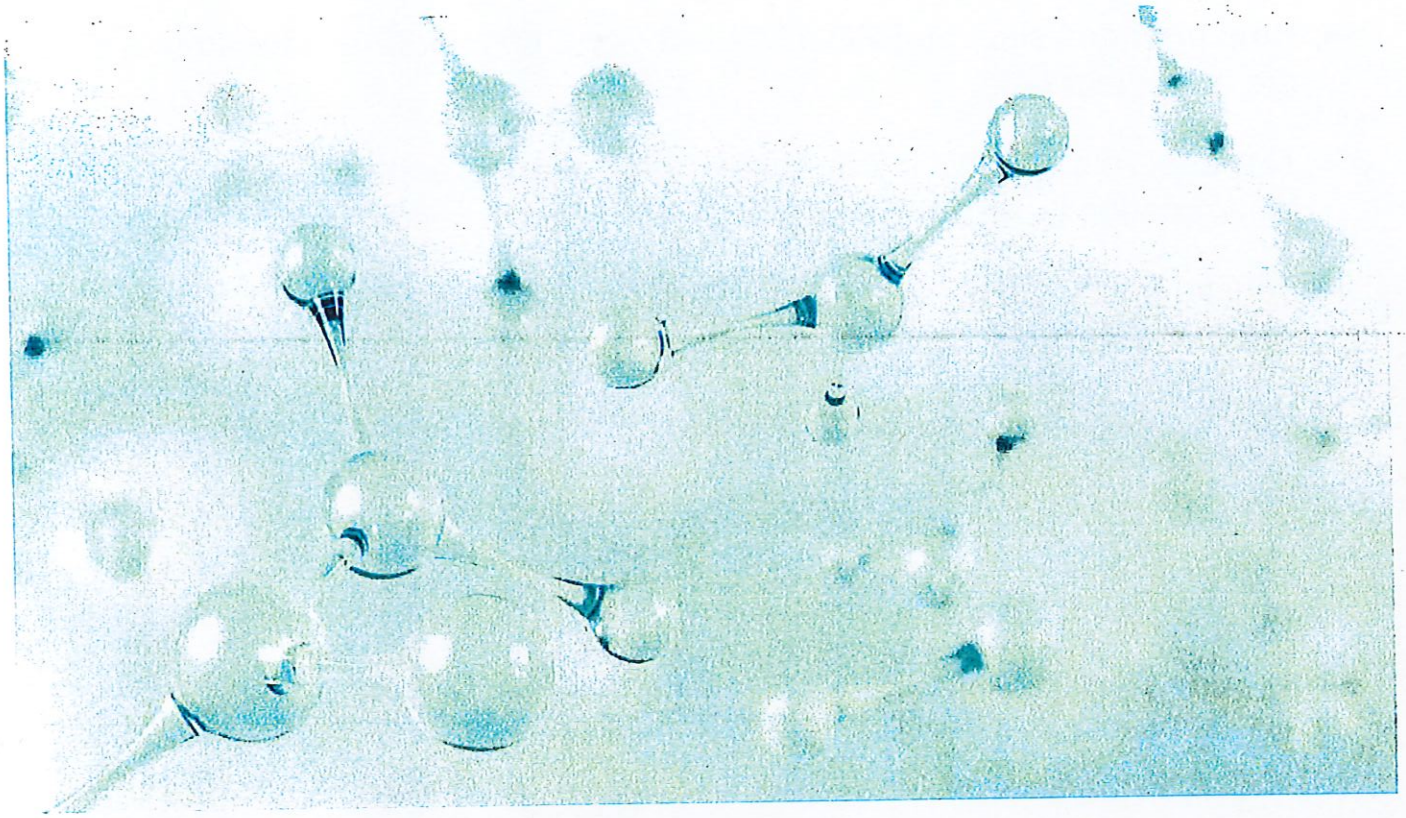
Physician:

Printed Name_____ License # and Type _____

Board Certification_____

Signature_____ Date_____

PERIO-IMPLANT ADVISORY™



CLINICAL TIPS

Peptides: What are they, and how can they be used in dentistry?

Peptides such as BPC-157 are emerging as powerful tools in regenerative and integrative medicine. Anti-inflammatory peptides can reduce gum disease, protect gastric tissues, and accelerate healing—making them a promising adjunct in both oral and systemic care.

Scott Froum, DDS Oct. 6, 2025 4 min read

What you'll learn in this article

- How peptides such as BPC-157, LL-37, and KPV modulate inflammation at the molecular level
- The dual role of BPC-157 in accelerating healing and reducing inflammation in both the oral cavity and gastrointestinal tract
- Clinical implications for periodontal therapy, implant integration, and mucosal healing
- Emerging evidence on the systemic benefits of peptides for broader tissue repair and recovery

What are peptides?

In the world of regenerative medicine and performance optimization, peptides have emerged as one of the most exciting breakthroughs. These short chains of amino acids—essentially the building blocks of proteins—act as signaling molecules in the body, instructing cells to repair, regenerate, or optimize specific functions. Beyond esthetics, peptides may play a crucial role in regenerative hard and soft tissue repair, metabolic control, weight management, and even long-term health.

As dental professionals, physicians, and wellness practitioners expand their scope into integrative health, understanding the science behind peptides can help us better educate patients and make informed decisions about adjunctive therapies. This article will focus on anti-inflammatory peptides that can be used to treat inflammation in both the mouth and stomach.

How can peptides decrease inflammation, thereby decreasing gum disease and gut problems?

Peptides such as BPC-157 (body protection compound 157), LL-37 (antimicrobial peptide LL-37), and KPV (a tripeptide fragment of alpha-MSH: Lys-Pro-Val) are gaining significant attention in functional medicine because of their potent anti-inflammatory properties. They work by modulating the immune response at a molecular level, helping to restore balance between pro-inflammatory and anti-inflammatory pathways. Although all these peptides work, the most amount of research to date has been on BPC-157.[1]

What is BPC-157?

BPC-157 is a synthetic peptide fragment derived from a naturally occurring protein in gastric juice. Its primary role is to accelerate healing, reduce inflammation, and promote angiogenesis (new blood vessel growth). Unlike many peptides, BPC-157 has strong stability in the acidic stomach environment, making oral formulations effective.

Mechanism of action in the mouth (oral cavity)

- **Wound healing:** Stimulates fibroblast activity, collagen synthesis, and keratinocyte migration, accelerating soft tissue repair (important for periodontal disease, oral ulcers, or mucosal trauma)[2]
- **Anti-inflammatory modulation[3]:** Reduces neutrophil and macrophage overactivation, limiting collateral damage to gum tissue
- **Bone and ligament support:** Early studies suggest BPC-157 promotes tendon-to-bone healing and osteogenesis, potentially relevant for periodontitis-related bone loss or implant integration.
- **Neuroprotective role[4]:** Modulates local nerve signaling, which may decrease neuropathic pain associated with chronic oral inflammation

Mechanism of action in the stomach (GI tract)[5]

- **Mucosal protection:** BPC-157 stabilizes and strengthens the gastric mucosal lining, helping prevent ulcers and tissue erosion.

- **Nitric oxide modulation:** It increases nitric oxide (NO) signaling, improving blood flow to gastric tissues and reducing ischemic injury.
- **Anti-inflammatory effects:** Downregulates pro-inflammatory cytokines (IL-6, TNF-α, IL-1β) and reduces oxidative stress
- **Gut barrier integrity:** Promotes repair of tight junctions, limiting "leaky gut" and preventing translocation of inflammatory molecules
- **Angiogenesis and collagen production:** Enhances growth of new blood vessels and collagen fibers, accelerating tissue repair after injury or chronic inflammation

How BPC-157 decreases inflammation[3]

- **Suppresses pro-inflammatory pathways:** Inhibits NF-κB signaling, reducing the cascade of inflammatory cytokines
- **Enhances anti-inflammatory factors:** Upregulates protective growth factors such as VEGF (vascular endothelial growth factor) and TGF-β
- **Reduces oxidative stress:** Neutralizes reactive oxygen species (ROS), decreasing tissue damage in the inflamed oral mucosa or stomach lining
- **Restores tissue balance:** Unlike broad anti-inflammatories (NSAIDs), BPC-157 doesn't shut down inflammation entirely; it rebalances immune activity to promote controlled healing.

Clinical implications

- **Oral health:** May accelerate recovery in periodontal surgery, mucosal ulcerations, and implant integration by reducing inflammation and promoting tissue repair. More studies are needed in this area.
- **Gastrointestinal health:** Protects against gastric ulcers, inflammatory bowel disease, and damage from NSAIDs or alcohol
- **Systemic effect:** Because of its stability and signaling capacity, oral BPC-157 may also support systemic healing in joints, tendons, and nerves.

Conclusion

Oral BPC-157 decreases inflammation in the mouth and stomach by repairing mucosal barriers, modulating cytokines, reducing oxidative stress, and promoting angiogenesis and collagen synthesis. This dual effect makes it a promising peptide for both dental and gastrointestinal healing.

Editor's note: This article originally appeared in *Perio-Implant Advisory*, a chairside resource for dentists and hygienists that focuses on periodontal- and implant-related issues. Read more articles and subscribe to the newsletter.

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Review

Peptides in Dentistry: A Scoping Review

Louis Hardan [1,†], Jean Claude Abou Chedid [2,†], Rim Bourgi [1,3], Carlos Enrique Cuevas-Suárez [4,*], Monika Lukomska-Szymanska [5], Vincenzo Tosco [6], Ana Josefina Monjarás-Ávila [4], Massa Jabra [7], Fouad Salloum-Yared [8], Naji Kharouf [3,9,*], Davide Mancino [3,9,10] and Youssef Haikel [3,9,10,*]

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Abstract: Currently, it remains unclear which specific peptides could be appropriate for applications in different fields of dentistry. The aim of this scoping review was to scan the contemporary scientific papers related to the types, uses and applications of peptides in dentistry at the moment. Literature database searches were performed in the following databases: PubMed/MEDLINE, Scopus, Web of Science, Embase, and Scielo. A total of 133 articles involving the use of peptides in dentistry-related applications were included. The studies involved experimental designs in animals, microorganisms, or cells; clinical trials were also identified within this review. Most of the applications of peptides included caries management, implant osseointegration, guided tissue regeneration, vital pulp therapy, antimicrobial activity, enamel remineralization, periodontal therapy, the surface modification of tooth implants, and the modification of other restorative materials such as dental adhesives and denture base resins. The in vitro and in vivo studies included in this review suggested that peptides may have beneficial effects for treating early carious lesions, promoting cell adhesion, enhancing the adhesion strength of dental implants, and in tissue engineering as healthy promotors of the periodontium and antimicrobial agents. The lack of clinical trials should be highlighted, leaving a wide space available for the investigation of peptides in dentistry.

Keywords: antimicrobial; osseointegration; surface modification; tissue engineering

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1. Introduction

Dental plaques contain over 750 different bacterial species, which are the major reason for dental caries, with streptococci being the most predominantly present. These bacteria, due to the production of acids, can demineralize and affect mineralized tooth tissues [1]. Different additives and biomaterials were used in dental treatments in order to eliminate and decrease the number of bacteria in the oral cavity and teeth tissues. Some dental materials, such as calcium silicate-based products, have been introduced in the dental market due to their antibacterial, antioxidant and remineralization properties [2]. Other solutions

that have antibacterial effects are used to clean the root canal and kill resistant bacteria in the root canal system [3]. Even though they sometimes display high cytotoxicity [4,5], these materials are still currently used in dentistry.

It should be remembered that a peptide is expressed as a short polymer of amino acids (AA) [6]. According to the description of diverse authors in the literature, sizes of peptides may vary from <20, <50, to <100 [7–10]. The use of peptides has been paid attention to over the last two decades [6,11]. These peptides were used in various dental fields such as in endodontic treatment, coronal restoration, caries management, bone and dental tissue remineralization and in the modification of dental materials in order to promote the biological effects of these materials in the oral environment [6,12].

In the last periods, over 7000 native peptides (NP) have been considered by means of significant human physiological functions [13]. These peptides have functions by way of cell-penetrating, cell adhesion motifs, tumor-homing peptides, neuropeptides, structural peptides, peptide hormones, antimicrobial peptides, peptide tags, matrix metalloprotease substrates, growth factors, amyloid peptides, and erstwhile diverse NPs [10].

Nevertheless, one should state that NPs are frequently not truthfully appropriate for therapeutic usage since they have intrinsic drawbacks, including their poor physical and chemical stability, low oral bioavailability, short flowing plasma half-life, and quick removal from the circulation through the kidneys and the liver [9,13,14]. It is well described that peptides such as insulin and adrenocorticotrophic hormone were used for human therapeutic purposes in the first half of the 20th century [15]. Later on, synthetic oxytocin and vasopressin arrived in clinical use in the 1950s with the chemical elucidation of the sequences of these peptides [16].

Lately, pharmaceutical manufacturing has amplified the consideration of novel therapeutic peptides, persistently touching clinical claims [9,17]. By 2018, more than 60 peptides were approved by the Food and Drug Administration (FDA), and more than 600 were undergoing preclinical and clinical examinations [9,18]. With the current elaborations of solid-phase peptide synthesis, the production of therapeutic synthetic peptides (SP) has become achievable [9]. Accordingly, innovative synthetic approaches permit the modulation of pharmacokinetic assets and focus on specificity through AAs, the integration of non-natural AAs, backbone adjustments, and the peptide conjugates refining solubility or prolonging the half-life [8,13,14].

It is recognized that human dental masses, once fashioned, cannot be biologically replaced or repaired, and their multifaceted conformations require diverse approaches for regeneration [6]. However, it is unclear in the literature which specific peptides could be effective for applications in different fields of dentistry. Thus, the aim of this scoping review was to map the contemporary scientific papers related to the use and applications of peptides in dentistry at present.

2. Materials and Methods

The present scoping review has been described according to the PRISMA extension for scoping reviews guideline [19]. The review protocol was registered at Open Science Framework, and it is available at https://osf.io/up6ty (accessed on 18 December 2022). The systematic search was performed according to the following parameters: (i) population: peer-reviewed articles; (ii) intervention: use of natural or synthetic peptides; (iii) comparison: other substances or treatments; (iv) outcome: dental applications, (v) study design: in vitro or in vivo articles. The general question of the review was as follows: what scientific applications of products based on peptides are being used for dental applications?

2.1. Information Sources and Search

The literature database search was performed by two independent reviewers (RB and CECS) until September 2022. The search was carried out in the following databases: PubMed/MEDLINE, Scopus, Web of Science, Embase, and Scielo. The search strategy was first defined for the MEDLINE database using a controlled vocabulary and free keywords

(Table 1). The MEDLINE search strategy was then adapted to other electronic databases. The reviewers also hand-searched the reference lists of the included articles to identify additional manuscripts.

Table 1. Search strategy used in the MEDLINE database.

(Peptide) OR (Polypeptides) OR (Polypeptide) AND (Materials, Dental) OR (Dental Material) OR (Material, Dental)

2.2. Selection Process and Data Collection Process

After running the search strategy, a reference management program was used (EndNote X9, Clarivate Analytics, Philadelphia, PA, USA) to store the files of all databases. Then, duplicate articles were removed, followed by manual removal after the organization of titles in alphabetical order. All studies were initially scanned for relevance by title followed by abstract using an online software program (Rayyan, Qatar Computing Research Institute, HBKU, Doha, Qatar). The titles and abstracts of the articles were screened according to the following inclusion criterium: in vitro or in vivo studies that evaluated or reported the use of peptides for dental applications. The search was carried out on documents published in any language without restrictions on their date of publication. Reviews, case reports, case series, pilot studies, and conference abstracts were excluded. If the review authors were not sure about the eligibility of any study, it was kept for the next phase. All phases were carried out by two independent reviewers (RB and CECS) to check whether they met the inclusion criteria. The same two reviewers summarized and categorized the data using a standardized form. The information collected included the type of study, the peptide used, the application proposed and the main results.

3. Results

This scoping review is described according to the PRISMA extension for scoping reviews guideline [19]. After database screening and duplicate removal, a total of 6450 articles were recognized (Figure 1). After title and abstract screening, 156 articles remained for full-text inspection. From the 156 articles assessed for eligibility, 23 articles were excluded due to the following reasons: in 11 articles, the full text was not retrieved [20–30], 4 articles were not related to the dentistry field [31–34], 4 studies were reviews [6,12,35,36], 3 studies were not related to peptides [37–39], and 1 study was a pilot clinical trial [40]. Thus, a total of 133 articles were included in the present review.

3.1. Characteristics of Studies

The main characteristics of the studies included in the present review are presented in Table 2.

Table 2. Characteristics of the included studies.

Study and Year	Type of Study	Peptide Used	Application	Main Results
Bagno, 2007 [41]	In vitro	Two adhesive peptides: an RGD-containing peptide and a peptide recorded on human vitronectin	Implant osseointegration	It was observed that there was a capacity of the peptides to promote enhanced cell adhesion
Artzi, 2006 [42]	Experimental study	A synthetic peptide (P-15)	Guided tissue regeneration and guided bone regeneration techniques	The use of a synthetic peptide showed increased osteoconductive and biocompatible features
Bröseler, 2020 [43]	Randomized clinical trial	Self-assembling peptide (SAP) P11-4	Early buccal carious lesions	Self-assembling peptide regenerated enamel caries lesions

Table 2. *Cont.*

Study and Year	Type of Study	Peptide Used	Application	Main Results
Butz, 2011 [44]	Prospective in vivo study	Synthetic Peptide in a Sodium Hyaluronate Carrier (PepGen P-15 Putty)	Sinus grafting	The peptide evaluated was successful for maxillary sinus augmentation
Chung, 2013 [45]	In vitro	Asparagine–serine–serine (NSS) peptide.	Remineralization of eroded enamel.	Peptide increased the nanohardness and elastic modulus of eroded enamel
Altankhishig, 2021 [46]	In vitro and in vivo	Peptide	Vital pulp therapy	The dentin phosphophoryn-derived arginine-glycine-aspartic acid-containing peptide showed adequate properties as a bioactive material for dentin regeneration
Afami, 2021 [47]	In vitro	Ultrashort peptide hydrogel, (naphthalene-2-ly)-acetyl-diphenylalanine-dilysine-OH (NapFFεKεK-OH)	Antimicrobial activity and angiogenic growth factor release by dental pulp stem/stromal cells	Peptide-containing hydrogels have potential in tissue engineering for pulp regeneration
Babaji, 2019 [48]	In vitro	SAP P11-4 and casein phosphopeptides-amorphous calcium phosphate (CPP-ACP)	Enamel remineralization	The peptide was more effective and efficient when compared to CPP-ACP
Dettin, 2002 [49]	In vitro	Novel osteoblast-adhesive peptides	Osteoblast adhesion	The novel peptide promotes proteoglycan-mediated osteoblast adhesion efficiently
Cirera, 2019 [50]	In vivo	TGF-β1 inhibitor peptide: P144	Osseointegration of synthetic bone grafts	The healing period of osseointegrated biomaterials can be shortened when peptide biofunctionalization is used
Boda, 2020 [51]	In vitro	Mineralized nanofiber segments combined with calcium-binding bone morphogenetic protein 2 (BMP-2)-mimicking peptides	Alveolar bone regeneration	Mineralized nanofibers functionalized with peptides have the potential to regenerate craniofacial bone defects
Chen, 2017 [52]	In vivo	GL13K-peptide	Osseointegration of implants	This study showed that titanium dental implants with an antimicrobial GL13K peptide coating enables in vivo implant osseointegration
Aref, 2022 [53]	In vitro	CPP-ACP	White spot lesion	CPP-ACP could be a promising approach to manage WSLs efficiently, with subsequent universal adhesive resin infiltration
Aruna, 2015 [54]	Clinical	Gingival crevicular fluid (GCF) N-terminal telopeptides of type I collagen (NTx)	Periodontal therapy	Cross-linked NTx can be successfully estimated in the GCF of chronic periodontitis subjects
Brunton, 2013 [55]	A clinical trial	Biomimetic SAP: P11-4	Early caries lesions	Treatment of early caries lesions with P11-4 is safe, and a single application of this peptide is associated with significant enamel regeneration

P162

Table 2. *Cont.*

Study and Year	Type of Study	Peptide Used	Application	Main Results
Fang, 2020 [56]	In vitro	Two hexapeptide coatings	Dental implants	The novel hexapeptide coating can inhibit the attachment of Porphyromonas gingivalis and prevent the formation of dental biofilm
Goldberg, 2009 [57]	In vitro	Polypeptide	Occluding dentin tubules	Peptide catalysts that mediate mineral formation can retain functionality on dentin, suggesting a wide range of preventive and treatment strategies
Amin, 2012 [58]	In vitro	Amelogenin Peptides	Osteogenic differentiation	Amelogenin-derived peptide could be a useful tool for limiting pathological bone cell growth
Godoy-Gallardo, 2015 [59]	In vitro	hLf1-11 Peptide	Antibacterial properties on titanium surfaces	A greater amount of peptide attached to the surfaces functionalized via atom transfer radical polymerization than those functionalized via silane
Dommisch, 2019 [60]	In vivo and in vitro	Antimicrobial peptides	Gingival inflammation	The study delivers evidence on the role of antimicrobial peptides as guardians of a healthy periodontium
Dommisch, 2015 [61]	Experimental study	Antimicrobial peptides	Gingivitis	Differential temporal expression for antimicrobial peptides could guarantee continuous antimicrobial activity alongside changes in the bacterial composition of the growing dental biofilm
Fernandez-Garcia, 2015 [62]	In vitro	Peptide-functionalized zirconia	Implant	Surface bioactivation of zirconia-containing constituents for dental implant applications will allow their perfected clinical implementation by incorporating signaling oligopeptides to accelerate osseointegration, improve mucosal sealing, and/or incorporate antimicrobial properties to avoid peri-implant infections
Fiorellini, 2016 [63]	In vitro	Osteopontin-derived synthetic peptide: OC-1016	Osseointegration of implants	OC-1016 was capable of meaningfully accelerating the initial stage of osseointegration and bone healing around implants
Goeke, 2018 [64]	Clinical	Antimicrobial peptides	Caries risk	The incidence of low-susceptible strains to antimicrobial peptides appears to relate to individual caries status

Table 2. *Cont.*

Study and Year	Type of Study	Peptide Used	Application	Main Results
Galler, 2012 [65]	In vitro	SAP hydrogel	Dental pulp tissue engineering	The use of this innovative biomaterial was considered a highly favorable candidate for upcoming treatment hypotheses in regenerative endodontics
Kirkham, 2007 [66]	In situ	SAP scaffolds	Enamel remineralization	SAP might be useful for dental tissue engineering
Kämmerer, 2011 [67]	In vitro	RGD peptides	Dental implants	Modifications of titanium surfaces with c-RGD peptides are an encouraging way to endorse endothelial cell growth
Golland, 2017 [68]	In vitro	SAP	Remineralization of white spot lesions	The application of SAP on demineralized bovine enamel indicated an irregular crystal or a lack of remineralization
Hsu, 2010 [69]	In vitro	Aspartate-serine-serine (8DSS) pep- tides	Nucleation of calcium phosphate carbonate from free ions	8DSS peptides reduced the surface roughness of demineralized enamel and promoted the uniform deposition of nano-crystalline calcium phosphate carbonate over demineralized enamel surfaces
Kwak, 2017 [70]	In vitro	Leucine-rich amelogenin peptide (LRAP)	Enamel regeneration	LRAP has the power to enhance the linear growth of mature enamel crystals
Kong, 2015 [71]	In vivo	Histatin-5 (Hst-5)	Oral Candidiasis	Hst-5 was able to clear existing lesions
Koch, 2019 [72]	In vitro	SAP: P11-4 and P11-28/29	Periodontal therapy	SAP hydrogels were effective for periodontal therapy
Hashimoto, 2011 [73]	In vitro	Peptide motif	Zirconia	A peptide motif was successful in binding zirconia
Kind, 2017 [74]	In vitro	SAP: P11-4	Remineralization of carious lesions	The application of P11-4 might facilitate the subsurface regeneration of the enamel lesion
Gonçalves, 2020 [75]	In vitro	Casein phosphopeptide-amorphous calcium phosphate (MI Paste Plus)	Enamel demineralization and dental caries	MI Paste Plus might be effective in improving oral health
Kim, 2019 [76]	In vitro and in vivo	A laminin-derived functional peptide	Implant	Peptide DN3 promotes bone healing
Kohgo, 2011 [77]	In vitro	SAP	Implant	SAP could be useful for bone regeneration around dental implants
Gungormus, 2012 [78]	Ex vivo	Amelogenin-derived peptides	Periodontal tissues	Amelogenin-derived peptide 5 promoted the regeneration of periodontal tissues

P164

Table 2. *Cont.*

Study and Year	Type of Study	Peptide Used	Application	Main Results
Kakegawa, 2010 [79]	In vitro	Enamel sheath protein peptides	Construction of the enamel sheath during tooth development	A specific peptide sequence encourages the cytodifferentiation and mineralization activity of human periodontal ligaments
Kramer, 2009 [80]	In vitro	Integrin blocking peptide	Titanium surfaces	Antibody and peptide treatment reduced the number of fibroblast cells involved on the implant surfaces
Hua, 2010 [81]	In vitro	Antimicrobial peptide	Oral cavity	The antimicrobial peptide was demonstrated as an anti-Candida agent
Hua, 2010 [81]	In vitro	Antimicrobial peptide	Oral cavity	The antimicrobial peptide exhibits potent activity against both *A. actinomycetemcomitans* and *P. gingivalis* biofilms
Kohlgraf, 2010 [82]	In vitro	Human neutrophil peptide α-defensins (HNPs)	Cytokine responses	The ability of HNPs to attenuate proinflammatory cytokines was dependent upon both the defensin and antigen of *P. gingivalis*
Holmberg, 2013 [83]	In vitro	Antimicrobial peptide: GL13K	Dental and orthopedic implants	The antimicrobial activity and cytocompatibility of GL13K-biofunctionalized titanium make it a promising candidate for sustained inhibition of bacterial biofilm growth
Koidou, 2019 [84]	In vitro	Bioinspired peptide coatings	Peri-implant mucosal Seal	Peptide coatings were considered a promising candidate for inducing a peri-mucosal seal around dental implants
Knaup, 2021 [85]	In vitro	SAP: P11-4	Metal brackets	The application of the caries-protective SAP P11-4 before the bonding of brackets did not influence the shear bond strength
Kihara, 2018 [86]	In vitro	Novel synthetic peptide (A10)	Titanium surface	The novel peptide has a useful presentation that might enhance advanced clinical outcomes by means of titanium implants and abutments by preventing or reducing peri-implant disease
Jablonski-Momeni, 2020 [87]	In vitro	SAP P11-4	Early enamel lesions adjacent to orthodontic brackets	The application of p11-4 with fluoride varnish was demonstrated to be superior for the remineralization of enamel adjacent to brackets when compared to the use of fluorides alone
Kamal, 2018 [88]	In vitro	SAP P11-4	Artificially induced enamel lesions	SAP confers a higher remineralizing efficacy
Mao, 2021 [89]	In vitro	CPP-ACP	Dental caries	The use of 5% CPP-ACP reduced 39% of bacterial biofilm

Table 2. *Cont.*

Study and Year	Type of Study	Peptide Used	Application	Main Results
Makihira, 2011 [90]	In vivo	Antimicrobial peptide derived from histatin: JH8194	Dental implant	JH8194 might deliver a viable biological modification of titanium surfaces to amplify trabecular bone formation around dental implants
Li, 2014 [91]	In vitro	Synthetic and self-assembled oligopeptide amphiphile (OPA)	Mineralization of enamel	OPA was successful in the biomimetic mineralization of demineralized enamel
Liu, 2016 [92]	Experimental	Chimeric peptides comprising antimicrobial and titanium-binding motifs	Biofilm formation	Chimeric peptides provide a promising alternative to inhibit the formation of biofilms on titanium surfaces with the power to prevent peri-implantitis
Min, 2013 [93]	In vitro	Laminin-derived functional peptide, Ln2-P3	Implant	An Ln2-P3-coated implant surface enhances bone cell adhesion
Moore, 2015 [94]	Ex vivo	Multidomain peptide hydrogels	Dental pulp	Multidomain peptide hydrogels offered centrally and peripherally within whole dental pulp tissue are demonstrated to be biocompatible and preserve the architecture of the local tissue
Muruve, 2017 [95]	In vitro	PEGylated metal-binding peptide (D-K122-4-PEG)	Titanium surface	D-K122-4-PEG promotes resistance to corrosion
Nguyen, 2018 [96]	In vitro	Dentinogenic peptide	Dental pulp stem cells	The SAP promised guided dentinogenesis
Mardas, 2007 [97]	An experimental study in rats	PepGen	Bone regeneration	The anorganic bovine-derived hydroxyapatite matrix coupled with a synthetic cell-binding peptide failed to promote new bone formation
Mateescu, 2015 [98]	In vitro	Antimicrobial peptide Cateslytin	Peri-implant diseases	The new peptide could be ideal in the prevention of peri-implant diseases
Liu, 2021 [99]	In vitro	RADA16-I: (SAP)	Pulp regeneration	The novel SAP could be ideal in endodontic tissue engineering
Li, 2020 [100]	In vitro	GH12: antimicrobial peptide	Root canal irrigant	GH12 suppressed *E. faecali* in dentinal tubules
Mancino, 2022 [101]	In vitro	Catestatin-derived peptides	Oral candidiasis	The catestatin-derived peptides were considered for the treatment of oral candidiasis
Mai, 2016 [102]	In vitro	Antimicrobial peptides	Caries and pulpal infections	Antimicrobial peptide mimics offer opportunities for new therapeutics in regenerative endodontics and root canal treatments
Lv, 2015 [103]	In vitro	Amelogenin based peptide	Remineralization of initial enamel caries	The amelogenin-based peptide enhances enamel caries remineralization
Lee, 2007 [104]	In vitro and in vivo	Collagen-binding peptide	Osteogenesis	Collagen-binding peptide induced biomineralization of bone

P166

Table 2. *Cont.*

Study and Year	Type of Study	Peptide Used	Application	Main Results
Liang, 2018 [105]	In vitro	8DSS peptide	Dentinal tubule occlusion	8DSS peptide induced strong dentinal tubule occlusion and can be used in dentin hypersensitivity
Lee, 2018 [106]	In vitro and in vivo	Bone formation peptide-1 (BFP1)	Bone regeneration	BFP1 was considered promising for bone repair
Na, 2005 [107]	Preformulation study	Antimicrobial decapeptide (KSL)	Antiplaque agent	KSL served as a novel antiplaque agent in the oral cavity
Magalhães, 2022 [108]	In vitro	Self-assembly peptide: P11-4	Bleached enamel	The use of P11-4 after bleaching results in the fastest recovery to baseline enamel properties
Lallier, 2003 [109]	In vitro	Collagen-binding peptide P-15	Periodontal treatment	P-15 promoted fibroblast attachment to root surfaces
Li, 2021 [110]	In vitro	Small-size peptide: RR9	Oral streptococci	RR9 might be considered a possible antimicrobial agent for periodontal disease
Matsugishi, 2021 [111]	In vitro	Rice peptide	Biofilm formation	Rice peptide hindered the biofilm formation of *F. nucleatum* and *P. gingivalis*
Li, 2022 [112]	In vitro	Amelogenin-based peptide hydrogel	Human dental pulp cells	The amelogenin peptide hydrogel enhanced mineralization and encouraged odontogenic differentiation
Mishra, 2019 [113]	A randomized clinical trial	Anorganic bone matrix/cell-binding peptide (ABM/P-15)	Human infrabony periodontal defects	The combination of ABM/P-15 was established to be a favorable material for periodontal regeneration
Padovano, 2015 [114]	In vitro	DMP1-derived peptides	Remineralization of human dentin	DMP1-derived peptides could be useful in modulating mineral deposition
Park, 2020 [115]	In vitro	BMP-mimetic peptide	Dental pulp stem cells	BMP-mimetic peptide accelerated human dental pulp stem cells
Pellissari, 2021 [116]	In vitro	Statherin-derived peptides	Biofilm development	The natural peptides from statherin are able to decrease biofilm proliferation and Candida albicans colonization
Petzold, 2012 [117]	In vivo	Proline-rich synthetic peptide	Titanium implants	Proline-rich peptides have a probable biocompatible capacity for endorsing osseointegration by lessening bone resorption
Picker, 2014 [118]	In vitro	Binding peptides	Calcium silicate hydrate	A new strong calcium silicate hydrate-binding additive influenced the physical properties of cement
Pihl, 2021 [119]	In vivo	Antimicrobial peptide: RRP9W4N	Titania implant	RRP9W4N was demonstrated to be successful in the control of infection in osseointegrating implants

Table 2. *Cont.*

Study and Year	Type of Study	Peptide Used	Application	Main Results
Ren, 2018 [120]	In vitro	Chitosan hydrogel containing amelogenin-derived peptide	Initial caries lesions	Chitosan hydrogel containing amelogenin-derived peptide was demonstrated to be effective in controlling caries and promoting the remineralization of the initial enamel carious lesion
Santarpia, 1991 [121]	In vivo	Histidine-rich polypeptides	Denture stomatitis	Histidine-rich polypeptides were effective in the treatment of denture stomatitis
Schmidlin, 2015 [122]	In vitro	SAP	Mineralization of artificial caries lesions	SAP improved the hardness profile of deep demineralized artificial lesions
Schmitt, 2016 [123]	In vivo	Synthetic peptide (P-15)	Osseointegration	There is no advantage in the early phase of osseointegration for dental implants with P-15-containing surfaces
Schuler, 2006 [124]	In vitro	RGDSP-peptide sequence	Titanium dental implant	There is no communication between RGD-peptide surface density and surface topography for osteoblasts
Schuster, 2020 [125]	In vitro	Hydroxyapatite/BMP-2 mimetic peptide	Bone tissue engineering	Biofunctionalization of collagen-hydroxyapatite composites with BMP-2 simulated peptides was considered cost-effective and fast for prolonged and improved jaw periosteal cell proliferation
Secchi, 2007 [126]	In vitro	Arginine-glycine-aspartic acid (RGDS) peptides	Implant	The modification of the titanium surface with RGDS peptides promoted osseointegration
Segvich, 2009 [127]	In vitro	Binding peptide sequences	Bone regeneration	The binding peptide sequences can be used in dentin and bone tissue engineering
Sfeir, 2014 [128]	In vitro	Multiphosphorylated peptides	Mineralized collagen fibrils of bone and dentin	Using phosphopeptides, there is progress in biomimetic nanostructured materials for mineralized tissue regeneration and repair
Shi, 2015 [129]	In vitro	Antimicrobial peptide-loaded coatings	Dental implant	The antimicrobial peptide-loaded coatings were demonstrated to be a potential approach for preventing peri-implantitis
Shinkai, 2010 [130]	In vitro	Synthetic peptides derived from dentin matrix protein 1 (pA and pB)	Direct pulp capping and bonding agent	The primer containing synthetic peptides derived from dentin matrix protein 1 negatively affected the bond strength to dentin

Table 2. *Cont.*

Study and Year	Type of Study	Peptide Used	Application	Main Results
Shinkai, 2010 [131]	In vitro	Synthetic peptides (pA and pB)	Bonding agent	A significant difference was seen in bond strength among $CaCl_2$ concentrations in Primer-I (comprising 10 wt.% $CaCl_2$) and pA/pB concentrations in Primer-II comprising 10 wt.% pA/pB, and there is a noteworthy interaction between these two factors
Shuturminska, 2017 [132]	In vitro	Statherin-derived peptide	Enamel biomineralization	The use of statherin-derived peptide was considered effective in enamel therapy
Su, 2017 [133]	In vitro	Peptide nisin	Dental adhesive	The cured nisin included in the dental adhesive showed a noteworthy inhibitory effect on the growth of *S. mutans*
Suaid, 2010 [134]	Histologic and histomorphometric study	Anorganic bone matrix–synthetic cell-binding peptide 15	Periodontal class III furcation defects	The use of anorganic bone matrix–synthetic cell-binding peptide 15 was effective in bone formation
Sugawara, 2016 [135]	In vitro	Platelet-activating peptide	Titanium surface	An epithelial basement membrane was formed on the titanium surface when platelet activating peptide was used
Sun, 2016 [136]	Clinical	Peptidome	Early childhood caries	The magnetic bead-founded matrix-assisted laser desorption/ionization time-of-flight mass spectrometry was considered an effective technique for screening distinctive peptides from the saliva of junior patients with early childhood caries
Takahashi, 2002 [137]	In vitro	Dipeptide: aspartylaspartate and glutamylglutamate	Periodontal pathogens	Dipeptides can be employed as growth substrates for *P. intermedia*, *P. gingivalis*, *F. nucleatum*, and *P. nigrescens*
Tanhaieian, 2020 [138]	In vitro	Recombinant peptide	Dental diseases	The recombinant peptide was demonstrated effective as an antimicrobial agent against *E. faecalis* and oral streptococci
Üstün, 2019 [139]	In vitro	SAP: P11-4	Artificial enamel lesions	P11-4 was demonstrated to have the best remineralization efficacy
Wag, 2020 [140]	In vivo	Neural peptide	Angiogenesis and osteogenesis around oral implants	Alpha-calcitonin gene-related peptide up-regulated the expression of Hippo-YAP and downstream genes in order to encourage osteogenesis and angiogenesis around the implants

Table 2. *Cont.*

Study and Year	Type of Study	Peptide Used	Application	Main Results
Wang, 2015 [141]	In vitro	Peptide DJK-5	Dentin canals	The peptide DJK-5 showed an imperative antibacterial property against mono- and multispecies biofilms in dentin canals
Warnke, 2013 [142]	In vitro	Human beta-defensins (HBDs), small cationic antimicrobial peptides	Dental implants	HBD-2 is not only biocompatible with but further encourages the proliferation of human mesenchymal stem cells
Wener, 2009 [143]	In vitro	Laminin-derived peptide	Dental implants	Laminin-derived peptide improved and enhanced the integration of soft tissue on titanium implants used in dentistry
Winfred, 2014 [144]	In vitro	Cationic peptides	Endodontic procedures	Cationic peptides prevented the spread of endodontic infections
Wu, 2022 [145]	In vitro	TGF-β1 binding peptide–modified bioglass	Endodontic therapy	TGF-β1 binding peptide–modified bioglass was effective for regeneration in endodontic therapy
Xue Xie, 2019 [146]	In vitro	Antimicrobial peptide	Dental adhesive system	Antimicrobial peptide-hydrophilic adhesive delivers an advanced adhesive/dentin interface
Xue Xie, 2020 [147]	In vitro	Antimicrobial peptide	Dental adhesive system	Peptide-conjugated dentin adhesives were effective in secondary caries treatment and improved the durability of dental composites
Yakufu, 2020 [147]	In vitro	Osteogenic growth peptide (OGP)	Osteogenesis activity	OGP was promising in dental and orthopedic applications
Yamamoto, 2012 [148]	In vivo	Peptide including Arg-Gly-Asp (RGD) sequence	Periodontal ligament cells	Glial cell line-derived neurotrophic factor, which was hindered by pre-treatment with the peptide-embracing Arg-Gly-Asp (RGD) sequence, enhanced the appearance of bone sialoprotein and fibronectin on human periodontal ligament cells
Yamashita, 2010 [149]	In vitro	Anabolic peptide	Periodontal regeneration	Anabolic peptide has a positive influence on bone cells
Yang, 2017 [150]	In vitro	Peptide-modified tannic acid	Hydroxyapatite surface	Peptide-modified tannic acid inhibited the adhesion of bacteria
Yang, 2018 [151]	In vitro	Salivary acquired pellicle (SAPe)-inspired peptide DDDEEK	Biofilms	SAPe-inspired peptide DDDEEK has a great advantage in the field of implant materials

Table 2. *Cont.*

Study and Year	Type of Study	Peptide Used	Application	Main Results
Yang, 2017 [152]	In vitro and in vivo	Bioinspired peptide-decorated tannic acid	Remineralization of tooth enamel	Bioinspired peptide-decorated tannic acid has a good influence on the remineralization of tooth enamel
Yang, 2019 [153]	In vitro	Dual-functional polypeptide	Implant materials	Dual-functional polypeptide has a potential application in the treatment of hard tissue-related diseases
Yang, 2019 (b) [154]	In vitro and in vivo	Immunomodulatory peptide 1018	Plaque biofilms	Immunomodulatory peptide 1018 was effective as an anti-biofilm agent
Yang, 2017 (b) [155]	In vitro	DpSpSEEKC peptide	Demineralized tooth enamel	DpSpSEEKC restored demineralized tooth enamel
Yang, 2020 [156]	In vitro	Cell-adhesion peptides via polydopamine crosslinking	Zirconia abutment surfaces	Cell-adhesion peptides improved soft tissue integration around zirconia abutments via polydopamine crosslinking
Yazici, 2013 [157]	In vitro	Modular peptides	Titanium implant	Modular peptides on titanium surfaces improved the bioactivity of fibroblast and osteoblast cells on implant-grade materials
Ye, 2017 [158]	In vitro	Peptide-based approach	Adhesive-dentin interface	The peptide-based remineralization approach was effective in designing integrated tissue-biomaterial interfaces
Ye, 2019 [159]	In vitro	*D-enantiomeric* and *L-enantiomeric* antimicrobial peptides	Root canal wall biofilms	*D-enantiomeric* peptides exhibited more antimicrobial potent activity than *L-enantiomeric* peptides against *E. faecalis* biofilms on the canal space
Yonehara, 1986 [160]	In vivo	Opioids and opioid peptides	Tooth pulp stimulation	There is an interaction between substance P and enkephalin systems in the superficial layer of the brain-stem trigeminal sensory nuclear complex for the regulation of dental pain transmission. In addition, the native application of naloxone (5×10^{-7} M) partly antagonized the inhibitory effects of locally applied morphine and the opioid peptide
Yoshinari, 2005 [161]	In vitro	Antimicrobial peptide histatin 5	Poly (methyl methacrylate) denture base	*C. albicans* colonization on histatin-adsorbed PMMA was knowingly less than the control

Table 2. *Cont.*

Study and Year	Type of Study	Peptide Used	Application	Main Results
Yoshinari, 2010 [162]	In vitro	Antimicrobial and titanium-binding peptides	Titanium surfaces	Antimicrobial and titanium-binding peptides were encouraging for the reduction of biofilm formation on titanium surfaces
Yuca, 2021 [163]	In vitro	Dual-peptide tethered polymer system	Dental adhesives	The adhesive system formed of co-tethered peptides revealed both localized calcium phosphate remineralization and strong metabolic inhibition of *S. mutans*
Zhang, 2022 [164]	In-vitro	Dual-sensitive antibacterial peptide	Dental caries	This peptide prevented damage from bacteria and, thus, from dental caries
Zhang, 2016 [165]	In vitro	D-Enantiomeric peptide	Oral biofilms	D-enantiomeric peptide was effective against oral biofilms
Zhao, 2020 [166]	In vitro	Antimicrobial peptide nisin	Dental adhesive	3% (*w*/*v*) nisin-incorporated Single Bond Universal substantially inhibited the development of both saliva-derived multispecies biofilms and monospecific *S. mutans* biofilms without hindering the bonding performance
Zhou, 2008 [167]	In vitro	Genetically engineered peptides for inorganics	Tooth repair	Genetically engineered peptides for inorganics were effective in tooth repair
Zhou, 2015 [168]	In vitro	Antimicrobial peptide	Titanium surfaces	Antimicrobial peptide provided a promising bifunctional surface
Gungormus, 2021 [169]	In vitro	Peptide-assisted pre-bonding	Remineralization of dentin	Pre-bonding remineralization of dentin using peptide during 10 min notably enhanced the stiffness of dentin and the resistance to hydrolysis. In addition, it can reduce shrinkage due to drying
Koidou, 2018 [84]	In vitro	Laminin 332- and ameloblastin-derived peptides (Lam, Ambn)	Peri-implant mucosal seal	Laminin 332- and ameloblastin-derived peptides were demonstrated to be effective in producing a peri-mucosal seal around dental implants
Gug, 2022 [170]	In vivo	CPNE7-derived functional peptide	Dentin regeneration of dental caries	CPNE7-derived functional peptide repaired caries by dentin regeneration

P172

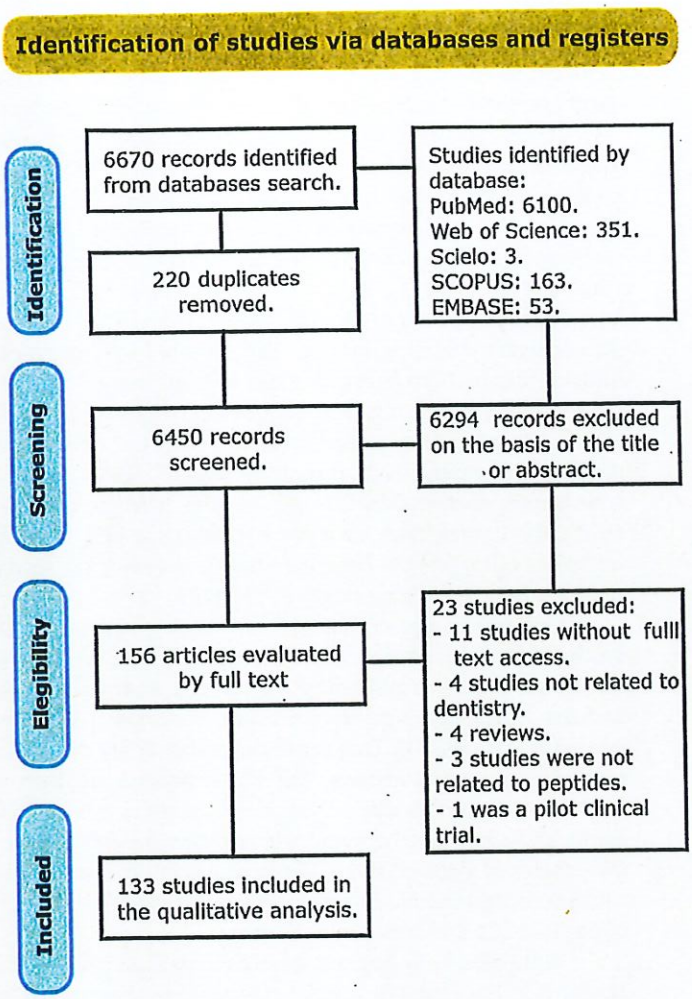


Figure 1. Flowchart summarizing the selection process of articles.

The studies included experiments in animals and/or using bacteria or cells; also, several clinical trials were found. Most of the applications of the peptides included caries management, implant osseointegration, guided tissue regeneration, vital pulp therapy, antimicrobial activity, enamel remineralization, occlusion of dentin tubules, periodontal therapy, the surface modification of dental implants, and the modification of dental materials such as dental adhesives and denture base resins.

3.2. *Synthesis of Results and Summary of Evidence*

The in vitro and in vivo studies included in the present review stated that peptides may have beneficial effects for treating early carious lesions. Additionally, the use of peptides seems to be beneficial for promoting cell adhesion and enhancing the adhesion strength of dental implants. In addition, peptides were useful for tissue engineering for cell-based pulp regeneration. Peptides were also successfully used as healthy promotors of the periodontium, acting as inflammatory mediators. Finally, most peptides were used as effective antimicrobial agents.

4. Discussion

A scoping review was performed regarding the use and applications of peptides in the dental field at present. Appropriately, most of the applications of the peptides included caries management, implant osseointegration, guided tissue regeneration, vital

pulp therapy, antimicrobial activity, enamel remineralization, occlusion of dentin tubules, periodontal therapy, the surface modification of dental implants, and the modification of dental materials such as dental adhesives and denture base resins.

One should keep in mind that dental caries is considered the most common disease worldwide [171], and it can lead to the destruction of dental surfaces by means of acidogenic bacteria changing sugars to acids [43]. Dissolution of the mineral tooth structure begins with caries formation, therefore generating a demineralized subsurface lesion body, similar to white spots [172], followed by the development of irreversible cavitation of the mineralized surface layer [173,174]. Treatment of manifested caries involves an oral hygiene regulation and a follow-up visit to identify whether the caries has been prevented or has advanced into a cavity, which is subsequently treated by means of restoration [173]. The use of fluoride varnish can prevent caries formation by reinforcing the inorganic surface layer, consequently inhibiting the progression of caries [175–177]. Fluoride ions are preserved within the inorganic surface layer covering the demineralized carious lesion due to the high correspondence to hydroxyapatite [178]. Subsequently, the demineralized subsurface zone is not penetrated by fluoride; yet this is where remineralization would be essential in an attempt to regenerate decayed enamel tissue [43]. For this reason, novel methods for the treatment of caries have been introduced to mimic the structure of the enamel matrix, such as guided enamel regeneration (GER) [179].

It should be noted that self-assembling peptide (SAP) technology was designated on the reasonable design of a short hydrophilic peptide in combination with GER that builds into fibers, establishing a three-dimensional (3D) scaffold [180–182]. The surface features of the fibers might fluctuate, concurring with the physiological desires of the treated tissue [66,183]. This could be explained by the rational design criteria [183]. When treating early caries lesions, SAP P11-4 fibers have been adjusted to suitably bind ionic calcium and template hydroxyapatite formation, thus, accompanying remineralization in a comparable approach of amelogenin that supports the construction of the enamel. From this analysis, the SAP P11-4 fibers might be known as a biomimetic agent [66,74]. This could be in agreement with the finding of this review that demonstrated the potential effect of peptide P11-4 in caries management.

With regards to implant osseointegration, pure titanium is commercially used for implants in the dental field due to its possible resistance to corrosion, biocompatibility, and suitable mechanical properties [184–186]. Researchers have detected peri-implant bone resorption produced by peri-implantitis, which is considered the key reason for the failure of osseointegrated dental implants [187,188]. In this manner, surface modification of dental implants has been a topic of interest for researchers since titanium is an inert material that decreases the aptitude for remedial tissue therapy to succeed and resists bacterial settlement [189–191]. To counteract peri-implantitis and advance osseointegration, different type of coatings have been investigated [192]. Surfaces incorporating chlorhexidine, antimicrobial agents and antibiotics such as gentamicin, and surfaces incorporating chlorhexidine, poly-lysine, sliver, and chitosan have all been established for coating the titanium surface of implants [52]. However, some drawbacks could be noted with antibiotic-coated titanium, such as the controversial opinion about their bacterial resistance and host cytotoxicity [193]. In 2015, Zhou et al. demonstrated that antimicrobial peptides provided a promising bifunctional titanium surface and enhanced its bactericidal activity and cytocompatibility [168]. Likewise, a previous report suggested that after 6 weeks of implantation in rabbit femurs, titanium dental implants with an antimicrobial peptide GL13K coating allowed in vivo dental implant osseointegration at similar bone growth rates to gold-standard non-coated dental implants [52]. This could be explained by the fact that GL13K is bactericidal in solution against *Escherichia coli*, *Pseudomonas aeruginosa*, *Porphyromonas gingivalis* and *Streptococcus gordonii* [83,194,195]. Similarly, Yoshinari et al. proved that the antimicrobial and titanium-binding peptides were favorable for the diminution of biofilm formation on titanium surfaces [162]. In addition, a laminin-derived peptide was demonstrated to improve and enhance the integration of soft tissue on dental titanium implants [143].

Furthermore, an epithelial basement membrane was formed on a titanium surface when platelet-activating peptide was used [135]. All in all, this could clearly support the result of this review that the use of peptides seems to be beneficial for promoting cell adhesion and enhancing the adhesion strength of dental implants.

In addition, this analysis determined that peptides were useful for guided tissue regeneration [42]. This could be achieved when a combination of a synthetic peptide named P-15 (analog of collagen) and an anorganic bovine bone mineral (ABM) was used. ABM enhanced cell attachment by differentiation and cell binding, thus enhancing osseous formation and ensuing an accelerated periodontal ligament fibroblast attachment [109,196]. Adding to P-15, biocompatible and osteoconductive filler material was thus detected [42].

A major task in the use of tissue engineering for therapy in dentistry involves the initiation of tooth and bone regeneration. The dentin phosphophoryn-derived arginine-glycine-aspartic acid-containing peptide was demonstrated as a biodegradable, biocompatible, and bioactive material for dentin regeneration. These results could be clarified by the short AA sequences of the peptide used and by its 3D conformation essential for acquiring this function [46]. Accordingly, the peptide can be used in vital pulp therapy when a specific sequence is used.

Further, most peptides were used as effective antimicrobial agents. Peptide hydrogels have shown that ultrashort peptides (<8 amino acids) might self-assemble into hydrogels. These ultrashort peptides might be intended to integrate antimicrobial motifs, such as positively charged lysine residues; thus, the peptides have integral antimicrobial features [47]. The scheme and synthesis of biocompatible hydrogels with antimicrobial activity are of numerous interests for tissue engineering drives comprising the replacement of tissue in infected root canals [65,197,198]. Moreover, antimicrobial peptides were used in coated titanium surfaces [168], dental adhesives [147], caries infection [102], and plaque biofilm inhibition [36].

Peptides were also successful for enamel remineralization. It is imperative to note that the acidic nature of dental cavities created by a massive amount of sugar intake leads to bacterial colonization and a reduction in the pH. Accordingly, the demineralization of the enamel surface begins [48]. In order to prevent this issue, numerous remineralizing agents were presented [48]. A perfect agent should be free of toxicity and qualified to initiate remineralization without any harm to the dental surface. Matrix-facilitated mineralization equal to a natural process should be carried out, though this ability is absent in almost all these agents [199]. The arrival of SAP P11-4 has overwhelmed this restriction. It has the ability to regenerate enamel. In addition, these agents initiate remineralization by making 3D constructions mimic the extracellular matrix of the dental surface [200]. Therefore, when talking about enamel remineralization, clinicians should focus on SAP due to its efficient and effective outcomes obtained in this review.

The occlusion of dentin tubules is considered possible with the help of peptides. This theory became conceivable when mineral particles were observed on dentinal tubules, thus reducing dentinal permeability and enhancing the seal of the material-tooth interfaces [57]. Bonding agents and desensitizers have been demonstrated to be effective for occluding tubules by mineral precipitation; however, these techniques are sensitive, and the long-term performance of the resin is doubtful [201,202]. As a balancing method for the protein mediation of hydroxyapatite mineralization, streamlined synthetic cationic macromolecules comprising poly(L-lysine) (PLL) that cover primary and secondary amine groups are organizationally comparable to the functional areas of the natural proteins and have further been presented to encourage silicification [203]. This review implies that this peptide-catalyst-mediated method of mineral formation for occluding tubules and/or reinforcing dentin-bonding resins might retain function on the dentin surface, advising a wide range of protective and treatment plans.

Peptides have also been successfully used as healthy promotors of the periodontium, acting as inflammatory mediators. Periodontitis is a chronic inflammatory and tissue-destructive illness. Meanwhile, the oral cavity with its polymicrobial effect makes it

problematic to treat; thus, new healing approaches are mandatory. In a minimally invasive way, SAP delivers the benefit of being functional at a defect site without creating a toxic area [204]. Furthermore, their tunable mechanical characteristics and reasonably designed physicochemical features permit a high variety of encapsulated drugs [205]. Some peptides called P11-4 and P11-28/29 were considered SAP-applicable for periodontal therapy, due to their biocompatibility, injectability, tunable mechanical and physicochemical properties, and cargo-loading capacity [72].

Finally, peptides were used in the modification of dental materials such as dental adhesives and denture base resins. Recurrent decay that grows at the composite-tooth interface was demonstrated to be a disadvantage when using resin-based composite [163]. Primarily, the composite-tooth interface becomes coated by a low-viscosity adhesive system; however, when a fragile seal to the dentin is obtained, damage from enzymes, acids, and oral fluids will be achieved. This impairment is chief in crevices that are occupied by cariogenic bacteria such as *Streptococcus mutans* [206–209]. Various bacterial-inhibition strategies have been incorporated into adhesive systems, but none of these strategies address the multifaceted interplay of the mechanical and physicochemical influences of the durability of the adhesive seal at the composite-tooth interface. Antimicrobial peptides have been coupled into the adhesive system using non-bonded interactions [146], and subsequently, antimicrobial peptides were conjugated into the network of the adhesive system in order to improve the antimicrobials' effectiveness [147]. An antimicrobial peptide AMP2-derivative (AMPM7) sequence using a functional spacer was used for integration into a monomer site. This adhesive system formed of co-tethered peptides demonstrated both localized calcium phosphate remineralization and strong metabolic inhibition of *S. mutans* [163]. An adhesive system incorporated with an antimicrobial peptide inhibited bacterial attack, and a hydroxyapatite-binding peptide promoted the remineralization of damaged tooth structures [146,163]. In 2017, Su et al. demonstrated that a cured antimicrobial peptide with nisin-incorporated dental adhesive showed a significant inhibitory effect on the growth of *S. mutans* [133], and recently, a paper showed that 3% (*w*/*v*) of nisin-incorporated universal adhesive system substantially inhibited the growth of both saliva-derived multispecies biofilms and *S. mutans* monospecific biofilms without hindering the bonding performance [166].

Moreover, it was demonstrated that *C. albicans* colonization on the denture's base was significantly less than the control when histatin-adsorbed PMMA (poly methyl methacrylate), an antimicrobial peptide, was used [161]. Another report suggested that histidine-rich polypeptides were effective in the treatment of denture stomatitis [121], thus evidencing the important use of peptides in removable prostheses.

Some limitations relative to the applications of peptides in the dental field can be cited. One restriction is the absence of homogeneity of the type and obtention of the peptides used in the different applications described in the present review. Another limitation that can be highlighted is that due to the heterogeneity of the analytical techniques used for distinguishing the peptides, analyzing data using any statistical analysis was avoided.

5. Conclusions

The use of peptides has been gaining increasing attention in contemporary dentistry. Dental research evidence suggests that peptides have several applications, including osseointegration, guided tissue regeneration, vital pulp therapy, antimicrobial activity, enamel remineralization, and the surface modification of dental implants. The lack of clinical trials should be highlighted, leaving a wide space available for the investigation of peptides in dentistry.

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P176

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REGULATORY & LEGAL 20 min read

Are Peptides Legal? State-by-State Guide (2026)

The short answer: it depends on which peptide, how you got it, and what you plan to do with it.

November 11, 2025

The short answer: it depends on which peptide, how you got it, and what you plan to do with it.

The long answer fills the rest of this article. Peptide legality in the United States is a patchwork of federal regulations, FDA category designations, state pharmacy laws, medical board standards, and enforcement trends that vary by jurisdiction. A peptide that a physician can prescribe legally in one state may trigger a medical board investigation in another. A product sold freely online as a "research chemical" may be the target of an attorney general enforcement action in a third.

This guide breaks down the federal framework first, then walks through the key state-by-state differences, explains the different legal channels for obtaining peptides, and provides practical guidance for patients, providers, and anyone trying to figure out whether what they are doing (or planning to do) is legal.

Last updated: February 2026. Peptide regulations are changing rapidly. Check the FDA's bulk drug substances page and your state pharmacy board for the latest updates.

Table of Contents

- The Federal Framework
- Three Legal Categories of Peptides
- Prescription vs. OTC vs. Research: The Three Channels
- State-by-State Overview
- Permissive States
- Moderate States
- Restrictive States
- State Attorney General Enforcement Actions
- Telemedicine and Peptide Prescribing
- Peptides and Anti-Doping: WADA and Sports Rules
- Dietary Supplements and the DSHEA Question
- Selling Peptides: Business Licensing Requirements
- Practical Guidance
- FAQ
- The Bottom Line
- References

The Federal Framework

Federal law sets the floor. Every state must comply with federal rules, but states can add their own restrictions on top. No state can make something legal that federal law prohibits.

The FDA's Role

The FDA regulates peptides as drugs when they are intended for diagnosis, treatment, or prevention of disease. This intent-based framework means that the same physical substance can be treated differently depending on how it is marketed and used:

- A vial of BPC-157 sold "for research use only" to a laboratory? Legal to sell.
- The same vial sold with dosing instructions and marketed for gut healing? The FDA considers that an unapproved drug.

The distinction between these two scenarios is not the substance itself but the **intended use**, as demonstrated by labeling, marketing, and the context of the sale.

The Controlled Substances Act

Most peptides are not scheduled controlled substances under the DEA's Controlled Substances Act. There is no "Schedule I peptide" list. However:

- **Some growth-hormone-related substances** are subject to specific federal restrictions. Human growth hormone (somatropin) is controlled under a separate statute (21 U.S.C. 333(e)) that makes it illegal to distribute for non-approved purposes.
- **The DEA has reviewed** certain growth hormone secretagogues for potential scheduling due to sports doping concerns, though as of early 2026, no commonly discussed research peptides have been scheduled.
- **Anabolic steroids** are Schedule III controlled substances, but peptides are structurally distinct from steroids and are not classified under this category.

The FD&C Act

The Federal Food, Drug, and Cosmetic Act (FDCA) is the primary federal statute governing peptide regulation. Under the FDCA:

- A "new drug" requires FDA approval before it can be marketed in interstate commerce.
- Compounded drugs are exempt from the new drug approval requirement if they meet the conditions of Section 503A or 503B.
- A substance marketed as a dietary supplement must meet DSHEA requirements (more on this below).
- Misbranded or adulterated drugs can be seized, and their sellers can face criminal prosecution.

Three Legal Categories of Peptides

For practical purposes, every peptide you might encounter falls into one of three categories:

1. FDA-Approved Peptide Drugs

These have gone through clinical trials and received FDA approval. They are fully legal to prescribe, dispense, and use for their approved indications. Off-label prescribing (using the drug for an unapproved condition) is legal at the physician's discretion.

Examples: Semaglutide (Ozempic, Wegovy), tirzepatide (Mounjaro, Zepbound), liraglutide (Victoza, Saxenda), leuprolide (Lupron), octreotide (Sandostatin), tesamorelin (Egrifta),

bremelanotide (Vyleesi).

Legal status: Fully legal with a valid prescription.

2. Compoundable Peptides

These are substances that can be legally prepared by compounding pharmacies under Section 503A or 503B of the FDCA. They are not themselves FDA-approved drugs, but they meet the criteria for compounding: they appear on the Category 1 bulks list, have USP monographs, or are active ingredients in FDA-approved drugs.

Examples: Sermorelin, gonadorelin, GHK-Cu (topical only), VIP (vasoactive intestinal peptide), NAD+.

Legal status: Legal with a valid prescription from a licensed prescriber, compounded by a licensed pharmacy that meets regulatory requirements.

3. Non-Approved Peptides (Research Chemicals)

These are peptides that have not been FDA-approved and cannot be legally compounded. They are often sold as "research chemicals" or "for research use only" (RUO). This includes the peptides the FDA has placed on Category 2 (safety concerns) and Category 3 (insufficient data).

Examples: BPC-157, TB-500, CJC-1295, ipamorelin, AOD-9604, Melanotan II, Selank, Semax, KPV, DSIP, Epitalon.

Legal status: Selling for research purposes is generally legal. Selling or marketing for human consumption is illegal under federal law. Purchasing for personal self-administration occupies a gray area that is increasingly subject to enforcement.

Prescription vs. OTC vs. Research: The Three Channels

Prescription (Rx)

FDA-approved peptide drugs and compounded peptides from licensed pharmacies require a valid prescription from a licensed healthcare provider. The provider must have a legitimate patient-provider relationship, which in most states requires at minimum a consultation (increasingly, telemedicine consultations are accepted -- see the telemedicine section below).

Over-the-Counter (OTC) / Cosmetic

Some peptide products are sold without a prescription:

- **Topical skincare peptides.** Products containing matrixyl, argireline, copper peptides, palmitoyl peptides, and others are sold as cosmetics. They are regulated by the FDA as cosmetics, not drugs, as long as they do not make drug claims. Read more in our peptide skincare guide.
- **Collagen peptides.** Hydrolyzed collagen sold as a dietary supplement is legal because collagen peptides are derived from food sources and have a long history of use in food.
- **Oral BPC-157?** Some companies sell oral BPC-157 as a "supplement." The FDA considers this illegal because BPC-157 is a synthetic peptide that does not meet the DSHEA definition of a dietary ingredient. Enforcement has been limited but is increasing.

Research Use Only (RUO)

The "research chemical" channel is where most of the legal ambiguity lives. Companies sell peptides labeled "for research use only" or "not for human consumption." When purchased by an actual laboratory for genuine research purposes, this is legal.

The problem arises when:

- The seller packages peptides with syringes, bacteriostatic water, and dosing guides
- Marketing materials describe human health benefits
- Customer reviews discuss personal use
- The website targets consumers rather than laboratories

In these cases, the FDA considers the products to be unapproved drugs marketed for human use, regardless of the RUO label. Several companies have received FDA warning letters on this basis, and state attorneys general have brought enforcement actions against sellers whose marketing clearly targets human consumers.

State-by-State Overview

Federal law provides the baseline, but states layer on additional rules through pharmacy boards, medical boards, consumer protection statutes, and specific legislation. The result is a spectrum from relatively permissive to highly restrictive.

The following categorization reflects the overall regulatory environment as of early 2026. States can move between categories as new laws take effect.

Permissive States

These states have lighter regulatory frameworks for peptide therapy. Clinics operate more openly, enforcement against gray-market peptides is less aggressive, and prescribers generally face less scrutiny from medical boards for peptide prescribing.

Florida

- **Peptide clinic environment:** Florida has one of the highest concentrations of peptide therapy clinics in the country. The state's warm climate, large retiree population, and business-friendly regulatory environment have made it a hub for anti-aging and regenerative medicine.
- **Pharmacy regulation:** Florida mandates registration for drug manufacturers and wholesale distributors handling peptides. The state pharmacy board enforces federal compounding rules but has not imposed additional peptide-specific restrictions beyond the federal framework.
- **Telemedicine:** Florida allows broad telemedicine prescribing for non-controlled substances. GLP-1 peptides (non-controlled) can be prescribed via telehealth with appropriate documentation.
- **Enforcement trend:** Moderate. Florida has not been among the states leading enforcement actions against peptide sellers, but the state attorney general's office participated in the multi-state letter to the FDA.

Texas

- **Peptide clinic environment:** Similar to Florida, Texas has a large and active peptide therapy market. Multiple clinics in Dallas, Houston, Austin, and San Antonio offer peptide prescribing.

- **Pharmacy regulation:** The Texas State Board of Pharmacy regulates compounding pharmacies. Texas follows federal Category designations without additional state-level peptide restrictions.
- **Medical board:** The Texas Medical Board has not issued specific guidance restricting peptide prescribing, though prescribers are expected to follow standard-of-care requirements including informed consent and documentation.
- **Research chemicals:** Texas has not enacted specific legislation targeting the sale of research peptides to consumers.
- **Enforcement trend:** Low to moderate.

Nevada

- **Peptide clinic environment:** Nevada, particularly Las Vegas, has a growing anti-aging and wellness industry that includes peptide therapy.
- **Pharmacy regulation:** Nevada follows federal compounding rules. The state has not enacted additional peptide-specific restrictions.
- **Enforcement trend:** Low. Nevada has not been prominent in peptide enforcement actions.

Arizona

- **Peptide clinic environment:** Phoenix and Scottsdale have significant numbers of peptide therapy and regenerative medicine clinics.
- **Medical board:** Arizona has not issued specific restrictions on peptide prescribing. The state's health freedom laws provide somewhat more latitude for alternative therapies.
- **Enforcement trend:** Low.

Moderate States

These states follow federal rules without significant additional restrictions but have more active enforcement, medical board oversight, or pending legislation.

Illinois

- **Pharmacy regulation:** Illinois follows federal compounding guidelines. The state pharmacy board enforces Category designations.
- **Medical board:** Active oversight. Providers prescribing off-label or compounded peptides should document clinical rationale thoroughly.
- **Enforcement trend:** Moderate. Illinois has participated in multi-state enforcement coordination.

Colorado

- **Peptide clinic environment:** Denver and Boulder have active wellness communities with peptide therapy clinics.
- **Pharmacy regulation:** Follows federal framework. Colorado has not enacted peptide-specific legislation.
- **Medical board:** Colorado has been generally accepting of integrative medicine practices, but documentation requirements are enforced.
- **Enforcement trend:** Moderate.

Ohio

- **Pharmacy regulation:** Ohio follows federal compounding rules. The state has specific requirements for pharmacy compounding inspections.

- **Medical board:** Has investigated practitioners for substandard peptide prescribing practices in individual cases but has not issued blanket restrictions.
- **Enforcement trend:** Moderate.

Pennsylvania

- **Pharmacy regulation:** Follows federal framework with state-level compounding pharmacy licensing requirements.
- **Enforcement trend:** Moderate, with some activity from the PA attorney general on health product marketing claims.

Georgia

- **Peptide clinic environment:** Atlanta has a growing peptide therapy market.
- **Pharmacy regulation:** Follows federal Category designations. Georgia has enacted legislation requiring additional oversight of compounding pharmacies in the wake of the NECC tragedy (several Georgia patients were affected).
- **Enforcement trend:** Moderate.

Restrictive States

These states impose additional restrictions beyond federal requirements, have more aggressive enforcement, or have specific legislation targeting peptide-adjacent products.

New York

- **Pharmacy regulation:** New York requires facility inspection and compliance documentation for peptide production and labeling. The state imposes additional quality control requirements on compounding pharmacies beyond federal standards.
- **Medical board:** The New York State Office of Professional Medical Conduct (OPMC) actively investigates physicians prescribing unapproved substances. Documentation, informed consent, and evidence-based rationale are held to high standards.
- **Telemedicine:** In May 2025, the New York State Department of Health finalized rules governing prescription of controlled substances through telemedicine. While most peptides are not controlled, the rules signal increasing oversight of remote prescribing.
- **Minor access restrictions:** As of April 2025, New York law prohibits the sale of products marketed for muscle building or weight loss to individuals under 18. This potentially affects peptide sellers targeting younger demographics.
- **Enforcement trend:** High. New York has been among the more active states in peptide-related enforcement.

California

- **Pharmacy regulation:** The California Board of Pharmacy imposes strict compounding standards. California has historically been among the most aggressive states in regulating compounding pharmacies.
- **Medical board:** The Medical Board of California has investigated practitioners for prescribing unapproved peptides, particularly when safety concerns or complaints arise.
- **PDMP requirements:** All providers prescribing controlled substances must consult California's Prescription Drug Monitoring Program (CURES) database. While most peptides are not controlled, the infrastructure signals a culture of prescription oversight.

- **Minor access legislation:** California has introduced legislation targeting underage access to performance-enhancing supplements, which could affect peptide products marketed for muscle building or athletic performance.
- **Enforcement trend:** High. California consumer protection laws are among the strongest in the country, and the state attorney general has broad enforcement authority.

Massachusetts

- **Sharps disposal:** Massachusetts has some of the strictest sharps disposal rules -- sharps cannot be placed in household trash. This is relevant for injectable peptide users. See our peptide disposal guide.
- **Pharmacy regulation:** Massachusetts pharmacy regulations are among the most restrictive, with additional requirements for sterile compounding in the wake of the NECC tragedy (NECC was based in Massachusetts).
- **Enforcement trend:** High.

Connecticut

- **Enforcement action:** In 2025, the Connecticut Attorney General required a peptide seller to cease operations in the state and accept a monetary judgment. Connecticut has been one of the most active states in peptide enforcement.
- **May 2025 notice:** The AG issued a statewide notice to weight-loss clinics and medspas emphasizing that compounding of semaglutide and tirzepatide is no longer permitted.
- **Enforcement trend:** Very high.

Alabama

- **Enforcement action:** Alabama's Attorney General obtained a temporary restraining order in November 2025 against a company selling unapproved peptide products.
- **Enforcement trend:** High, particularly regarding online peptide sellers.

Louisiana

- **Pharmacy regulation:** Louisiana imposes additional restrictions on compounding pharmacies, including stricter inspection and documentation requirements.
- **Enforcement trend:** Moderate to high. Louisiana is considered among the more restrictive states for supplement and peptide sales.

State Attorney General Enforcement Actions

The most significant enforcement development of 2025-2026 has been the entry of state attorneys general into peptide regulation. Previously, enforcement was primarily an FDA function. Now, AGs are using consumer protection tools independently.

Multi-State Coordination

More than 40 state attorneys general sent a formal multi-state letter to the FDA in 2025 describing:

- Products containing unknown contaminants or incorrect dosages
- Online sales of GLP-1 active ingredients labeled "research use only" but marketed to consumers without prescriptions
- Public health risks from unsanitary compounding

Individual State Actions

State	Action	Date
Connecticut	Forced peptide seller to cease operations; monetary judgment	2025
Alabama	Temporary restraining order against unapproved peptide seller	November 2025
Connecticut	Statewide notice to clinics on GLP-1 compounding	May 2025
Multiple states	Medical board audits of peptide therapy clinics	Throughout 2025

What This Means

"Research use only" labels do not provide legal protection when the product is clearly marketed for human consumption. State AGs are using consumer protection law, unfair trade practice statutes, and public health authority to go after sellers that the FDA might not prioritize.

If you are buying "research peptides" online and the seller's website shows before-and-after photos, discusses dosing protocols for humans, or sells the peptides alongside syringes and bacteriostatic water, that seller is a target for enforcement. And in some states, the purchaser may face scrutiny as well.

Telemedicine and Peptide Prescribing

Telemedicine has become a major channel for peptide prescribing. Here is where things stand:

Federal Telemedicine Rules

In January 2026, HHS and the DEA jointly extended telemedicine flexibilities for controlled substance prescribing through December 31, 2026. Under this extension, DEA-registered practitioners can prescribe Schedule II-V controlled substances via live audio-video telemedicine without a prior in-person exam.

However, most peptides are not controlled substances. For non-controlled peptides, telemedicine prescribing is governed by state medical practice acts rather than DEA rules.

State Telemedicine Requirements for Peptides

The key question is whether a state requires an in-person visit before a physician can prescribe a non-controlled injectable medication.

- **Most states** allow non-controlled substance prescriptions via telemedicine as long as the provider establishes a legitimate patient-provider relationship (which can be done remotely in most jurisdictions).
- **Some states** (including New York, as of May 2025) have specific rules about telehealth prescribing that may require additional documentation or follow-up in-person visits.
- **The standard-of-care requirement** applies everywhere: even via telemedicine, the provider must perform an adequate assessment, make an appropriate diagnosis, and document their clinical reasoning.

Enforcement Against Telehealth Peptide Mills

The FDA's September 2025 enforcement initiative specifically targeted telehealth companies promoting compounded GLP-1 products. Warning letters went to providers making claims about "generic" or "clinically proven" compounded versions of FDA-approved drugs.

State medical boards have also begun scrutinizing telehealth peptide prescribing, particularly "peptide mills" where providers prescribe peptides with minimal assessment. If

you are obtaining peptides via telemedicine, ensure your provider conducts a thorough consultation, reviews your medical history, and documents clinical rationale.

Peptides and Anti-Doping: WADA and Sports Rules

For athletes, peptide legality has an additional layer: anti-doping rules.

The World Anti-Doping Agency (WADA) prohibits many peptides regardless of their legal status:

Peptide Category	WADA Status	Examples
Growth hormone secretagogues	**Prohibited**	CJC-1295, ipamorelin, GHRP-2, GHRP-6, MK-677
GLP-1 agonists	Generally **not prohibited**	Semaglutide, tirzepatide (check current list)
Thymosin beta-4 / TB-500	**Prohibited**	TB-500
BPC-157	Status varies by sport	Check specific federation rules
EPO-mimetic peptides	**Prohibited**	Peginesatide
SARMs	**Prohibited** (not peptides, but often sold alongside)	

NCAA, IOC, and professional sports leagues have their own rules that may differ from WADA. Athletes in any organized sport should check their specific federation's prohibited

list before using any peptide. See our peptides for athletes guide for more detail.

Dietary Supplements and the DSHEA Question

Can a peptide be sold as a dietary supplement? Under the Dietary Supplement Health and Education Act of 1994 (DSHEA), a substance can be marketed as a dietary supplement if it is:

- A vitamin, mineral, herb, or botanical
- An amino acid
- A dietary substance to supplement the diet
- A concentrate, metabolite, constituent, extract, or combination of the above

Where Peptides Fit

- **Collagen peptides** (hydrolyzed collagen): These are derived from food sources (animal bone, skin, and connective tissue). They have a long history of use in food and are generally recognized as safe. They can legally be sold as dietary supplements.
- **Individual amino acids** (L-glutamine, L-arginine, etc.): Legal as dietary supplements.
- **Synthetic peptides** (BPC-157, TB-500, CJC-1295, etc.): These are not "dietary substances" under DSHEA. They are synthetic compounds that do not occur naturally in foods and have no history of food use. The FDA considers them unapproved drugs when marketed for human consumption, not dietary supplements.
- **Bioactive peptides from food** (casein-derived peptides, whey peptides): These are in a gray area. If derived from food sources and marketed without specific drug claims,

they may qualify as supplements. But claims about treating, curing, or preventing disease would make them drugs under the FDCA.

The bottom line: most of the peptides that people in the biohacking and anti-aging communities are interested in cannot legally be sold as dietary supplements. Companies that do so are operating in violation of federal law, though enforcement has been inconsistent.

Selling Peptides: Business Licensing Requirements

If you are (or are considering) selling peptides, the licensing requirements are significant and vary by state:

Federal Requirements

- **FDA registration** is required for any entity manufacturing, processing, packing, or distributing drugs in the United States.
- **DEA registration** is required if any products are controlled substances (most peptides are not).
- **API sourcing** must be from FDA-registered suppliers. Peptide APIs labeled "research use only" cannot be used in products intended for human use.

State Requirements

- **Drug manufacturer licensing:** Most states require separate state-level licensing for drug manufacturers, even if federally registered.

- **Wholesale drug distributor licensing:** Required in most states for distributing pharmaceutical products.
- **Pharmacy licensing:** If you are compounding peptides, you need a state pharmacy license.
- **Specific state requirements vary:** Florida mandates registration for drug manufacturers and wholesale distributors handling peptides. New York requires facility inspection and compliance documentation. Other states have their own requirements.

The LegitScript Factor

Payment processors increasingly use LegitScript certification to vet merchants selling health products online. LegitScript has published guidance specifically addressing peptides, classifying many research peptides as "not eligible for certification" when marketed for human use. This means many peptide sellers lose access to credit card processing, which is a significant practical enforcement mechanism independent of FDA or state action.

Practical Guidance

For Patients

1. **FDA-approved peptide drugs** are the safest legal route. If an FDA-approved alternative exists for your condition, start there. See our complete list of FDA-approved peptides.

2. **Compounded peptides from a licensed pharmacy** with a valid prescription are legal for Category 1 substances. How to find a compounding pharmacy and how to choose a peptide therapy clinic are relevant guides.

3. **"Research" peptides purchased online** for personal use carry legal, quality, and medical risks. If you choose this route, understand that:

   - You are in a legal gray area that is subject to increasing enforcement
   - Product quality varies dramatically and third-party testing is not guaranteed to be accurate
   - You bear full responsibility for any adverse effects without medical oversight
   - Your state may be more or less aggressive about enforcement

4. **Know your state's rules.** If you live in New York, California, Connecticut, Alabama, or Massachusetts, be aware that enforcement is more active than in Florida, Texas, or Nevada.

5. **Document everything.** If you are using peptides under medical supervision, ensure your physician documents the clinical rationale, informed consent, and monitoring plan.

For Providers

1. **Prescribe within the current framework.** FDA-approved peptides and Category 1 compounded peptides are the safest legal ground.

2. **Document aggressively.** Medical board audits of peptide-prescribing practices are increasing. For every peptide prescription, document: medical necessity, informed consent (including that the substance may be off-label or compounded), monitoring plan, and the source pharmacy.

3. **Know your state medical board's position.** Some boards have published guidance on peptide therapy; others have not. Contact your board if uncertain.

4. **Be cautious with telemedicine.** Telehealth peptide prescribing is legal in most states but is under increasing scrutiny. Ensure thorough consultations and proper documentation.

5. **Do not facilitate access to Category 2 substances.** Prescribing or directing patients to obtain substances that cannot be legally compounded exposes you to medical board disciplinary action and potential civil liability.

For Businesses

1. **Consult a healthcare attorney** before selling any peptide product. Firms like Frier Levitt and Holt Law specialize in this area.

2. **State licensing is mandatory.** If you sell across state lines, you may need licenses in every state where you have customers.

3. **"Research use only" labels do not provide legal immunity** if your marketing targets human consumers.

4. **Payment processing** may be your biggest practical challenge. LegitScript and major payment processors are increasingly restricting merchants who sell peptides intended for human use.

FAQ

Are peptides legal to buy?

It depends on the peptide and the context. FDA-approved peptides with a valid prescription: yes. Compounded Category 1 peptides with a prescription: yes. Research peptides purchased for actual laboratory research: yes. Research peptides purchased for personal self-administration: gray area with increasing enforcement risk.

Can I get in trouble for buying research peptides online?

Enforcement to date has focused on sellers rather than individual purchasers. However, state attorneys general have signaled that they view the entire supply chain -- from manufacturers to sellers to marketers -- as potential enforcement targets. Individual purchasers face theoretical legal exposure, though prosecution of individual buyers is rare.

Are peptides banned in my state?

No state has "banned peptides" as a category. The restrictions come from the federal framework (Category 2 designations, compounding limits) and state enforcement of existing consumer protection, pharmacy, and medical practice laws. Some states enforce more aggressively than others.

Can my doctor prescribe any peptide they want?

Physicians have broad prescribing authority, but it is not unlimited. They can prescribe FDA-approved drugs for any indication (off-label). They can prescribe compounded medications that meet 503A/503B requirements. They cannot prescribe substances that cannot be legally compounded (Category 2/3) through a compounding pharmacy. If they direct patients to obtain such substances through other channels, they face medical board and liability risks.

Are cosmetic peptide products (serums, creams) legal?

Yes. Topical peptide skincare products are regulated as cosmetics, not drugs, as long as they do not make drug claims (treating disease, altering the structure or function of the body beyond cosmetic effects). Products containing matrixyl, argireline, copper peptides, and similar cosmetic peptides are sold freely. Read our peptide skincare guide and how to read peptide skincare labels.

Collagen peptides derived from food sources are legal dietary supplements. They are not subject to the FDA compounding restrictions because they are food-derived, have a history of dietary use, and are not being used as drugs.

Is it legal to import peptides from other countries?

Generally no. Importing unapproved drugs into the United States violates the FDCA. The FDA exercises enforcement discretion for small quantities of personal-use imports in some cases, but this is not a legal right. Customs can and does seize imported peptide shipments.

Will the laws change?

Almost certainly. The SAFE Drugs Act (H.R. 6509) would tighten federal compounding rules if passed. Multiple states have pending legislation. PCAC reviews could add peptides to Category 1. Court rulings in ongoing litigation could affect enforcement timelines. The direction of travel is toward more restriction, not less.

The Bottom Line

Peptide legality in 2026 comes down to three questions:

1. **Is the peptide FDA-approved?** If yes, it is legal with a prescription. Full stop.
2. **Is the peptide on the Category 1 compounding list?** If yes, a licensed pharmacy can compound it with a valid prescription.
3. **Is the peptide Category 2, Category 3, or not on any list?** Then it cannot be legally compounded. It can be sold for research, but using it for personal health sits in a gray area that is shrinking.

Where you live matters. Florida and Texas offer a more permissive environment for peptide therapy. New York, California, and Connecticut have more aggressive enforcement and stricter rules. But the federal framework applies everywhere, and the trend is clearly toward tighter regulation at all levels.

The safest legal approach is straightforward: work with a licensed physician who understands the current regulatory framework, use FDA-approved peptides where they exist, use legally compounded peptides through licensed pharmacies when appropriate, and talk to your doctor about alternatives when the peptide you want is no longer available through legal channels.

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PRESS RELEASE

Utah Licensed Osteopathic Physician Indicted for Allegedly Receiving Misbranded Drugs from China and Selling them to Patients

Wednesday, April 1, 2026

For Immediate Release

U.S. Attorney's Office, District of Utah

Drugs received, recommended, and sold to patients by defendant were not FDA-approved

SALT LAKE CITY, Utah – A federal grand jury in Salt Lake City returned an indictment today against a Utah physician who allegedly received, recommended, delivered, and sold to his unwitting patients, misbranded drugs from China that were not approved by the United States Food and Drug Administration (FDA).

According to the allegations in court documents, Justin Bradley Watkins, 39, of Pleasant View, Utah, obtained misbranded drugs from China, specifically peptides that he knew were not FDA approved. Watkins obtained the drugs through a middleman between February 2024 to April 2025. The peptide orders included, among others, Tirzepatide, Semaglutide, Retatrutide, Cagrilinitide, BPC-157, TB500, Ipamorelin, CJC 1295, GHK, GHK-CU, and NAD+. Watkins purchased the peptides at a deeply discounted price, and knew they were not backed by proper, reliable testing and clinical trials. In furtherance of the fraud, Watkins made and affixed labels to vials and/or pill bottles before providing them to clinic staff. None of the labels disclosed the name and place of business of the

manufacturer, packer or distributor, as required by the FDA's Food, Drug, and Cosmetic Act (FDCA). During the fraud period, Watkins recommended, provided, delivered, and sold misbranded, non-FDA-approved peptides to over 200 trusting patients.

Watkins is charged with receipt in interstate commerce and delivery for pay misbranded drugs with intent to defraud or mislead, and aiding and abetting. His initial appearance on the indictment is scheduled for April 22, 2026, at 2:00 p.m. in courtroom 8.4 before a U.S. Magistrate Judge at the Orrin G. Hatch United States District Courthouse in downtown Salt Lake City.

First Assistant United States Attorney Melissa Holyoak of the District of Utah made the announcement.

The case is being investigated jointly by the U.S. Food and Drug Administration Office of Criminal Investigations (FDA-OCI), and the Utah Division of Professional Licensing (DOPL).

Assistant United States Attorney Mark Y. Hirata of the United States Attorney's Office for the District of Utah is prosecuting the case.

An indictment is merely an allegation and all defendants are presumed innocent until proven guilty beyond a reasonable doubt in a court of law.

Contact

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Public Affairs Officer
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Updated April 1, 2026

Topic

FINANCIAL FRAUD

Component

USAO - Utah

Press Release Number: 26-35

Related Content

PRESS RELEASE

Washington County Man Sentenced to 15 Years' Imprisonment for Wire Fraud

ST. GEORGE, Utah – A Southern Utah man was sentenced to 180 months' imprisonment after he posed as a 'savant' stock trader, obtaining at least $89 million from approximately...

September 3, 2026

PRESS RELEASE

Woman Charged with Health Care Fraud After Submitting False Claims to Utah Medicaid and Receiving Millions in Payout

SALT LAKE CITY, Utah – A federal grand jury in Salt Lake City returned an indictment today charging Jazzamin Clark with health care fraud after she allegedly submitted fraudulent...

August 26, 2026

PRESS RELEASE

U.S.-Congolese Citizen Sentenced to Nine Years' Imprisonment for Sprawling Check Fraud Conspiracy

SALT LAKE CITY, Utah – A Utah man was sentenced today to 108 months' imprisonment and five years of supervised release after he pleaded guilty to running a check...

July 28, 2026

District of Utah

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PRESS RELEASE

Illinois Man and Indiana Woman Sentenced Respectively to 70 Months and 16 Months in Prison For Selling Unapproved Drugs in Interstate Commerce

Thursday, July 30, 2026

For Immediate Release

U.S. Attorney's Office, Northern District of Indiana

SOUTH BEND – Matthew J. Kawa, 48 years old, of Grant Park, Illinois, and his sister Jennifer L. Stechkober, 32 years old, of Michigan City, Indiana, were sentenced by United States District Court Judge Cristal C. Brisco after pleading guilty to introducing unapproved new drugs into interstate commerce with the intent to defraud and mislead, announced United States Attorney Adam L. Mildred. Additionally, Kawa pled guilty to illegally importing merchandise into the United States.

Kawa was sentenced to 70 months of prison followed by 1 year of supervised release. Stechkober was sentenced to 16 months of prison followed by 1 year of supervised release. Both defendants were ordered to pay $78,317.52 in restitution. The Court also entered a money judgment against Kawa in the amount of $5 million.

"The owner of Paradigm Peptides and his accomplice have been held accountable, sentenced to prison, and ordered to pay restitution to the identified victims. He and his accomplice lied to the world at large saying their company was legitimate; their products were safe, pure, tested, and

manufactured in the United States; and that they were approved by the FDA. They were all lies. What's worse is that the two defendants fleeced an estimated 54,000 people out of over 5 million dollars, in total, and acted with callous disregard for the truth and the significant harm that could and, in some cases, was inflicted on those customers. These customers trusted them and consumed the products in the hope of improving their health or physique and instead were poisoned with known and unknown substances that were illegally imported from China, India, and other countries. Hopefully this outcome will deter bad actors who would try to make quick, easy money selling unregulated and untested products in interstate commerce. Thanks to the extensive efforts by the Food and Drug Administration, Office of Criminal Investigations, and the United States Postal Inspection Service, Assistant United States Attorney Luke N. Reilander and with cooperation of brave victims and witnesses, the Defendants have been held accountable," said U.S. Attorney Adam Mildred.

"The Defendant operated a business called Paradigm Peptides that marketed products online. Through his website, the Defendant and his sister/accomplice illegally sold peptides, Selective Androgen Receptor Modulators ("SARMs"), Human Chorionic Gonadotropin ("HCG"), and other drugs for human consumption without approval from the Food and Drug Administration ("FDA"). He then shipped his products to customers through the mail. On the business website and in representations to customers by email, the Defendant and his employees falsely said that his business was licensed and registered with the FDA, that the business manufactured its products at its own laboratories in the United States, that it tested its products to ensure the highest quality, and that its products were safe and of pharmaceutical quality. In reality, the Defendant imported the products from Asia, including China and India, and he did not test the products for quality before selling them to customers. It was later determined that many of the SARMs sold by Paradigm Peptides were actually testosterone and not the SARM listed on the product's label. Stechkober worked in the business's location in Michigan City, Indiana, where they packaged and shipped products to customers," said U.S. Attorney Adam L. Mildred.

"Kawa continued to sell these products online despite receiving letters in 2020 and 2022 from the FDA warning him that he was marketing and selling unapproved drugs in violation of the Food, Drug and Cosmetic Act. From 2019 to 2024, he sold products to more than 54,000 customers in each of the 50 United States and throughout more than 80 countries worldwide. Kawa derived $5 million in proceeds from the illegal sales. Several customers, including those who ingested testosterone mislabeled as SARMs, reported severe negative effects on their physical, psychological, and mental health after using the products. In particular, customers reported skin irritation and chronic acne; drops in natural testosterone requiring testosterone replacement therapy; cardiac health issues; and stress, anxiety, and other psychological issues up to suicidal ideation," U.S. Attorney Adam Mildred said.

"The FDA's requirements help ensure that individuals receive safe and effective drugs. Evading the FDA process and distributing unapproved drugs to consumers poses a serious risk to public health and safety," said Special Agent in Charge Ronne Malham, FDA Office of Criminal Investigations,

Chicago Field Office. "FDA will continue to investigate and hold accountable those who traffic in unapproved drugs."

"The U.S. Postal Inspection Service is dedicated to defending the nation's mail system from criminal activity, preserving the integrity of the U.S. Mail, and protecting the United States Postal Service employees," said Inspector in Charge Felicia B. George, United States Postal Inspection Service, Detroit Division. "The public has a right to expect the U.S. Mail and its contents to be safe, and Mr. Kawa and Ms. Stechkober eroded that trust by distributing unsafe and dangerous substances through the United States Postal Service. The U.S. Postal Inspection Service works tirelessly with our Local, State, and Federal law enforcement partners to protect the public from dangerous substances."

This case was investigated by the Food and Drug Administration, Office of Criminal Investigations, and the United States Postal Inspection Service. The case was prosecuted by Assistant United States Attorney Luke N. Reilander.

Updated July 31, 2026

Topic

FRAUD

Component

USAO - Indiana, Northern

Related Content

PRESS RELEASE

U.S. Attorney's Office for the Northern District of Indiana Joins DOJ Fraud Division, SBA, and SBA OIG in Surge Takedown Exceeding $245 Million in



COVID-era Loan Fraud

September 14, 2026

PRESS RELEASE

Gary Man Sentenced to 15 Months in Prison for Postal Money Order Fraud Scheme

September 9, 2026

PRESS RELEASE

Former Schererville Insurance Agent Sentenced to 70 Months in Prison for Life Insurance Fraud Scheme

September 2, 2026

Northern District of Indiana

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PRESS RELEASE

Med Spa Owner Pleads Guilty to Performing Thousands of Injections Using Counterfeit Products

Tuesday, April 7, 2026

For Immediate Release

U.S. Attorney's Office, District of Massachusetts

Defendant owned and operated Skin Beaute Med Spa in Randolph and South Easton

BOSTON – A Stoughton, Mass. woman pleaded guilty today in federal court in Boston to charges relating to thousands of injections she performed using counterfeit Botox and dermal fillers imported from China and Brazil. The defendant, who was not licensed to perform injections, received more than $1 million in client payments for these procedures.

Rebecca Fadanelli, 40, pleaded guilty to four counts of importing merchandise contrary to law, two counts of selling or dispensing a counterfeit drug and two counts of selling or dispensing a counterfeit device. U.S. District Court Judge Julia E. Kobick scheduled sentencing for July 1, 2026. Fadanelli was arrested and charged in November 2024.

According to the charging documents, beginning in at least March 2021, Fadanelli, the owner of Skin Beaute Med Spa with locations in Randolph and South Easton, Mass., imported counterfeit Botox, Sculptra and Juvéderm from China and Brazil and performed thousands of injections using these and other counterfeit drugs and devices for which she received more than $1 million in client

payments. Fadanelli falsely represented to her clients and employees that she was a nurse; in fact, Fadanelli is an aesthetician and was never licensed to perform injections or otherwise dispense or administer prescription drugs or devices.

The charge of importing merchandise contrary to law provides for a sentence of up to 20 years in prison, three years of supervised release and a fine of $250,000. The charges of knowingly selling or dispensing a counterfeit drug or counterfeit device each provide for a sentence of up to 10 years in prison, three years of supervised release and a fine of $250,000. Sentences are imposed by a federal district court judge based upon the U.S. Sentencing Guidelines and statutes which govern the determination of a sentence in a criminal case.

If you or a family member believe you received services involving a counterfeit drug or counterfeit device from Fadanelli and/or Skin Beaute Med Spa between 2021 and 2025, please complete the questionnaire located on the FDA's website at https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/criminal-investigations/oci-vw-assistance. Information about the status of the case is located on the U.S. Attorney's Office website: https://www.justice.gov/usao-ma/victim-and-witness-assistance-program/united-states-v-rebecca-fadanelli.

United States Attorney Leah B. Foley; Fernando P. McMillan, Special Agent in Charge of the New York Field Office of the U.S. Food and Drug Administration, Office of Criminal Investigations; and Jennifer De La O, Director of Field Operations, U.S. Customs and Border Protection, Boston Field Office made the announcement today. The Medicaid Fraud Division of the Massachusetts Attorney General's Office and the Stoughton and Randolph Police Departments also provided valuable assistance in the investigation. Assistant U.S. Attorneys Leslie Wright and Sarah Hoefle of the Health Care Fraud Unit are prosecuting the case.

Updated April 7, 2026

Topics

CONSUMER PROTECTION | **HEALTHCARE FRAUD**

Component

USAO - Massachusetts

Related Content

PRESS RELEASE

Pharmacist Pleads Guilty to Drug Diversion from National Pharmacy Chain

BOSTON – A Pittsfield pharmacist pleaded guilty yesterday in federal court in Boston to diverting Adderall and Dextroamp-amphetamin (generic Adderall) from a national pharmacy chain.

September 18, 2026

PRESS RELEASE

Massachusetts Man Sentenced to Prison for Conspiring to Violate the Anti-Kickback Statute

BOSTON – A Massachusetts man was sentenced on Sept. 10, 2026 for conspiring to violate the Anti-Kickback Statute.

September 17, 2026

PRESS RELEASE

Eye Practice and Physician Owner Agree to Pay $350,000 to Resolve Allegations of False Claims to Medicare

BOSTON – St. Michael's Eye & Laser Institute, a Florida ophthalmology practice, and Dr. John Michaelos, an ophthalmologist and owner of St. Michael's Eye & Laser Institute, have agreed to...

September 11, 2026

District of Massachusetts

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Boston: 617-748-3100

Springfield: 413-785-0235

Worcester: 508-368-0100

PRESS RELEASE

Spa Owner Arrested for Allegedly Performing Thousands of Illegal Counterfeit Injections on Clients for Over Three Years

Friday, November 1, 2024

For Immediate Release

U.S. Attorney's Office, District of Massachusetts

Defendant owns Skin Beaute Med Spa in Randolph and South Easton

BOSTON – A Stoughton woman has been arrested and charged in connection with smuggling goods into the United States and selling/dispensing counterfeit drugs and devices.

Rebecca Fadanelli, 38, was charged by criminal complaint with one count of illegally importing merchandise contrary to law, one count of selling or dispensing a counterfeit drug, and one count of selling or dispensing a counterfeit device. Fadanelli was arrested this morning and will appear in federal court in Worcester at 1 p.m. this afternoon.

According to the charging documents, since March 2021, Fadanelli, the owner of Skin Beaute Med Spa with locations in Randolph and South Easton, Mass., has been importing counterfeit Botox, Sculptra and Juvederm from China and Brazil and performing thousands of injections of counterfeit drugs and devices for which she received over $900,000 in client payments. It is alleged that Fadanelli consistently represented to clients and employees that she is a nurse; in fact, Fadanelli is

an aesthetician and is not licensed nor certified to dispense or administer prescription drugs or devices. According to payment records, from approximately March 2021 through March 2024, Fadanelli completed approximately 1,631 Botox appointments, totaling $522,869 in client payments, and 1,085 filler appointments, totaling $410,545 in client payments.

> ***"For years, Ms. Fadanelli allegedly put unsuspecting patients at risk by representing herself to be a nurse and then administering thousands of illegal, counterfeit injections. Protecting the people of Massachusetts covers a wide range of conduct and here it involves an individual who ignored safety regulations against bringing unapproved, counterfeit drugs and devices into our country and endangered the health of hundreds of her clients. The type of deception alleged here is illegal, reckless and potentially life-threatening," said Acting United States Attorney Joshua S. Levy. "Today's arrest underscores our commitment to protecting the public from fraudulent and dangerous practices in the medical and cosmetic fields."***

"Individuals who dispense and administer counterfeit injectable cosmetic drugs or medical devices, such as Botox or Juvederm, put the health of unsuspecting American consumers at significant risk," said Special Agent in Charge Fernando McMillan, FDA Office of Criminal Investigations New York Field Office. "We will continue to pursue and bring to justice those who choose to subvert the safeguards of the legitimate drug and device regulatory regime and supply chain and jeopardize the public health."

"Every day, our frontline CBP officers and agriculture specialists work tirelessly to protect the American public from illegal and harmful counterfeit products being smuggled into the United States. This case is a prime example of the collaborative efforts that are taken by our law enforcement community to bring these violators to justice," said Jennifer De La O, Director of Field Operations for U.S. Customs and Border Protection in Boston.

The charge of importing merchandise contrary to law provides for a sentence of up to 20 years in prison, three years of supervised release and a fine of $250,000. The charges of knowingly selling or dispensing a counterfeit drug or counterfeit device each provide for a sentence of up to 10 years in prison, three years of supervised release and a fine of $250,000. Sentences are imposed by a federal district court judge based upon the U.S. Sentencing Guidelines and statutes which govern the determination of a sentence in a criminal case.

If you or a family member believe you received services involving a counterfeit drug or counterfeit device from Fadanelli and/or Skin Beaute Med Spa between 2021 through and including to the present date, please complete the questionnaire located on the FDA's website at https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/criminal-investigations/oci-vw-assistance. Information about the status of the case is located on the U.S. Attorney's Office website: https://www.justice.gov/usao-ma/victim-and-witness-assistance-program/united-states-v-rebecca-fadanelli.

Acting U.S. Attorney Levy, FDA OCI SAC McMillan and CBP Field Operations Director De La O made the announcement today. Assistant U.S. Attorneys Leslie Wright and Sarah Hoefle of the Criminal Division are prosecuting the case.

The details contained in the charging documents are allegations. The defendant is presumed innocent unless and until proven guilty beyond a reasonable doubt in a court of law.

Updated November 1, 2024

Topic

CONSUMER PROTECTION

Component

USAO - Massachusetts

Related Content

PRESS RELEASE

Med Spa Owner Sentenced to 46 Months in Prison for Performing Thousands of Counterfeit Botox and Filler Injections

BOSTON – A Massachusetts woman has been sentenced in federal court in Boston to nearly four years in prison for performing thousands of cosmetic injection procedures using counterfeit Botox and...

September 4, 2026

PRESS RELEASE

Med Spa Owner Pleads Guilty to Performing Thousands of Injections Using Counterfeit Products

BOSTON – A Stoughton, Mass. woman pleaded guilty today in federal court in Boston to charges relating to thousands of injections she performed using counterfeit Botox and dermal fillers imported...

April 7, 2026

PRESS RELEASE

Federal Court Orders SunSetter to Pay $9.25 Million for Alleged Failure to Timely Report Defective Awning Covers to Regulators

BOSTON – A federal court in Massachusetts entered a consent decree today requiring SunSetter Products LP (SunSetter) to pay $9.25 million in civil penalties and implement and maintain a robust...

April 2, 2025

District of Massachusetts

Boston Office:

1 Courthouse Way, Suite 9200

Boston, MA 02210

PRESS RELEASE

Gobles Man Sentenced for Selling Chinese Drugs Without FDA Approval

Thursday, July 23, 2026

For Immediate Release

U.S. Attorney's Office, Western District of Michigan

GRAND RAPIDS, MICHIGAN – U.S. Attorney for the Western District of Michigan Timothy VerHey today announced that Brandon Piper, age 35, of Gobles, Michigan was sentenced to 21 months in prison for conspiracy to introduce misbranded drugs into the market with the intent to defraud and mislead both the U.S. Food and Drug Administration (FDA) and consumers. During sentencing, U.S. District Judge Robert J. Jonker stated that his sentence was designed to send a message to Piper and to the public about the consequences of ignoring the FDA and the law.

According to sentencing filings, Piper helped perpetrate an extensive scheme to import unapproved, misbranded prescription drugs, including peptides, which are popular weight loss drugs, into the United States from China for distribution to customers. The customers purchased the illicit drugs first on a Canadian website and later on Piper's own site – www.MilestonePurity.com. Both websites claimed that the drugs were "for research purposes only" even though Piper and his co-conspirators knew that customers would be using them personally. Many of the drugs also purported to be a "Product of the USA" even though conspirators purchased them from China.

Examples of the drugs sold on the websites included semaglutide and tirzepatide. Both drugs require the purchaser to have a prescription from a licensed practitioner before they can be dispensed. However, the drugs were sold without obtaining prescriptions from customers and were shipped to customers without adequate directions for use.

FDA-approved semaglutide products bear a boxed warning, commonly referred to as a "black box warning," which is the strongest warning FDA requires. This warning indicates that the drug carries a significant risk of serious or even life-threatening adverse effects. The boxed warning addresses the risk of thyroid C-cell tumors. FDA-approved tirzepatide also bears a boxed warning addressing the risk of thyroid C-Cell tumors. Piper's drugs omitted these warnings.

"Brandon Piper's business bypassed important drug safeguards that made him a danger to his customers," said United States Attorney Timothy VerHey. "By going around the prescription requirement, he made drugs available to his customers that are dangerous – and even deadly – when used improperly. Also, the foreign drugs Piper was selling lacked any kind of quality control and could have contained anything. Put those two factors together and you have a recipe for disaster. Because of that, my office will always treat people like Piper just like street level drug dealers."

"The FDA is committed to disrupting and dismantling the illegal sales of drugs online," said Special Agent in Charge Ronne Malham, FDA Office of Criminal Investigations, Chicago Field Office. "We will continue to investigate and bring to justice those who exploit the internet for profits with reckless disregard for the risk to public health and safety."

The FDA Office of Criminal Investigations prepared the case, and Assistant U.S. Attorney Stephanie M. Carowan is prosecuting it. One of Piper's co-defendants, Mayze Nichols, is scheduled to be sentenced on related charges before United States Magistrate Judge Ray Kent on September 15, 2026.

Updated July 23, 2026

Topics

DRUG TRAFFICKING | **PRESCRIPTION DRUGS**

Component

USAO - Michigan, Western

Alabama Dental Hygiene Program(ADHP)

Addressing Alabama's Dental Hygiene Workforce Shortages

Presented by Melodie Anderson Jones, DMD, FACD, FICD, FPFA

Past - President, Board of Dental Examiners of Alabama

Disclaimer

I served on the Board of Dental Examiners of Alabama 2020-2025. I just rotated off the Board of Dental Examiners on October 10, 2025. I am Past President of the Board of Dental Examiners of Alabama.

- My presentation is based on my personal experiences in organized dentistry, as an ADHP instructor, and as board member of the Board of Dental Examiners of Alabama. The presentation represents my views and not those of the Board of Dental Examiners of Alabama. The presentation is not and should not be considered a formal Board of Dental Examiners of Alabama Opinion or Ruling. Please consult the Board at www.dentalboard.org for any information needed.



Dr. Melodie A. Jones



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- Past Chair, ADPH (Alabama Department of Public Health) Dental Council
- Past Member, State Committee of Public Health in Alabama

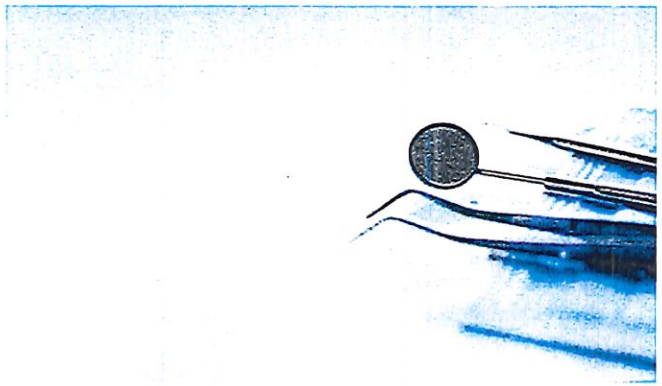




Dr. Melodie Jones

ADHP Experience

- Over 34 years of private practice in General Dentistry
- Instructed and Sponsored 4 of my own dental assistants who became dental hygienists in my practice and remained in my employment
- Served as an examiner at the licensure exam for ADHP
- Served on the Board of Dental Examiners of Alabama and oversaw the program as a board member





The Workforce Challenge



Alabama and National Dental Hygiene Shortages

- Dental workforce shortages continue to impact access to care
- Rural and underserved areas experience the greatest need.
- Recruiting and retaining hygienists remains challenging
- Preventive dental services are essential to overall health



Dental Auxiliary Training in Alabama

- **Dental Assisting**
  1. On the Job Training
  2. Dental Assisting Schools
  3. Future Students in the Alabama School of Healthcare Sciences
- **Dental Lab Technicians**
  1. On the Job Training
  2. Dental Lab Technician Schools
  3. Future Students at the Alabama School of Healthcare Sciences
- **Dental Hygienists**
  1. Alabama Dental Hygiene Program
  2. Dental Hygiene Schools - only 3 hygiene schools in Alabama

ALABAMA SCHOOL OF HEALTHCARE SCIENCES

COMPASSION • INNOVATION • INTEGRITY • SERVICE

ASHS school in Demopolis, AL

Demopolis, AL is in the Black Belt of Alabama , underserved part of AL in the Southwest portion of the state

ASHS FOUNDATION

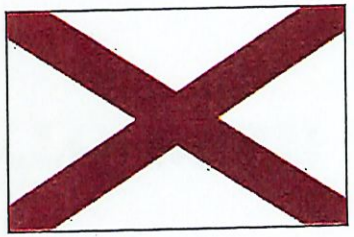
Helping build tomorrow's healthcare workforce

History of the Alabama Dental Hygiene Program (ADHP)

A Proven Workforce Model in Alabama Since 1959

- In 1959, the Alabama Legislature authorized the Board of Dental Examiners of Alabama to establish a dental hygiene training permit program
  Rule 270-X-3-.04 - Alabama Dental Hygiene Program Requirements(Alabama Administrative Code and Alabama Dental Practice Act)
- The ADHP was created to address statewide shortages of dental hygienists particularly in rural and underserved communities
- ADHP became one of the nation's earliest accelerated dental hygiene certification pathways developed through direct dentist supervision and Board oversight.

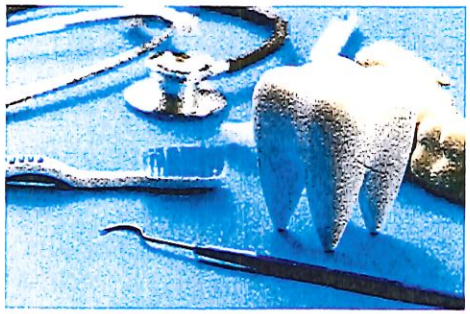




Alabama Dental Hygiene Program

Over the past 60 plus years

- The program has evolved into a structured educational model with-
  - Formal didactic program
  - Clinical competency requirements
  - Standardized board examinations- ADEX
  - Certified instructor training



- Produces each year 150 Licensed Dental Hygienists(RDH) in Alabama
- Graduates of the ADHP receive 17 hours of College Credit from the American Council on Education (ACE) to use if they choose to pursue an advanced education- associates or bachelor degree

Alabama Dental Hygiene Program

Requirements

- Applicants must be 19 years of age
- Must have worked for a dentist as a dental assistant chairside 30 hours(or 3 and 1/2 days)per week for a minimum of 24 months within a 3 year period prior to enrollment
- Must have worked for the Dentist Instructor/Sponsor for 12 months (One Dentist can only instruct one ADHP student, 1:1 ratio)
- Must remain in full time employment of the Dentist Instructor/Sponsor
- Must remain under direct supervision of the Dentist Instructor/ Sponsor while enrolled in ADHP

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For more information on the ADHP

Consult the Following-

Board *of* Dental Examiners *of* Alabama

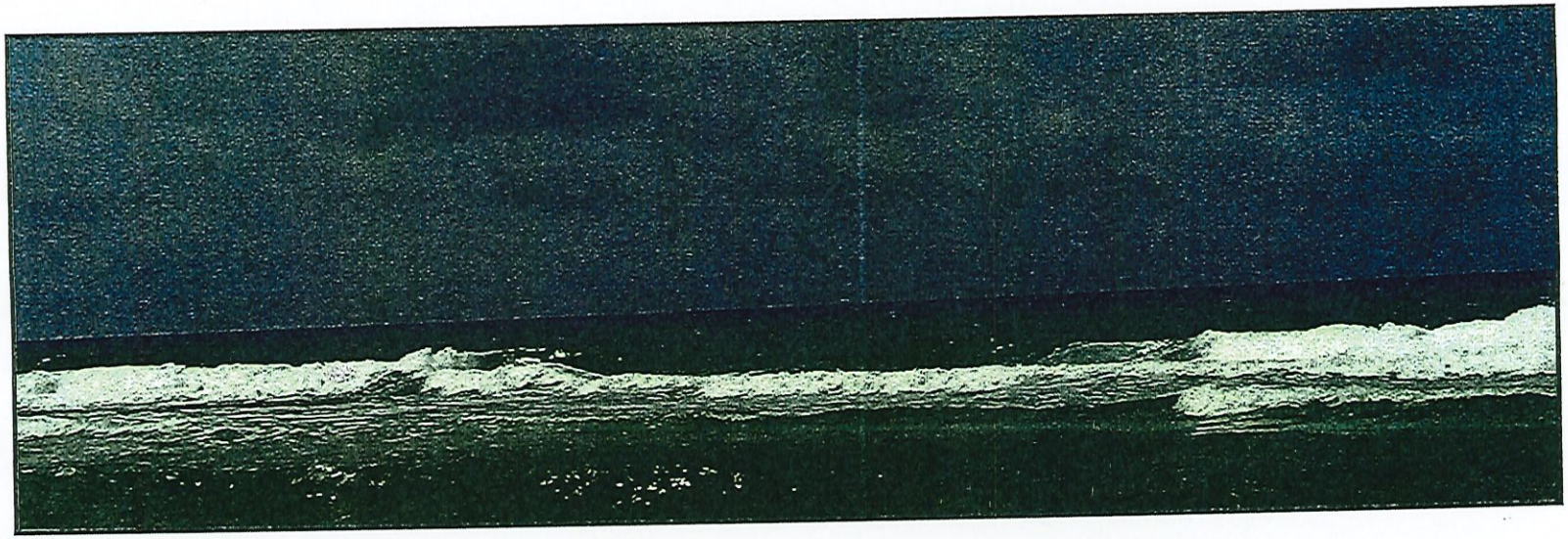
dentalboard.org

ADHP Information

ADHP Handbook

https://admincode.legislature.state.al.us/administrative-code/270-X-3-.04

Rule 270-X-3-.04 - Alabama Dental Hygiene Program Requirements



Thank you!



Melodie Jones, DMD

melodieandersonjones04@gmail.com



270-X-3.04 Alabama Dental Hygiene Program (ADHP) Requirements.
(1) Student Hygienists must be at least eighteen (18) years of age prior to the time the employer makes application to begin training, of good moral character, and of good health.

(2) Student Hygienist must be a graduate of an accredited high school or hold a GED certificate.

(3) Student Hygienists must have had at least twenty-four (24) full months of full time employment as a dental assistant, or the equivalent of twenty-four (24) full months in Part-time employment. This time must be spent assisting at the chair. Fulltime shall mean employment of at least three and one-half (3 1/2) days or thirty (30) hours of Board approved employment per week. Graduates of an approved school of dental assisting will be given credit for such course on a formula determined by the Board.

(4) Student Hygienists must be employed full time during the effective period of the training permit before being eligible to take the Dental Hygiene Licensure examination. Full time shall mean employment of at least three and one-half (3 1/2) days or thirty (30) hours of Board approved employment per week with their primary certified dentist instructor whose name appears on the training permit. Any dentist licensed and practicing dentistry full time in the State of Alabama may be issued a training permit upon application to the Board of Dental Examiners, which shall have the discretion to grant or deny such permit. No dentist shall be issued a training permit unless certified by the Board of Dental Examiners of Alabama, which shall have the discretion to grant or deny such certification. The certification shall be valid for three (3) years from the date of issuance. In the event the certification expires during the effective period of the training permit, the dentist shall be allowed to continue training subject to enrolling in and taking the online certification course. Any dentist who is certified shall be given credit for continuing dental education.

(5) Student Hygienists may practice only under the direct supervision of the dentist whose name appears on the training permit; however, another dentist employed in the same office who is certified pursuant to this Rule may perform pre and post prophylactic examinations of the student hygienist's patients.

(6) The closing date for accepting applications for training permits for the current year is May 30.

(7) Student hygienists are allowed one transfer of their training permit per class cycle based upon approval by the Board of Dental Examiners of Alabama. During the period of the student hygienist training permit, the student may only be terminated for good cause which shall be determined by the Board. A student hygienist who has participated in the Alabama Dental Hygiene Program twice unsuccessfully may apply to participate in the program a third time at the discretion of the Board after two (2) years of continual full time employment as a dental assistant.

(8) All student hygienists must attend all sessions of the academic instruction given at the University of Alabama in Birmingham under the auspices of the Board. Each student hygienist's grades shall be given to the Board for review.

(9) If the student hygienist fails to attend all sessions of academic instruction then such student hygienist is no longer eligible for a renewal training permit without consent of the entire Board.

(10) No dentist shall be permitted to train more than one (1) student hygienist at a time.

(11) Student Hygienists who obtain training in the ADHP must pay a fee in an amount fixed by the Board, (this includes training permit, examination, certificate and workshop fees), which must be enclosed with the application for training permit. The academic instruction portion of the fee may be refunded only within the first thirty (30) days of issuance and only at the Board's discretion.

Statutory Authority Code of Alabama (1975), §§ 34-9-2, 34-9-4, 34-9-16, 34-9-26, 34-9-43(10).
Original Rule Filed: September 28, 1982, Amended Filed December 7, 2011, Adopted February 3, 2012

26102763D

SENATE BILL NO. 178

Offered January 14, 2026
Prefiled January 9, 2026

A BILL to amend and reenact §§ 54.1-2708.5 and 54.1-2729.01 of the Code of Virginia, relating to preventative dental assistants; licensing.

Patrons—Locke, Pillion, Craig, Favola, Head, Pekarsky and Srinivasan

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2708.5 and 54.1-2729.01 of the Code of Virginia are amended and reenacted as follows:

§ 54.1-2708.5. Digital scans for use in the practice of dentistry; practice of digital scan technicians.

A. No person other than a dentist, dental hygienist, dental assistant I, dental assistant II, *preventative dental assistant,* digital scan technician, or other person under the direction of a dentist shall obtain dental scans for use in the practice of dentistry.

B. A digital scan technician who obtains dental scans for use in the practice of teledentistry shall work under the direction of a dentist who is (i) licensed by the Board to practice dentistry in the Commonwealth, (ii) accessible and available for communication and consultation with the digital scan technician at all times during the patient interaction, and (iii) responsible for ensuring that the digital scan technician has a program of training approved by the Board for such purpose. All protocols and procedures for the performance of digital scans by digital scan technicians and evidence that a digital scan technician has complied with the training requirements of the Board shall be made available to the Board upon request.

§ 54.1-2729.01. Practice of dental assistants.

A. A person who is employed to assist a licensed dentist or dental hygienist by performing duties not otherwise restricted to the practice of a dentist, dental hygienist, ~~or~~ dental assistant II, *or preventative dental assistant* as prescribed in regulations promulgated by the Board may practice as a dental assistant I.

B. A person who (i) has met the educational and training requirements prescribed by the Board~~;~~, (ii) holds a certification from a credentialing organization recognized by the American Dental Association~~;~~, and (iii) has met any other qualifications for registration as prescribed in regulations promulgated by the Board may practice as a dental assistant II. A dental assistant II may perform duties not otherwise restricted to the practice of a dentist or dental hygienist under the direction of a licensed dentist that are reversible, intraoral procedures specified in regulations promulgated by the Board.

C. Notwithstanding subsection A, a dental assistant I or dental assistant II with a minimum of 1,800 hours of clinical experience may be certified as a preventative dental assistant, provided that:

1. The preventative dental assistant has undergone training, consisting of at least 120 hours of didactic and clinical manikin or human subject training in the areas specified in this subsection (i) by a licensed dentist or licensed dental hygienist employed or engaged by a licensed dentist and implementing an educational curriculum provided by a statewide association that is exempt under 26 U.S.C. § 501(c)(6) of the Internal Revenue Code and primarily represents dentists licensed in the Commonwealth, (ii) by a federal program approved by or associated with the U.S. Department of Veterans' Affairs or U.S. Indian Health Services or while serving on active military duty, or (iii) by an existing dental assistant education program; and

2. The licensed dentist who provides, supervises, or confirms the training of the preventative dental assistant certifies under oath that the dental assistant has completed the training described in subdivision 1, as well as at least 20 supervised full-mouth supragingival scaling procedures with consent of the patients. Documentation of such certification shall be maintained in writing or electronically by the licensed dentist and produced to the Board upon request. Such certifications and documentation thereof may be relied upon and maintained by subsequent employers of a preventative dental assistant. A licensed dentist may certify any preventative dental assistant who presents evidence of such training completed pursuant to clause (ii) of subdivision 1.

A licensed dentist shall not indirectly supervise more than two preventative dental assistants at any one time while such assistants are performing polishing or supragingival scaling patients.

D. A preventative dental assistant may, in addition to the duties authorized for a dental assistant I or dental assistant II, perform the following under indirect supervision of a licensed dentist:

1. Placing and finishing restoration material after a dentist prepares a tooth for restoration;

2. Taking impressions;

3. Creating and fitting temporizations;

4. Packing cord;

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5. Removing cement from crowns;
6. Adjusting dentures and other removable oral appliances;
7. Removing sutures and dressings;
8. Performing supragingival scaling with hand and ultrasonic scalers;
9. Performing coronal polishing;
10. Preparing dental armamentarium; and
11. Explaining periodontal etiology and classification to a patient.

2. That regulations promulgated by the Board of Dentistry pursuant to this act shall be exempt from the requirements of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

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SENATE BILL NO. 282

Offered January 14, 2026

Prefiled January 13, 2026

A BILL to amend and reenact §§ 54.1-2722 and 54.1-3408 of the Code of Virginia, relating to dental hygienist licensure; dentists eligible to practice in a foreign country or jurisdiction.

Patrons—Aird, Srinivasan, Favola, Locke, Pekarsky, Pillion and VanValkenburg

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2722 and 54.1-3408 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2722. License; application; qualifications; practice of dental hygiene; report.

A. No person shall practice dental hygiene unless he possesses a current, active, and valid license from the Board ~~of Dentistry~~. The licensee shall have the right to practice dental hygiene in the Commonwealth for the period of his license as set by the Board, under the direction of any licensed dentist.

B. An application for such license shall be made to the Board in writing and shall be accompanied by satisfactory proof that the applicant (i) is of good moral character, (ii) is a graduate of a *dental school outside the United States as approved by the Board pursuant to subsection D or a* dental hygiene program accredited by the Commission on Dental Accreditation and offered by an accredited institution of higher education, (iii) has passed the dental hygiene examination given by the Joint Commission on National Dental Examinations, and (iv) has successfully completed a clinical examination acceptable to the Board.

C. The Board may grant a license to practice dental hygiene to an applicant licensed to practice in another jurisdiction if he (i) meets the requirements of subsection B; (ii) holds a current, unrestricted license to practice dental hygiene in another jurisdiction in the United States; (iii) has not committed any act that would constitute grounds for denial as set forth in § 54.1-2706; and (iv) meets other qualifications as determined in regulations promulgated by the Board.

D. *The Board may grant a license to practice dental hygiene to an applicant if he (i) provides proof of graduation from a dental school outside the United States, (ii) is eligible to practice dentistry in a country or jurisdiction outside the United States, and (iii) meets the requirements of subsection B.*

E. A licensed dental hygienist may, under the direction or general supervision of a licensed dentist and subject to the regulations of the Board, perform services that are educational, diagnostic, therapeutic, or preventive. These services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Pursuant to subsection W of § 54.1-3408, a licensed dental hygienist may administer topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine.

A dentist may also authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia. In its regulations, the Board ~~of Dentistry~~ shall establish the education and training requirements for dental hygienists to administer such controlled substances under a dentist's direction.

For the purposes of this section, "general supervision" means that a dentist has evaluated the patient and prescribed authorized services to be provided by a dental hygienist; however, the dentist need not be present in the facility while the authorized services are being provided.

The Board shall provide for an inactive license for those dental hygienists who hold a current, unrestricted license to practice in the Commonwealth at the time of application for an inactive license and who do not wish to practice in Virginia. The Board shall promulgate such regulations as may be necessary to carry out the provisions of this section, including requirements for remedial education to activate a license.

~~E.~~ *F.* For the purposes of this subsection, "remote supervision" means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.

Notwithstanding any provision of law, a dental hygienist employed by the Virginia Department of Health or the Department of Behavioral Health and Developmental Services who holds a license issued by the Board ~~of Dentistry~~ may provide educational and preventative dental care in the Commonwealth under the remote supervision of a dentist employed by the Department of Health or the Department of Behavioral Health and Developmental Services. A dental hygienist providing such services shall practice pursuant to protocols developed jointly by the Department of Health and the Department of Behavioral Health and Developmental Services for each agency, in consultation with the Virginia Dental Association and the Virginia Dental

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Hygienists' Association. Such protocols shall be adopted by the Board as regulations.

A report of services provided by dental hygienists employed by the Virginia Department of Health pursuant to such protocol, including their impact upon the oral health of the citizens of the Commonwealth, shall be prepared and submitted annually to the Secretary of Health and Human Resources by the Department of Health, and a report of services provided by dental hygienists employed by the Department of Behavioral Health and Developmental Services shall be prepared and submitted annually to the Secretary of Health and Human Resources by the Department of Behavioral Health and Developmental Services. Nothing in this section shall be construed to authorize or establish the independent practice of dental hygiene.

~~F.~~ *G.* For the purposes of this subsection, "remote supervision" means that a supervising dentist is accessible and available for communication and consultation with a dental hygienist during the delivery of dental hygiene services, but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.

Notwithstanding any other provision of law, a dental hygienist may practice dental hygiene under the remote supervision of a dentist who holds an active license by the Board and who has a dental practice physically located in the Commonwealth. No dental hygienist shall practice under remote supervision unless he has (i) completed a continuing education course designed to develop the competencies needed to provide care under remote supervision offered by an accredited dental education program or from a continuing education provider approved by the Board and (ii) at least two years of clinical experience, consisting of at least 2,500 hours of clinical experience. A dental hygienist practicing under remote supervision shall have professional liability insurance with policy limits acceptable to the supervising dentist. A dental hygienist shall only practice under remote supervision at a federally qualified health center; charitable safety net facility; free clinic; long-term care facility; elementary or secondary school; Head Start program; mobile dentistry program for adults with developmental disabilities operated by the Department of Behavioral Health and Developmental Services' Office of Integrated Health; or women, infants, and children (WIC) program.

A dental hygienist practicing under remote supervision may (a) obtain a patient's treatment history and consent, (b) perform an oral assessment, (c) perform scaling and polishing, (d) perform all educational and preventative services, (e) take X-rays as ordered by the supervising dentist or consistent with a standing order, (f) maintain appropriate documentation in the patient's chart, (g) administer topical oral fluorides, topical oral anesthetics, topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions, and any other Schedule VI topical drug approved by the Board ~~of Dentistry~~ under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine pursuant to subsection W of § 54.1-3408, and (h) perform any other service ordered by the supervising dentist or required by statute or Board regulation. No dental hygienist practicing under remote supervision shall administer local anesthetic or nitrous oxide.

Prior to providing a patient dental hygiene services, a dental hygienist practicing under remote supervision shall obtain (1) the patient's or the patient's legal representative's signature on a statement disclosing that the delivery of dental hygiene services under remote supervision is not a substitute for the need for regular dental examinations by a dentist and (2) verbal confirmation from the patient that he does not have a dentist of record whom he is seeing regularly.

After conducting an initial oral assessment of a patient, a dental hygienist practicing under remote supervision may provide further dental hygiene services following a written practice protocol developed and provided by the supervising dentist. Such written practice protocol shall consider, at a minimum, the medical complexity of the patient and the presenting signs and symptoms of oral disease.

A dental hygienist practicing under remote supervision shall inform the supervising dentist of all findings for a patient. A dental hygienist practicing under remote supervision may continue to treat a patient for 180 days. After such 180-day period, the supervising dentist, absent emergent circumstances, shall either conduct an examination of the patient or refer the patient to another dentist to conduct an examination. The supervising dentist shall develop a diagnosis and treatment plan for the patient, and either the supervising dentist or the dental hygienist shall provide the treatment plan to the patient. The supervising dentist shall review a patient's records at least once every 10 months.

Nothing in this subsection shall prevent a dental hygienist from practicing dental hygiene under general supervision whether as an employee or as a volunteer.

§ 54.1-3408. Professional use by practitioners.

A. A practitioner of medicine, osteopathy, podiatry, dentistry, or veterinary medicine, a licensed advanced practice registered nurse pursuant to § 54.1-2957.01, a licensed certified midwife pursuant to § 54.1-2957.04, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 shall only prescribe, dispense, or administer controlled substances in good faith for medicinal or therapeutic purposes within the course of his professional practice. A licensed midwife pursuant to § 54.1-2957.7 shall only obtain, possess, and administer controlled substances in good faith for medicinal or therapeutic purposes within the course of his professional practice.

B. The prescribing practitioner's order may be on a written prescription or pursuant to an oral prescription

as authorized by this chapter. The prescriber may administer drugs and devices, or he may cause drugs or devices to be administered by:

1. A nurse, physician assistant, or intern under his direction and supervision;

2. Persons trained to administer drugs and devices to patients in state-owned or state-operated hospitals or facilities licensed as hospitals by the Board of Health or psychiatric hospitals licensed by the Department of Behavioral Health and Developmental Services who administer drugs under the control and supervision of the prescriber or a pharmacist;

3. Emergency medical services personnel certified and authorized to administer drugs and devices pursuant to regulations of the Board of Health who act within the scope of such certification and pursuant to an oral or written order or standing protocol;

4. Persons who are employed or engaged at a medical care facility, as defined in § 32.1-3, who have a valid emergency medical services provider certification issued by the Board of Health as a requirement of being employed or engaged at the medical care facility within the scope of such certification, pursuant to an oral or written order or standing protocol to administer drugs and devices at the medical care facility; or

5. A licensed respiratory therapist as defined in § 54.1-2954 who administers by inhalation controlled substances used in inhalation or respiratory therapy.

C. Pursuant to an oral or written order or standing protocol, the prescriber, who is authorized by state or federal law to possess and administer radiopharmaceuticals in the scope of his practice, may authorize a nuclear medicine technologist to administer, under his supervision, radiopharmaceuticals used in the diagnosis or treatment of disease.

D. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize registered nurses and licensed practical nurses to possess (i) epinephrine and oxygen for administration in treatment of emergency medical conditions and (ii) heparin and sterile normal saline to use for the maintenance of intravenous access lines.

Pursuant to the regulations of the Board of Health, certain emergency medical services technicians may possess and administer epinephrine in emergency cases of anaphylactic shock.

Pursuant to an order or standing protocol issued by the prescriber within the course of his professional practice, any school nurse, school board employee, employee of a local governing body, or employee of a local health department who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order or standing protocol that shall be issued by the local health director within the course of his professional practice, any school nurse, licensed athletic trainer under contract with a local school division, school board employee, employee of a local governing body, or employee of a local health department who is authorized by the local health director and trained in the administration of albuterol inhalers and valved holding chambers or nebulized albuterol may possess or administer an albuterol inhaler and a valved holding chamber or nebulized albuterol to a student diagnosed with a condition requiring an albuterol inhaler or nebulized albuterol when the student is believed to be experiencing or about to experience an asthmatic crisis.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, any employee of a school for students with disabilities, as defined in § 22.1-319 and licensed by the Board of Education, or any employee of a private school that is accredited pursuant to § 22.1-19 as administered by the Virginia Council for Private Education who is authorized by a prescriber and trained in the administration of (a) epinephrine may possess and administer epinephrine and (b) albuterol inhalers or nebulized albuterol may possess or administer an albuterol inhaler or nebulized albuterol to a student diagnosed with a condition requiring an albuterol inhaler or nebulized albuterol when the student is believed to be experiencing or about to experience an asthmatic crisis.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, any nurse at an early childhood care and education entity, employee at the entity, or employee of a local health department who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, any employee of a public institution of higher education or a private institution of higher education who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, any employee of an organization providing outdoor educational experiences or programs for youth who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an order or a standing protocol issued by the prescriber within the course of his professional practice, and in accordance with policies and guidelines established by the Department of Health, such prescriber may authorize any employee of a restaurant licensed pursuant to Chapter 3 (§ 35.1-18 et seq.) of Title 35.1 to possess and administer epinephrine on the premises of the restaurant at which the employee is

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SB282

employed, provided that such person is trained in the administration of epinephrine.

Pursuant to an order issued by the prescriber within the course of his professional practice, an employee of a provider licensed by the Department of Behavioral Health and Developmental Services or a person providing services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services may possess and administer epinephrine, provided such person is authorized and trained in the administration of epinephrine.

Pursuant to an order or standing protocol issued by the prescriber within the course of his professional practice, any employee of a place of public accommodation, as defined in subsection A of § 2.2-3904, who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize pharmacists to possess epinephrine and oxygen for administration in treatment of emergency medical conditions.

E. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize licensed physical therapists to possess and administer topical corticosteroids, topical lidocaine, and any other Schedule VI topical drug.

F. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize licensed athletic trainers to possess and administer topical corticosteroids, topical lidocaine, or other Schedule VI topical drugs; oxygen and IV saline for use in emergency situations; subcutaneous lidocaine for wound closure; epinephrine for use in emergency cases of anaphylactic shock; and naloxone or other opioid antagonist for overdose reversal.

G. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, and in accordance with policies and guidelines established by the Department of Health pursuant to § 32.1-50.2, such prescriber may authorize registered nurses or licensed practical nurses under the supervision of a registered nurse to possess and administer tuberculin purified protein derivative (PPD) in the absence of a prescriber. The Department of Health's policies and guidelines shall be consistent with applicable guidelines developed by the Centers for Disease Control and Prevention for preventing transmission of mycobacterium tuberculosis and shall be updated to incorporate any subsequently implemented standards of the Occupational Safety and Health Administration and the Department of Labor and Industry to the extent that they are inconsistent with the Department of Health's policies and guidelines. Such standing protocols shall explicitly describe the categories of persons to whom the tuberculin test is to be administered and shall provide for appropriate medical evaluation of those in whom the test is positive. The prescriber shall ensure that the nurse implementing such standing protocols has received adequate training in the practice and principles underlying tuberculin screening.

The Health Commissioner or his designee may authorize registered nurses, acting as agents of the Department of Health, to possess and administer, at the nurse's discretion, tuberculin purified protein derivative (PPD) to those persons in whom tuberculin skin testing is indicated based on protocols and policies established by the Department of Health.

H. Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize, with the consent of the parents as defined in § 22.1-1, an employee of (i) a school board, (ii) a school for students with disabilities as defined in § 22.1-319 licensed by the Board of Education, or (iii) a private school accredited pursuant to § 22.1-19 as administered by the Virginia Council for Private Education who is trained in the administration of insulin and glucagon to assist with the administration of insulin or administer glucagon to a student diagnosed as having diabetes and who requires insulin injections during the school day or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia. Such authorization shall only be effective when a licensed nurse, an advanced practice registered nurse, a physician, or a physician assistant is not present to perform the administration of the medication.

Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize the possession and administration of undesignated glucagon as set forth in subsection F of § 22.1-274.2.

Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize an employee of a public institution of higher education or a private institution of higher education who is trained in the administration of insulin and glucagon to assist with the administration of insulin or administration of glucagon to a student diagnosed as having diabetes and who requires insulin injections or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia. Such authorization shall only be effective when a licensed nurse, an advanced practice registered nurse, a physician, or a physician assistant is not present to perform the administration of the medication.

Pursuant to a written order issued by the prescriber within the course of his professional practice, such prescriber may authorize an employee of a provider licensed by the Department of Behavioral Health and Developmental Services or a person providing services pursuant to a contract with a provider licensed by the

Department of Behavioral Health and Developmental Services to assist with the administration of insulin or to administer glucagon to a person diagnosed as having diabetes and who requires insulin injections or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia, provided such employee or person providing services has been trained in the administration of insulin and glucagon.

I. A prescriber may authorize, pursuant to a protocol approved by the Board of Nursing, the administration of vaccines to adults for immunization, when a practitioner with prescriptive authority is not physically present, by (i) licensed pharmacists, (ii) registered nurses, or (iii) licensed practical nurses under the supervision of a registered nurse. A prescriber acting on behalf of and in accordance with established protocols of the Department of Health may authorize the administration of vaccines to any person by a pharmacist, nurse, or designated emergency medical services provider who holds an advanced life support certificate issued by the Commissioner of Health under the direction of an operational medical director when the prescriber is not physically present. The emergency medical services provider shall provide documentation of the vaccines to be recorded in the Virginia Immunization Information System.

J. A dentist may cause Schedule VI topical drugs to be administered under his direction and supervision by either a dental hygienist or by an authorized agent of the dentist.

Further, pursuant to a written order and in accordance with a standing protocol issued by the dentist in the course of his professional practice, a dentist may authorize a dental hygienist under his general supervision, as defined in § 54.1-2722, or his remote supervision, as defined in subsection ~~E or~~ F *or G* of § 54.1-2722, to possess and administer topical oral fluorides, topical oral anesthetics, topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions, and any other Schedule VI topical drug approved by the Board of Dentistry.

In addition, a dentist may authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia.

K. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize registered professional nurses certified as sexual assault nurse examiners-A (SANE-A) under his supervision and when he is not physically present to possess and administer preventive medications for victims of sexual assault as recommended by the Centers for Disease Control and Prevention.

L. This section shall not prevent the administration of drugs by a person who has satisfactorily completed a training program for this purpose approved by the Board of Nursing and who administers such drugs in accordance with a prescriber's instructions pertaining to dosage, frequency, and manner of administration, and in accordance with regulations promulgated by the Board of Pharmacy relating to security and record keeping, when the drugs administered would be normally self-administered by (i) an individual receiving services in a program licensed by the Department of Behavioral Health and Developmental Services; (ii) a resident of the Virginia Rehabilitation Center for the Blind and Vision Impaired; (iii) a resident of a facility approved by the Board or Department of Juvenile Justice for the placement of children in need of services or delinquent or alleged delinquent youth; (iv) a program participant of an adult day center licensed by the Department of Social Services; (v) a resident of any facility authorized or operated by a state or local government whose primary purpose is not to provide health care services; (vi) a resident of a private children's residential facility, as defined in § 63.2-100 and licensed by the Department of Social Services, Department of Education, or Department of Behavioral Health and Developmental Services; or (vii) a student in a school for students with disabilities, as defined in § 22.1-319 and licensed by the Board of Education.

In addition, this section shall not prevent a person who has successfully completed a training program for the administration of drugs via percutaneous gastrostomy tube approved by the Board of Nursing and been evaluated by a registered nurse as having demonstrated competency in administration of drugs via percutaneous gastrostomy tube from administering drugs to a person receiving services from a program licensed by the Department of Behavioral Health and Developmental Services to such person via percutaneous gastrostomy tube. The continued competency of a person to administer drugs via percutaneous gastrostomy tube shall be evaluated semiannually by a registered nurse.

M. Medication aides registered by the Board of Nursing pursuant to Article 7 (§ 54.1-3041 et seq.) of Chapter 30 may administer drugs that would otherwise be self-administered to residents of any assisted living facility licensed by the Department of Social Services. A registered medication aide shall administer drugs pursuant to this section in accordance with the prescriber's instructions pertaining to dosage, frequency, and manner of administration; in accordance with regulations promulgated by the Board of Pharmacy relating to security and recordkeeping; in accordance with the assisted living facility's Medication Management Plan; and in accordance with such other regulations governing their practice promulgated by the Board of Nursing.

N. Advanced medication aides registered by the Board of Nursing pursuant to Article 7 (§ 54.1-3041 et seq.) of Chapter 30 may administer drugs that would be administered by a registered medication aide pursuant to subsection M, in addition to drugs determined permissible by the Board of Nursing, in a nursing home licensed by the Department of Health. Advanced medication aides shall administer drugs pursuant to this section in accordance with the prescriber's instructions pertaining to dosage, frequency, and manner of

INTRODUCED

SB282

administration; in accordance with regulations promulgated by the Board of Pharmacy relating to security and recordkeeping; in accordance with the licensed nursing home's policies and procedures; and in accordance with such other regulations governing their practice promulgated by the Board of Nursing.

O. In addition, this section shall not prevent the administration of drugs by a person who administers such drugs in accordance with a physician's instructions pertaining to dosage, frequency, and manner of administration and with written authorization of a parent, and in accordance with school board regulations relating to training, security and record keeping, when the drugs administered would be normally self-administered by a student of a Virginia public school. Training for such persons shall be accomplished through a program approved by the local school boards, in consultation with the local departments of health.

P. In addition, this section shall not prevent the administration of drugs by a person to (i) a child in a child day program as defined in § 22.1-289.02 and regulated by the Board of Education or a local government pursuant to § 15.2-914, or (ii) a student of a private school that is accredited pursuant to § 22.1-19 as administered by the Virginia Council for Private Education, provided such person (a) has satisfactorily completed a training program for this purpose approved by the Board of Nursing and taught by a registered nurse, a licensed practical nurse, an advanced practice registered nurse, a physician assistant, a doctor of medicine or osteopathic medicine, or a pharmacist; (b) has obtained written authorization from a parent or guardian; (c) administers drugs only to the child identified on the prescription label in accordance with the prescriber's instructions pertaining to dosage, frequency, and manner of administration; and (d) administers only those drugs that were dispensed from a pharmacy and maintained in the original, labeled container that would normally be self-administered by the child or student, or administered by a parent or guardian to the child or student.

Q. In addition, this section shall not prevent the administration or dispensing of drugs and devices by persons if they are authorized by the State Health Commissioner in accordance with protocols established by the State Health Commissioner pursuant to § 32.1-42.1 when (i) the Governor has declared a disaster or a state of emergency, the United States Secretary of Health and Human Services has issued a declaration of an actual or potential bioterrorism incident or other actual or potential public health emergency, or the Board of Health has made an emergency order pursuant to § 32.1-13 for the purpose of suppressing nuisances dangerous to the public health and communicable, contagious, and infectious diseases and other dangers to the public life and health and for the limited purpose of administering vaccines as an approved countermeasure for such communicable, contagious, and infectious diseases; (ii) it is necessary to permit the provision of needed drugs or devices; and (iii) such persons have received the training necessary to safely administer or dispense the needed drugs or devices. Such persons shall administer or dispense all drugs or devices under the direction, control, and supervision of the State Health Commissioner.

R. Nothing in this title shall prohibit the administration of normally self-administered drugs by unlicensed individuals to a person in his private residence.

S. This section shall not interfere with any prescriber issuing prescriptions in compliance with his authority and scope of practice and the provisions of this section to a Board agent for use pursuant to subsection G of § 18.2-258.1. Such prescriptions issued by such prescriber shall be deemed to be valid prescriptions.

T. Nothing in this title shall prevent or interfere with dialysis care technicians or dialysis patient care technicians who are certified by an organization approved by the Department of Health Professions or persons authorized for provisional practice pursuant to Chapter 27.01 (§ 54.1-2729.1 et seq.), in the ordinary course of their duties in a Medicare-certified renal dialysis facility, from administering heparin, topical needle site anesthetics, dialysis solutions, sterile normal saline solution, and blood volumizers, for the purpose of facilitating renal dialysis treatment, when such administration of medications occurs under the orders of a licensed physician, an advanced practice registered nurse, or a physician assistant and under the immediate and direct supervision of a licensed registered nurse. Nothing in this chapter shall be construed to prohibit a patient care dialysis technician trainee from performing dialysis care as part of and within the scope of the clinical skills instruction segment of a supervised dialysis technician training program, provided such trainee is identified as a "trainee" while working in a renal dialysis facility.

The dialysis care technician or dialysis patient care technician administering the medications shall have demonstrated competency as evidenced by holding current valid certification from an organization approved by the Department of Health Professions pursuant to Chapter 27.01 (§ 54.1-2729.1 et seq.).

U. Persons who are otherwise authorized to administer controlled substances in hospitals shall be authorized to administer influenza or pneumococcal vaccines pursuant to § 32.1-126.4.

V. Pursuant to a specific order for a patient and under his direct and immediate supervision, a prescriber may authorize the administration of controlled substances by personnel who have been properly trained to assist a doctor of medicine or osteopathic medicine, provided the method does not include intravenous, intrathecal, or epidural administration and the prescriber remains responsible for such administration.

W. A physician assistant, nurse, dental hygienist, or authorized agent of a doctor of medicine, osteopathic medicine, or dentistry may possess and administer topical fluoride varnish pursuant to an oral or written order or a standing protocol issued by a doctor of medicine, osteopathic medicine, or dentistry.

X. A prescriber, acting in accordance with guidelines developed pursuant to § 32.1-46.02, may authorize the administration of influenza vaccine to minors by a licensed pharmacist, registered nurse, licensed practical nurse under the direction and immediate supervision of a registered nurse, or emergency medical services provider who holds an advanced life support certificate issued by the Commissioner of Health when the prescriber is not physically present.

Y. Notwithstanding the provisions of § 54.1-3303, pursuant to an oral, written, or standing order issued by a prescriber or a standing order issued by the Commissioner of Health or his designee authorizing the dispensing of naloxone or other opioid antagonist used for overdose reversal in the absence of an oral or written order for a specific patient issued by a prescriber, and in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health, a pharmacist, a health care provider providing services in a hospital emergency department, and emergency medical services personnel, as that term is defined in § 32.1-111.1, may dispense naloxone or other opioid antagonist used for overdose reversal and a person to whom naloxone or other opioid antagonist has been dispensed pursuant to this subsection may possess and administer naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose. Law-enforcement officers as defined in § 9.1-101, employees of the Department of Forensic Science, employees of the Office of the Chief Medical Examiner, employees of the Department of General Services Division of Consolidated Laboratory Services, employees of the Department of Corrections designated by the Director of the Department of Corrections or designated as probation and parole officers or as correctional officers as defined in § 53.1-1, employees of the Department of Juvenile Justice designated as probation and parole officers or as juvenile correctional officers, employees of regional jails, employees of any state agency, school nurses, local health department employees that are assigned to a public school pursuant to an agreement between the local health department and the school board, school board employees who have completed training and are certified in the administration of an opioid antagonist for overdose reversal by a program administered or authorized by the Department of Health, other school board employees or individuals contracted by a school board to provide school health services, resident assistants in a student housing facility at a public institution of higher education who have completed training in the administration of an opioid antagonist for overdose reversal pursuant to § 23.1-802.2, and firefighters may also possess and administer naloxone or other opioid antagonist used for overdose reversal and may dispense naloxone or other opioid antagonist used for overdose reversal pursuant to an oral, written, or standing order issued by a prescriber or a standing order issued by the Commissioner of Health or his designee in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health.

Notwithstanding the provisions of § 54.1-3303, pursuant to an oral, written, or standing order issued by a prescriber or a standing order issued by the Commissioner of Health or his designee authorizing the dispensing of naloxone or other opioid antagonist used for overdose reversal in the absence of an oral or written order for a specific patient issued by a prescriber, and in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health, any person may possess and administer naloxone or other opioid antagonist used for overdose reversal, other than naloxone in an injectable formulation with a hypodermic needle or syringe, in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health.

Z. Notwithstanding any other law or regulation to the contrary, a person who is acting on behalf of an organization that provides services to individuals at risk of experiencing an opioid overdose or training in the administration of naloxone or other opioid antagonist for overdose reversal may dispense naloxone or other opioid antagonist, provided that such dispensing is (i) pursuant to a standing order issued by a prescriber and (ii) in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Department of Health. If the person acting on behalf of an organization dispenses naloxone or other opioid antagonist in an injectable formulation with a hypodermic needle or syringe, he shall first obtain authorization from the Department of Behavioral Health and Developmental Services to train individuals on the proper administration of naloxone or other opioid antagonist by and proper disposal of a hypodermic needle or syringe, and he shall obtain a controlled substance registration from the Board of Pharmacy. The Board of Pharmacy shall not charge a fee for the issuance of such controlled substance registration. The dispensing may occur at a site other than that of the controlled substance registration provided the entity possessing the controlled substances registration maintains records in accordance with regulations of the Board of Pharmacy. No person who dispenses naloxone or other opioid antagonist on behalf of an organization pursuant to this subsection shall charge a fee for the dispensing of naloxone or other opioid antagonist that is greater than the cost to the organization of obtaining the naloxone or other opioid antagonist dispensed. A person to whom naloxone or other opioid antagonist has been dispensed pursuant to this subsection may possess naloxone or other opioid antagonist and may administer naloxone or other opioid antagonist to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose.

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AA. A person who is not otherwise authorized to administer naloxone or other opioid antagonist used for overdose reversal may administer naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose.

BB. Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize, with the consent of the parents as defined in § 22.1-1, an employee of (i) a school board, (ii) a school for students with disabilities as defined in § 22.1-319 licensed by the Board of Education, or (iii) a private school accredited pursuant to § 22.1-19 as administered by the Virginia Council for Private Education who is trained in the administration of injected medications for the treatment of adrenal crisis resulting from a condition causing adrenal insufficiency to administer such medication to a student diagnosed with a condition causing adrenal insufficiency when the student is believed to be experiencing or about to experience an adrenal crisis. Such authorization shall be effective only when a licensed nurse, an advanced practice registered nurse, a physician, or a physician assistant is not present to perform the administration of the medication.

CC. Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize, with the consent of the student's parents as defined in § 22.1-1, an employee of (i) a school board, (ii) a school for students with disabilities as defined in § 22.1-319 licensed by the Board of Education, (iii) a private school accredited pursuant to § 22.1-19 as administered by the Virginia Council for Private Education, (iv) a local governing body, or (v) a local health department who is trained in the administration of seizure rescue medications for the treatment of seizures resulting from a condition causing seizures to administer such medications to a student diagnosed with a condition causing seizures when the student is believed to be experiencing or about to experience a seizure. Such authorization shall be effective only when a licensed nurse, an advanced practice registered nurse, a physician, or a physician assistant is not capable of reaching the student within the amount of time necessary to effectively perform the administration of the medication.

2. Any regulations promulgated by the Board of Dentistry pursuant to the provisions of this act shall be exempt from the requirements of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

CHAPTER 440

An Act to amend and reenact § 54.1-2729.01 of the Code of Virginia, relating to dental assistants; supragingival scaling and coronal polishing; certification.

[S 178]

Approved April 8, 2026

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2729.01 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2729.01. Practice of dental assistants.

A. A person who is employed to assist a licensed dentist or dental hygienist by performing duties not otherwise restricted to the practice of a dentist, dental hygienist, or dental assistant II, as prescribed in regulations promulgated by the Board may practice as a dental assistant I.

B. A person who (i) has met the educational and training requirements prescribed by the Board; (ii) holds a certification from a credentialing organization recognized by the American Dental Association; and (iii) has met any other qualifications for registration as prescribed in regulations promulgated by the Board may practice as a dental assistant II. A dental assistant II may perform duties not otherwise restricted to the practice of a dentist or dental hygienist under the direction of a licensed dentist that are reversible, intraoral procedures specified in regulations promulgated by the Board.

C. Notwithstanding subsections A and B, a dental assistant I or dental assistant II with a minimum of 1,800 hours of clinical experience may obtain certification to provide additional treatments pursuant to subsection D, provided that:

1. The dental assistant I or dental assistant II has undergone training and obtained certification (i) from a licensed dentist or licensed dental hygienist employed or engaged by a licensed dentist and implementing an education curriculum provided by a statewide association that is exempt under 26 U.S.C. § 501(c)(6) of the Internal Revenue Code and primarily represents dentists licensed in the Commonwealth, (ii) from a federal program approved by or associated with the Indian Health Service or while serving on active military duty, or (iii) from an existing dental assistant education program; and

2. The licensed dentist who provides, supervises, or confirms the training of the dental assistant I or dental assistant II certifies under oath that the dental assistant I or dental assistant II has completed the training described in subdivision 1, as well as at least 20 supervised full-mouth supragingival scaling procedures with consent of the patients. Documentation of such certification shall be maintained in writing or electronically by the licensed dentist and produced to the Board upon request. Such certifications and documentation thereof may be relied upon and maintained by subsequent employers of a dental assistant I or dental assistant II. A licensed dentist may certify any dental assistant I or dental assistant II who presents evidence of such training completed pursuant to clause (ii) of subdivision 1.

D. A dental assistant I or dental assistant II, upon obtaining certification and under indirect supervision of a licensed dentist, may perform (i) supragingival scaling with hand and ultrasonic scalers and (ii) coronal polishing.

E. A licensed dentist shall not indirectly supervise more than two dental assistants at any given time while such dental assistants are performing supragingival scaling or coronal polishing.

2. That regulations promulgated by the Board of Dentistry pursuant to this act shall be exempt from the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

DANB STATE OF THE STATES

Fall 2026

DANB's compilation of state dental assisting requirements is one of the most comprehensive resources available on this topic. The updates below highlight dental assisting state legislative and regulatory changes from April to July 2026.

Alabama

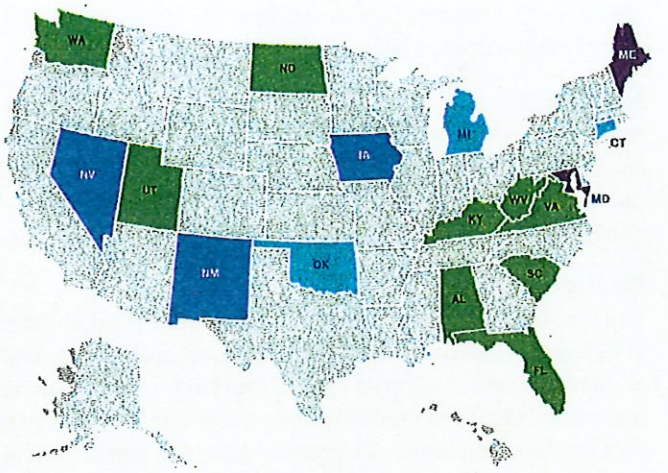
Effective April 13, 2026, the Alabama Board of Dental Examiners expanded the scope of allowable duties for dental assistants to include performing coronal polishing and the placement of pit and fissure sealants under the direct supervision of a duly licensed dentist.

Connecticut

Effective Oct. 1, 2026, a dentist who delegates the taking of dental x-rays by the dental assistant will assume responsibility for the procedure but need not remain on-site in the dental office or treatment facility.

Florida

Effective April 26, 2026, the Florida Board of Dentistry amended rules to add tasks delegable to dental assistants to include polishing clinical crowns using a rotary instrument if a hygienist is in the office when the polishing occurs; removing implant-hybrid prosthetic dentures with a string attached to the removing tool at all times; removing healing abutments and placing scan body on the implant in order to be able to perform intra oral digital scanning; and placing intermediate material that serves as a barrier between the implant screw and restoration of the access screw of the implant restoration. The new rules also remove all references to amalgam restorations.



Categories

- **Expanded functions** — Additional functions for DAs (9 states)
- **Implementing or modifying requirements** — Changes to dental assistant requirements (3 states)
- **Supervision** — Changes to supervision levels for DAs (3 states)
- **Reporting** — Reporting-related requirements that involve dental assistants (2 states)

Iowa

In Iowa, regulations effective June 3 allow dental assistants to practice without registration if they complete a specified term of practical training, which includes jurisprudence and infection control, under the supervision of a licensed dentist.

Kentucky

On April 13, 2026, Gov. Andy Beshear signed HB776, which allows dental assistants to utilize a dental hygiene cordless polisher in addition to the use of a rubber cap attached to a slow-speed rotary dental handpiece. The bill also removes language that would prohibit dental assistants from using any instrumentation that may elicit the removal of calcareous deposits or accretions on the crowns and roots of teeth and the making of final impressions from which casts are made to construct any dental restoration. Additionally, the bill allows the Board of Dentistry to designate funds to administer scholarships or education loan repayment assistance to qualified individuals.

Also signed in April 2026, HB459 will require the licensing authorities of healthcare occupations to collect workforce participation data during the annual, biennial, or triennial licensure renewal process. The new process must be implemented by Jan. 1, 2028.

DANB STATE OF THE STATES
Fall 2026

Maine
On April 13, Gov. Janet Mills signed HP1420/LD2105, updating state laws regarding who is required to report suspected child abuse or neglect, and clarifying the definition of a "health care practitioner" to include a dentist, dental hygienist, and dental assistant.

Maryland
Effective Jan. 1, 2027, a new law mandates criminal history record checks for individuals seeking or renewing licenses and certificates in various health occupations, including dentistry, dental hygiene, and dental assisting.

Categories

- **Expanded functions** — Additional functions for DAs (9 states)
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- **Reporting** — Reporting-related requirements that involve dental assistants (2 states)

Michigan
The Michigan Department of Licensing and Regulatory Affairs amended rule language July 23 to allow a dental therapist to delegate functions to a registered dental assistant or unlicensed dental auxiliary; require an unlicensed dental auxiliary to complete one additional hour of training in infection control, which must include the subject of water line maintenance; require a delegating dentist to keep proof that an unlicensed dental auxiliary has completed the education required to perform functions under delegation; allow the measurement of blood glucose to be delegated to a registered dental assistant or unlicensed dental auxiliary; and clarify that unlicensed dental auxiliaries must identify themselves as unlicensed dental auxiliaries to telehealth patients.

Nevada
Effective July 1, the Nevada Board of Dental Examiners approved amendments to the state Expanded Function Dental Assistant license. The updates specify the scope of practice, continuing education, and renewal and reinstatement requirements, while expanding eligibility criteria to recognize DANB's CDA, CPFDA, and CRFDA exams.

New Mexico
At its Feb. 20 meeting, the New Mexico Board of Dental Health Care approved rule revisions outlining two pathways to dental radiography certification: passing DANB's Radiation Health and Safety (RHS) exam or completing a board-approved course with an integrated exam (both valid 24 months). The new rules, effective Apr. 21, 2026, also add an ethics/jurisprudence course requirement for EFDA/CDHC renewal.

North Dakota
Effective April 1, 2026, amended state rules allow an unregistered dental assistant enrolled in a board-approved qualified dental assistant program and working under the direct supervision of a dentist to perform the duties of a qualified dental assistant. The change also expands the duties of a registered dental assistant under the general supervision of a dentist to include taking final impressions, holding a curing light for a dental procedure, and polishing the coronal surfaces of the teeth by use of air polishing.

Oklahoma
On May 5, Gov. Kevin Stitt signed HB3934, which allows dental assistants to perform certain procedures under general supervision — specifically, to assist a hygienist with procedures the hygienist can perform under general supervision and to complete radiation safety under general supervision.

South Carolina
Signed by Gov. Henry McMaster May 15, H4189 allows dental assistants to perform oral screenings utilizing the Department of Public Health and Environmental Control approved screening system in school and public health settings.

Utah

To implement changes to 2025 legislation (HB372), new administrative rules effective July 8 define the requirements and scope of practice for two new expanded function certifications for dental auxiliaries. Under indirect supervision, eligible dental assistants and dental hygienists may perform:

- Placement of direct restorations
- Removal of coronal adhesive

Categories

- **Expanded functions** – Additional functions for DAs (9 states)
- **Implementing or modifying requirements** – Changes to dental assistant requirements (3 states)
- **Supervision** – Changes to supervision levels for DAs (3 states)
- **Reporting** – Reporting-related requirements that involve dental assistants (2 states)

Virginia

Gov. Abigail Spanberger signed HB 970/SB 178 into law April 9, 2026. The new law, which goes into effect July 1, 2026, allows a Dental Assistant I or II with 1,800 hours of clinical experience to perform supragingival scaling and coronal polishing under dentist supervision.

Washington

Effective May 30, 2026, dental assistants may apply silver diamine fluoride to children in school-based and school-linked programs under the general supervision of a state licensed dentist.

West Virginia

Rule changes effective April 21, 2026, permit the use of dental retraction materials other than a packing cord for crown impressions to ensure flexibility in the standard and allow for the adoption of current and future innovations in retraction materials.

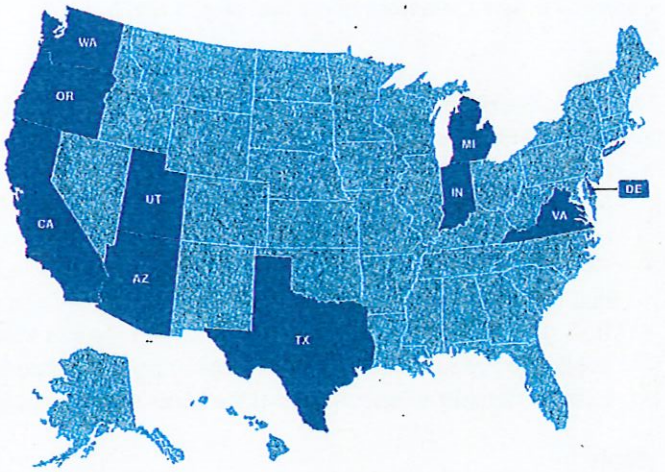
DANB STATE OF THE STATES

Spring 2026

DANB's compilation of state dental assisting requirements is one of the most comprehensive resources available on this topic. The updates below highlight dental assisting state legislative and regulatory changes from August 2025 to April 2026.

Arizona

Following a new state law enacted March 31, 2025, the Arizona State Board of Dental Examiners filed Substantive Policy Statement #1: Board Approved Oral Preventive Assistant Training Courses, effective Aug. 8, 2025. It outlines the minimum standards for prerequisites, curriculum, and clinical instruction that a course must meet to be considered Board approved.



California

On Oct. 10, 2025, Gov. Gavin Newsom signed SB 861, which updates requirements for multiple professional boards and agencies, including the Dental Board of California. The legislation changes the composition of the Board by removing a requirement that it include a registered dental hygienist and replacing this role with a second registered dental assistant. The registered dental assistant members must be registered in the state for at least five years before their appointment.

Delaware

On Sept. 3, 2025, Gov. Matt Meyer signed SB 122, Health Care Workforce Planning, which requires that state regulators work with professional boards to determine what data should be collected during licensing and renewal processes for a range of healthcare professions including medical, dental, and social work. By improving data collection and analysis, the bill seeks to address workforce gaps, support educational program alignment, and help the state better support its aging population and increasing rates of chronic disease.

Indiana

Gov. Mike Braun signed SB 180/HB 1254 on March 3, 2026. The new law, which goes into effect July 1, 2026, amends the requirements for administration of nitrous oxide by a dental assistant by updating training requirements to include completion of courses approved by the Board and also allows a foreign-trained dentist to practice as a dental hygienist.

Michigan

Signed by Gov. Gretchen Whitmer on Oct. 5, 2025, HB 4706 allocates $2 million for federally qualified health center (FQHC) training programs to partner with a state health center careers training program to provide additional recruitment and training opportunities for FQHC employees, including medical and dental assistants.

Oregon

At its Oct. 24, 2025, meeting, the Oregon Board of Dentistry (OBD) approved amended administrative rules clarifying state certification requirements. As they discontinued the administration of the Oregon Basic (ORB) exam in 2024, these regulations remove references to that exam. Candidates are instead required to pass DANB's Infection Control (ICE) exam for the Expanded Function Dental Assistant, Expanded Function Orthodontic Dental Assistant, and Expanded Function

Preventive Dental Assistant certificates. Candidates who passed the ORB before its discontinuation are still able to use their ORB result to qualify for an Oregon expanded function certificate. The new rules also add provisions for the Board to issue a Local Anesthesia Functions Certificate (LAFC) to a dental assistant who holds an Oregon Certified Anesthesia Dental Assistant Certificate and has successfully completed a Board-approved curriculum from a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board. The new rules went into effect Dec. 1, 2025.

Texas

The Texas State Board of Dental Examiners (TSBDE) recently revised a number of rules relating to registration requirements for dental assistants, including:

- Rule §114.2 Registration of Dental Assistants, to reflect the current TSBDE online application process. Effective March 16, 2026, the new rule also revises radiography requirements to include both film and digital formats, and adds a provision for the proper disposal of chemicals used in developing radiographs.
- Rule §114.6 General Qualifications for Registration for Dental Assistants, to specify the documentation required to ensure that only qualified and legally authorized individuals can practice in the state. The rule went into effect March 15, 2026.
- Rule §114.7 Exemption from Registration for Certain Military Service Members and Military Spouses, to modify application requirements and expedite application processing time from 30 days to 10 days for the TSBDE to notify the military member or spouse about the status of their application. The revision was effective March 12, 2026.

Utah

Regulations approved Nov. 24, 2025, establish a Dental Education Advisory Committee (DEAC) membership including one dental assistant with an expanded function certification. The DEAC will assist the Board in its duties, functions, and responsibilities, including advising on proposed practice areas for each expanded function dental auxiliary certification, recommending the minimum required education and training, the scope and limitations for each certification, and education courses for each expanded function.

Virginia

Gov. Abigail Spanberger signed HB 970/SB 178 into law April 9, 2026. The new law, which goes into effect July 1, 2026, allows a Dental Assistant I or II with 1,800 hours of clinical experience to perform supragingival scaling and coronal polishing under dentist supervision.

Washington

A new rule approved Dec. 18, 2025, amends licensure requirements for Expanded Function Dental Auxiliaries (EFDAs) by modifying the training requirements for amalgam restorations. Previously, EFDAs were required to complete training on both typodonts and clinical patients. The amendment makes this dual training optional, allowing EFDAs to complete training on either typodonts or clinical patients. A separate rule requires a minimum age of 18 for registered dental assistants, allowing exceptions for those under 18 who are enrolled in a recognized healthcare career training or vocational education program. Both new rules went into effect Jan. 18, 2026.

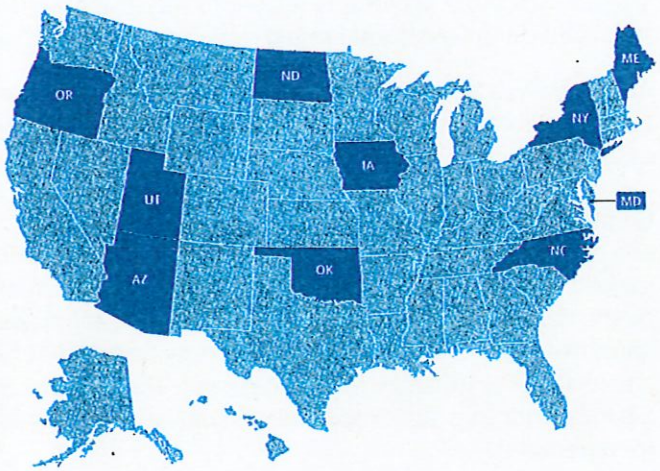
DANB STATE OF THE STATES

Fall 2025

DANB's compilation of state dental assisting requirements is one of the most comprehensive resources available on this topic. The updates below highlight dental assisting state legislative and regulatory changes from Jan. 1, 2025, to July 31, 2025.

Arizona

Arizona enacted a law March 31, 2025, that establishes a new category of oral healthcare professional known as "Oral Preventive Assistant" (OPA). To qualify as an OPA, a dental assistant must complete a board-approved 120-hour training course from a qualifying institution and meet prerequisites including current CPR certification, coronal polishing and radiography certification, and either "current national board certification in dental assisting" or graduation from an accredited dental assisting program. The OPA's practice is strictly limited to removing plaque, calculus, and stains using scalers or sonic/ultrasonic devices, and only on periodontally healthy patients or those with mild gingivitis.



Iowa

On May 1, 2025, the governor signed into law HF805, which allows dental assistants to work without being registered in Iowa. The Iowa Dental Board is in the process of developing rules to implement this new law.

Maine

Effective May 23, 2025, a new law simplifies EFDA and radiographer licensing by expanding EFDA scope to include radiography without needing a separate dental radiographer license. The law eliminates extra licensing costs and simplifies credentialing.

Maryland

Effective April 8, 2025, HB 573 modifies requirements to qualify as an EFDA, specifying that a candidate must complete at least 35 hours of hybrid instruction (online plus in-person), DANB certification, and a board exam. The bill also adds courses from the DALE Foundation and Trapezio Orthodontic Assistant Training Solutions to the list of accepted education and directs the board to establish continuing education requirements, including hands-on clinical training, for EFDAs.

New York

The New York Board for Dentistry added applying topical fluoride varnish to the list of duties that may be delegated to a Registered Dental Assistant in New York. An emergency rule addressing this topic was published in December 2024, and a permanent rule was subsequently approved and adopted as of April 2 , 2025.

North Carolina

Approved July 1, 2025, the North Carolina Board of Dental Examiners amended rules to clarify that supra- and subgingival scaling and use of an ultrasonic scaler may not be delegated to a Dental Assistant 1 or a Dental Assistant 2. The amendment also removes a prohibition on dental assistants applying resin infiltration treatment for incipient smooth surface lesions, following dentist's diagnosis that the lesion is non-penetrable.

North Dakota

A law enacted March 27, 2025, created a new "dental anesthesia assistant" designation for those assisting with sedation-related duties. The same law also authorized the board to conduct CE audits for dental assistants, streamlined other provisions related to registration and discipline of registrants, and added a definition for "qualified dental assistant limited radiology registrant," already defined in rule.

Additionally, a new law effective May 16, 2025, calls for a legislative management study in the 2025-2026 interim term on dental care access, including exploration of apprenticeships and on-the-job training pathways for dental assistants.

Oklahoma

Effective May 21, 2025, SB669 eliminates the "oral maxillofacial surgery assistant" permit and, instead, adds an "oral maxillofacial surgery expanded duty" permit to the list of dental assisting expanded duty permits administered by the Oklahoma Board of Dentistry. The new oral maxillofacial surgery expanded duty permit incorporates and takes the place of a similar expanded duty permit that had allowed dental assistants to assist a dentist holding a parenteral or pediatric sedation permit. The new law also requires all dental assistants to apply for and obtain permits prior to practicing; under the old law, dental assistants had 30 days from beginning employment to apply for a permit.

Oregon

The Oregon Board of Dentistry approved a temporary rule change to comply with a 2023 law that made changes to requirements for dental assisting certificates and became effective July 1, 2025. Under the new rules, applicants for any type of dental assisting expanded functions certificate may now meet the examination requirement by taking only one exam. Dental assisting exams required for any type of dental assisting certificate in Oregon are now available in English, Spanish, and Vietnamese.

Utah

The state legislature passed a law effective May 7, 2025, directing the Division of Professional Licensing to create certifications for dental assistants to perform placement of direct restorations and removal of coronal dental adhesive and to make rules regarding the education and minimum qualifications for certification.

DANB

Dental Assistants and Supragingival Scaling

Perspectives from patients and the profession

Many states are exploring allowing dental assistants to perform supragingival scaling, sometimes called an Oral Preventive Assistant. This is an important conversation and perspectives from all involved are needed.

To gather more perspectives, the Dental Assisting National Board (DANB) conducted research to capture essential insights from dental assistants and patients.

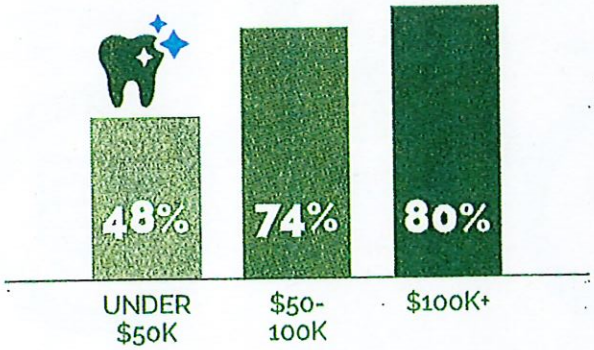
Patient Perspectives

Patients recognized the importance of routine cleanings and expected their provider to have education and credentials.

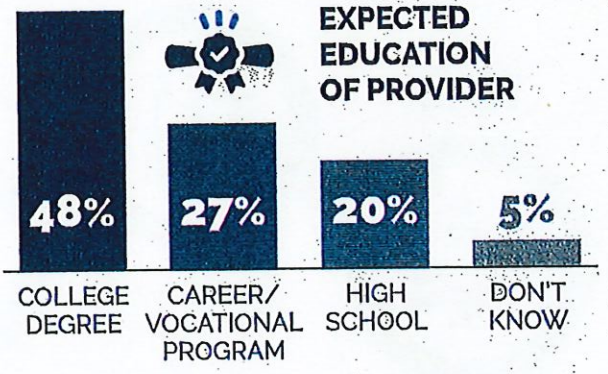
74% SAID ROUTINE CLEANINGS ARE VERY IMPORTANT

65% HAD A ROUTINE TEETH CLEANING WITHIN THE LAST 12 MONTHS

PATIENTS WITH HIGHER HOUSEHOLD INCOME WERE MORE LIKE TO RECEIVE A ROUTINE TEETH CLEANING



EXPECTED EDUCATION OF PROVIDER



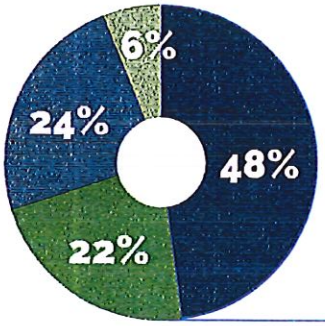
4 OUT OF 5 PATIENTS SAID IT WAS VERY IMPORTANT FOR PROVIDERS TO HAVE HANDS-ON CLINICAL TRAINING AND HOLD A LICENSE, REGISTRATION OR CERTIFICATION

Dental Assistant Perspectives

Dental assistants were mixed in their support and interest of performing supragingival scaling, but expressed the need for qualifications and receiving increased compensation.

65%

AWARE THAT SOME STATES ARE LOOKING TO ALLOW ASSISTANTS TO PERFORM SUPRAGINGIVAL SCALING

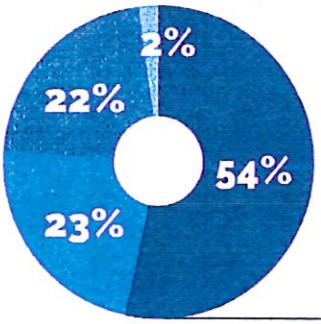


SUPPORT OF NEW ROLE

- Fully support
- Somewhat support
- Do not support
- No opinion

PAY AS TOP CONSIDERATION

$35 PER HOUR = FAIR PAY
(NATIONAL MEDIAN)

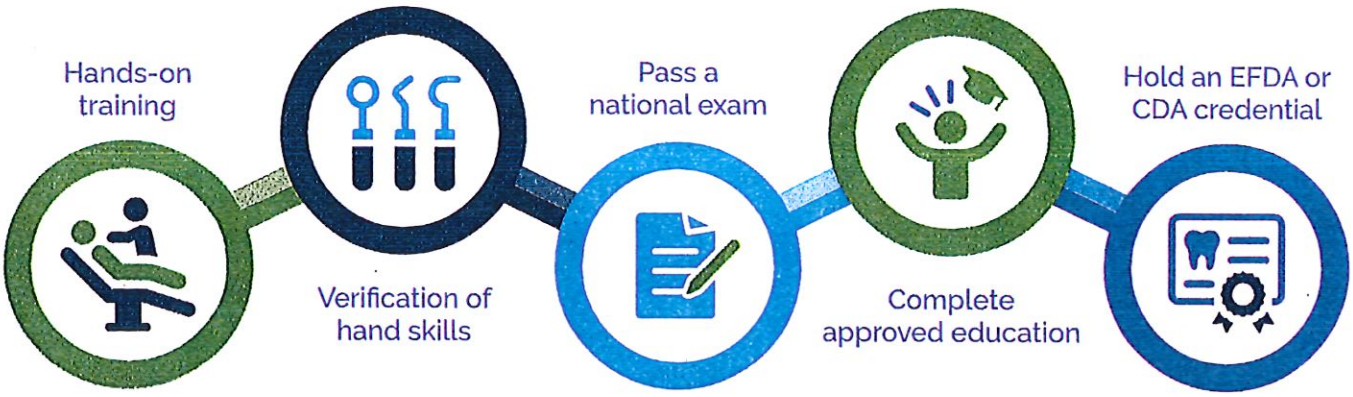


INTEREST IN NEW ROLE, IF ALLOWED

- Yes
- Maybe
- No
- Already qualified

IMPORTANT QUALIFICATIONS

Dental assistants expressed very strong support for training, education, and credentials.



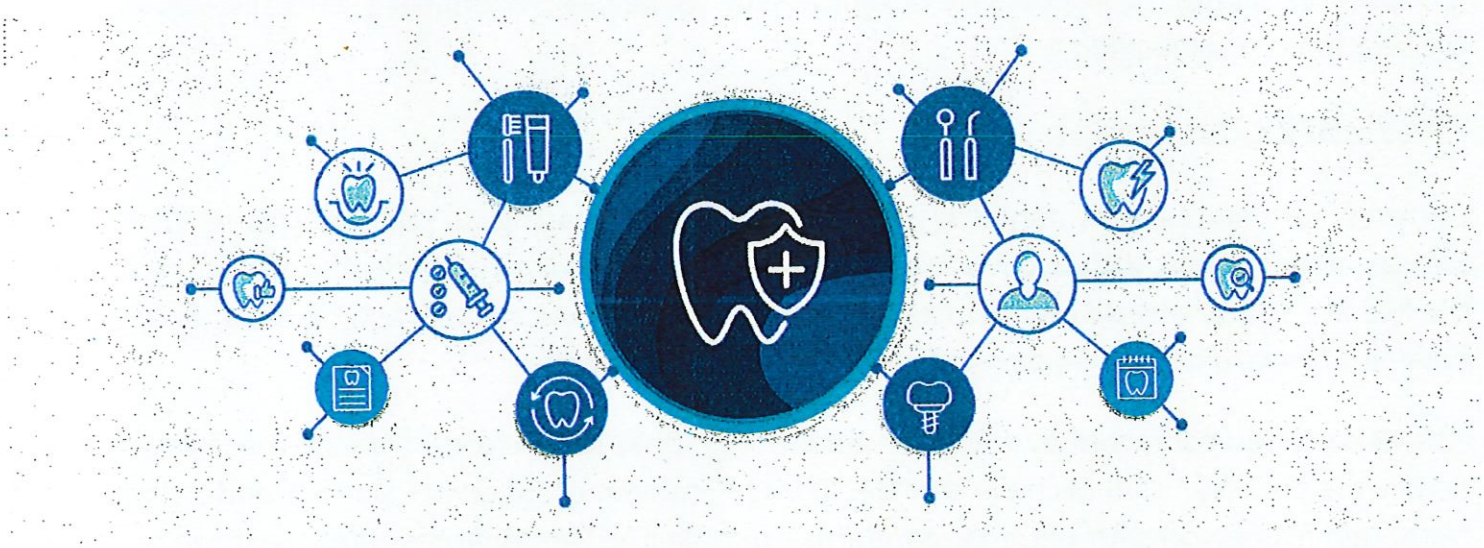
ABOUT THE SURVEY

The patient survey was conducted in July 2026 by Big Village Surveys, an online consumer omnibus survey. More than 1,000 adults responded, representing a variety of demographics. This survey sample size is sufficient to generalize the results to the U.S. adult population.

The dental assistant survey was conducted in conjunction with DANB's 2026 Dental Assistants Salary and Satisfaction Survey in April 2026. More than 1,500 dental assistants responded. This survey sample size is sufficient to generalize the results to the U.S. dental assistant population.

Surveys reveal new perspectives on scaling dental assistants

September 18, 2026



Many states are exploring allowing dental assistants to perform supragingival scaling, sometimes called an Oral Preventive Assistant (OPA), as a solution to the ongoing workforce challenges.

Such important considerations need to include perspectives and input from all who may be impacted or involved. To that end, the Dental Assisting National Board (DANB) conducted research to capture essential insights from dental assistants and patients.

"In many states, the groups discussing whether to create a scaling assistant or OPA provider l include dentists and dental hygienists," said Hanna Aronovich, DANB Chief Marketing and Str Officer. "The voices of dental assistants and patients need to be heard as well, and we wante ensure these perspectives are brought to the forefront."

CHAT

VIEW THE REPORT

Assistant and patient perspectives

Dental assistants were mixed in their support and interest, with about half expressing support for the new role and interest in pursuing it, if available. The other half were opposed or unsure. Dental assistants reported that thorough training, education and credentials are important qualifications, as is increased compensation.

Patients overwhelmingly said receiving routine cleanings is important, but those who reported receiving annual cleanings varied by income level. Like dental assistants, patients expressed that proper education, training and credentials were very important.

"It's notable that both dental assistants and patients were aligned in what they felt were necessary qualifications for dental assistants performing supragingival scaling," Aronovich noted. "Both groups emphasized the importance of clinical skills as well as credentials, such as licensure, registration or certification."

The current landscape

Currently four states allow dental assistants to perform supragingival scaling (Arizona, Illinois, Kansas, and Virginia), with two more states (Missouri and Nevada) moving proposals forward. In the last five years, several other states (Colorado, Kentucky, Montana, Washington, and Wisconsin) have put forward legislation or regulations that did not advance.

"DANB has been contacted by states for guidance and has been closely tracking these proposals across the country," said Michelle Lee, DANB Vice President of External Relations and Policy. "Although frameworks for national standards exist, like the Dental Access Model Act, we're observing that states are taking customized approaches to developing education, training, and credentialing requirements for this new provider level."

To share insights and learnings, DANB facilitated a workgroup of dental professionals from across the country to explore the evolving landscape of OPAs and scaling assistants. The group discussed potential future scenarios and training and competency models.

"DANB is committed to supporting the dental assisting profession and the critical role they pl[illegible] the dental team," Lee said. "DANB has been considering ways we can support dental assistan[illegible] states where these functions are allowed, as well as meeting with states that are exploring th[illegible] options to provide information and insights to aid in their decision-making."

CHAT

To view the additional survey results, download the report.

ARIZONA STATE SENATE

Fifty-Seventh Legislature, First Regular Session

AMENDED

FACT SHEET FOR S.B. 1124

dental board; oral preventive assistants

Purpose

Establishes a pathway for dental assistants to practice as oral preventative assistants (OPA) upon completion of a-training course approved by the Arizona State Board of Dental Examiners (BODEX) and outlines OPA scope of practice.

Background

Current statute allows dental assistants to expose radiographs for dental diagnostic purposes, under the general supervision of a dentist or the direct supervision of a dental hygienist, if the dental assistant has passed a BODEX-approved examination. Similarly, dental assistants may polish the natural and restored surfaces of teeth under the general supervision of a dentist or the direct supervision of a dental hygienist, if the dental assistant has passed a BODEX-approved examination (A.R.S. § 32-1291).

A *dental assistant* is any person who acts as an assistant to a dentist, dental therapist or dental hygienist by rendering personal services to a patient that involve close proximity to the patient while the patient is under treatment or observation or undergoing diagnostic procedures (A.R.S. § 32-1201).

An OPA is a type of expanded function dental assistant who has taken the required education and completed training to provide patients with additional preventive services and assist hygienists with preventive care practices. OPAs remove hard build up on visible, healthy teeth or on patients with reversible gum inflammation (American Dental Association).

There is no anticipated fiscal impact to the state General Fund associated with this legislation.

Provisions

1. Requires a dental assistant seeking to practice as an OPA to complete a BODEX-approved OPA training course provided by a qualifying institution that contains 120 hours of didactic and clinical instruction with patients.

2. Requires a dental assistant, prior to taking an OPA training course, to:
   a) hold a current certification in cardiopulmonary resuscitation;
   b) hold a BODEX-approved certification for both coronal polishing and radiography; and
   c) either hold a current national board certification in dental assisting or have successfully completed a dental assisting educational program accredited by a state or national organization that accredits dental programs.

3. Limits the scope of practice of an OPA to the removal of plaque, calculus and stains with scalers or sonic or ultrasonic scaling devices.

4. Limits OPAs to the treatment of periodontally healthy patients or patients with localized mild gingivitis who have first received a periodontal evaluation by a dentist or dental hygienist.

5. Prohibits an OPA from using an air polishing device or practicing on patients who:
   a) have been treated for periodontal disease;
   b) have generalized recession;
   c) are medically compromised; or
   d) are under sedation.

6. Requires an OPA providing coronal calculus removal services to:
   a) inform each patient and document in the patient's medical record that the dental care was not provided by a licensed dental provider; and
   b) prominently post the OPA's certification at the location where the procedure is performed.

7. Requires OPAs to practice only under the direct supervision of a dentist or dental hygienist.

8. Restricts a dentist from supervising more than three OPAs at any time and a dental hygienist from supervising more than one OPA at any time.

9. Specifies that any dentist or dental hygienist who allows an OPA to perform coronal calculus removal services outside statutory authority has committed unprofessional conduct.

10. Requires BODEX to coordinate with a statewide association representing dentists in Arizona to collect data regarding the:
    a) number of OPAs practicing in Arizona;
    b) location of each OPA's practice; and
    c) number of complaints filed against dentists pertaining to OPAs.

11. Requires BODEX to report the collected OPA data to the Governor, the President of the Senate, the Speaker of the House of Representatives and Secretary of State by January 1, 2029.

12. Repeals the OPA data reporting requirement on July 1, 2029.

13. Defines *qualifying institution* as an institution of higher education, including a community college, that provides a dental or dental hygiene program accredited by the Commission on Dental Accreditation.

14. Becomes effective on the general effective date.

Amendments Adopted by Committee

1. Limits an OPA's scope of practice to performing supragingival scaling and polishing on patients who have first received a periodontal evaluation by a dentist or dental hygienist.

2. Removes taking and recording periodontal probe readings and documenting areas of periodontal concern from an OPA's scope of practice.

3. Requires OPAs to practice only under the direct supervision of a dentist.

4. Restricts a dentist from supervising more than three OPAs at any time.

5. Requires BODEX to coordinate with a statewide association representing dentists in Arizona to collect specified data regarding OPAs and report the information to the Governor, the President of the Senate, the Speaker of the House and Secretary of State by January 1, 2028.

Amendments Adopted by Committee of the Whole

1. Requires the BODEX-approved OPA training course to be provided by a qualifying institution and contain 120 hours of didactic and clinical instruction with patients.

2. Requires a dental assistant, prior to taking an OPA training course, to:
   a) hold a current certification in cardiopulmonary resuscitation;
   b) hold a BODEX-approved certification for both coronal polishing and radiography; and
   c) either hold a current national board certification in dental assisting or have successfully completed a dental assisting educational program accredited by a state or national organization that accredits dental programs.

3. Removes the requirement that an OPA's first five years of practice in Arizona be limited to federally designated healthcare provider shortage areas or counties with fewer than 250,000 people.

4. Limits the scope of practice of an OPA to removing plaque, calculus and stains with scalers or sonic or ultrasonic scaling devices on periodontally healthy patients or patients with localized mild gingivitis who have first received a periodontal evaluation by a dentist or dental hygienist.

5. Prohibits an OPA from using an air polishing device or practicing on patients who have been treated for periodontal disease, have generalized recession, are medically compromised or are under sedation.

6. Requires an OPA providing coronal calculus removal services to:
   a) inform each patient and document in a patient's medical record that the dental care was not provided by a licensed dental provider; and
   b) prominently post the OPA's certification where the procedure is performed.

7. Allows a dental hygienist to supervise the practice of an OPA but limits supervision to no more than one OPA at a time.

8. Specifies that any dentist or dental hygienist who allows an OPA to perform coronal calculus removal services outside statutory authority has committed unprofessional conduct.

9. Defines *qualifying institution.*

10. Extends the BODEX data reporting deadline from January 1, 2028, to January 1, 2029.

11. Extends the repeal of the OPA data reporting requirement from July 1, 2028, to July 1, 2029.

Senate Action

HHS	1/29/25	DPA	5-1-1

Prepared by Senate Research
February 25, 2025
MM/AO/slp

Emerging and Current Models to Address Dental Team Workforce

Activities by State

Intro

Lack of a fully staffed dental team impacts patient access, unevenly redistributes responsibilities within the existing team, and leads to exacerbation of stressors on dental professionals and operation of the dental clinic. Despite variation in education and licensing requirements, there is uniformity among states in prioritizing workforce. This list provides examples of creative models of addressing the shortage of allied dental team members. Leadership of every State Dental Association has access to the most current and comprehensive resources on strategy and legislative tactics in the ADA Workforce Toolkit available on ADA Connect. If you do not have access, please contact your State Dental Associations directly. If you would like to feature your state effort please email dentalpractice@ada.org.

Supervision and Scope at a Glance by State

HYGIENIST SUPERVISION

Alabama is the only state remaining that requires direct supervision for hygienists regardless of the procedure they are performing. HB 1062, recently enacted in Mississippi, allows general supervision for hygienists, with the following limitations: a dental hygienist may provide services to patients of record, for not more than ten consecutive business days, the supervising dentist examined the patient of record at least seven months prior to treatment, the services are according to treatment protocol prescribed by dentist and the patient of record is notified in advance of the appointment that the supervising dentist will be absent from the location.

In 2024, state legislatures removed some restrictions on hygienist supervision. South Dakota removed a provision requiring recent active practice on the part of the hygienist before they can enter collaborative supervision. Tennessee increased the number of hygienists a dentist may supervise to five. Legislation enacted in Virginia, HB 605, allows a hygienist to treat a patient under remote supervision for 180 days before requiring the patient to be seen by a dentist (currently, the law allows this for 90 days).

HB 321, recently enacted in Montana, allows a dental hygienist to perform dental hygiene preventative services in a school-based oral health program under public health supervision.

DENTAL ASSISTANT SUPERVISION

In Alaska, a dental hygienist holding an advanced practice permit may delegate to a dental assistant the application of topical preventive agents under either indirect or direct supervision and the placement of pit and fissure sealants under direct supervision.

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In Nevada, Senate Bill 268 would allow a dental hygienist with a special endorsement to practice public health dental hygiene to authorize a dental assistant or expanded function dental assistant under his or her direct supervision to: apply dental sealants; apply topical fluoride; perform coronal polishing; take radiographs; and provide oral health education.

LOCAL ANESTHESIA

12 states allow hygienists to administer local anesthesia under general supervision: Alaska, Arizona, Colorado, Idaho, Maine, Minnesota, Montana, Nevada, New Mexico, Oregon, Utah, and Washington.

The Florida Board of Dentistry proposed a rule change to allow certified dental hygienists to provide local anesthesia under indirect supervision, provided the patient is eighteen years of age or older, the patient must not be sedated and the CRDH may administer intraoral block and soft tissue infiltration anesthesia.

In Iowa, HF 338, would allow the Iowa Dental Board to promulgate rules allowing dental assistants to administer local anesthesia. HF 805, which was enacted, will allow for an assistant to practice without being registered by the dental board, provided that they complete a term of practical training under the supervision of a dentist, as specified by the dental board.

In New Hampshire, HB144, would specify that a hygienist may administer local anesthesia only after sufficient training and passage of an examination by the Board of Dental Examiners.

In New York, AB 98/S 5727 allows dental hygienists to perform block anesthesia if the following conditions are satisfied: the hygienist possesses a local anesthesia/nitrous oxide analgesia certificate, as well as a dental hygiene block anesthesia certificate; The services must be performed under personal/direct supervision.

In Utah, HB 372 allows a dental hygienist under general supervision to administer local anesthesia, expose dental radiography; and make impressions or intraoral scans of teeth or jaws as authorized by a supervising dentist.

CORONAL POLISHING

41 states allow dental assistants (of varying levels and qualifications) to perform coronal polishing.

18 states have requirements specific to coronal polishing: Alaska, Arizona, Arkansas, California, Georgia, Illinois, Indiana, Kansas, Kentucky, Nebraska, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Tennessee, Texas, and West Virginia.

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ADA

Emerging and Current Models to Address Dental Team Workforce

Activities by State

EXPANDED FUNCTION DENTAL ASSISTANT (EFDA)

Having been around for two decades, the Expanded Function Dental Assistant, can in some states perform, with additional training, more procedures than the standard scope of a noncertified assistant such as scanning, final impression, prosthesis adjustment, placing cord, placing restorations and cementing crowns,

Two states, Wisconsin and Maryland, saw new laws allowing EFDA's to practice signed in the 2021-22 session, bringing the total number of states with these laws to 32.

Some states have a variation of an EFDA with additional certification to be a Restorative Dental Assistant or a Certified Orthodontic Assistant, including California, Illinois, Maryland, New Jersey and North Dakota.

Effective Jan. 1, 2025, Oregon adopted rules to allow an EFDA to obtain a local anesthesia functions certificate and thus to be allowed to administer local anesthesia under indirect supervision.

ORAL PREVENTIVE ASSISTANT (OPA)

An Oral Preventive Assistant is a type of Expanded Function Dental Assistant (EFDA) who has taken the required education and completed training to provide patients with additional preventive services. OPAs may provide care to patients classified as healthy or with gingivitis. Services include the removal of supragingival calculus, coronal polishing, providing oral hygiene instructions, and applying fluoride.

In 2023, the Missouri Dental Association (MDA) began working with the Missouri Dental Board on rules for a short-term pilot program to evaluate the safety of this type of EFDA. The MDA worked to identify the specific needs of patients in Missouri and designed a unique position to positively impact the oral health of underserved populations. Didactic training of OPA pilot participants commenced in early 2024, with the clinical phase beginning in December 2024 after the promulgation of related rules. Data collection on the program will begin in June 2025.

Arizona enacted SB 1124 in March 2025 to allow a pathway for a dental assistant to become an Oral Preventive Assistant, and SB 1680 is currently pending in Washington state.

COMMUNITY DENTAL HEALTH COORDINATOR (CDHC)

The Community Dental Health Coordinator works as a bridge between underserved communities in need of care and clinics or practices able to provide that care. The CDHC also works directly with the patient to ensure their treatment plan is followed, and that the patient has access to all community resources available to them, even if those are outside of dentistry, like HPV vaccination.

There are currently 21 CDHC programs across the country that offer the CDHC curriculum through continuing education programs or as part of existing programs in dental hygiene and dental assisting.

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To date, the program has seen approximately 730 graduates. Santa Fe Community College in New Mexico recently announced the start of their program. In an incredibly exciting development, the Indian Health Service (IHS) has signed an agreement to offer CDHC training throughout the entire system, vastly increasing the number of available sites at which CDHC's can continue their valuable work.

Model Initiatives by State

CREATE A DENTAL EDUCATION LOAN PROGRAM (ALABAMA, MAINE)

Alabama's Dental Service Program is administered by its Board of Dental Scholarship Awards, and issues need- and merit-based loans up to the price of in-state tuition and fees at its state dentistry school to dental students. Each applicant must agree to work full-time in a clinical practice as a licensed dentist in an area of critical need for a specified number of months and agree to provide care to a certain number of indigent patients or patients covered under Medicaid. Loans can be repaid in cash or through practice in an approved area. The program will issue a number of loans up to 20% of the state dentistry school's student population. Students can receive loans for up to four years.

In Maine, HP 1262/LD 1891 would establish the Extreme Shortage Area Dental Education Loan Program to provide loans and loan repayment agreements to eligible dental students and individuals who are eligible for licensure as a doctor of dental medicine or as a dental hygienist, dental therapist, expanded function dental assistant or dental assistant who agrees to serve an extreme shortage area in the State. The legislation also establishes the Dentists for Maine's Future Scholarship Program to provide a tuition subsidy of 50% of the cost of attendance, up to a maximum of $25,000 per student annually, for eligible students who enter dental school programs in Maine for the purpose of increasing the number of dentists who practice in extreme shortage areas. The bill also updates the dental care access tax credit to include eligible dental hygienists and changes the date that the tax credit is repealed to December 31, 2032.

CREATE A RURAL PRACTICE-FOCUSED DENTAL SCHOLARSHIP PROGRAM (ALABAMA, MARYLAND, MISSISSIPPI, WISCONSIN)

In 2023, The University of Alabama welcomed the inaugural class of its Rural Dental Scholars program. Open to Alabamans from rural areas, the postgraduate program includes a year of study and a master's degree in rural community health at University of Alabama College of Community Health Sciences, as well as early admission to the UAB School of Dentistry.

In 2024, the Maryland Department of Health launched the Pathways to a Bright Future scholarship, awarded to those interested in dentistry who plan to work in one of a few designated underserved areas. Funding for this initiative comes from a four-year, $1.6 million HRSA grant.

Mississippi's state legislature implemented the Mississippi Rural Dentists Scholarship Program (MRDSP)

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in 2013. The program provides $35,000 in scholarships annually for no more than four years provided the students fulfill an obligation, upon completion of their education, to practice in rural Mississippi areas for a period of at least the same number of years as they received scholarships. A 2023 audit of the program found that every dentist who was currently practicing during the obligation period following their education under the program was fulfilling that obligation by practicing in a designated rural area. Mississippi increased funding for the scholarship program once more in 2023, and the funding has held steady for 2024.

In Wisconsin, SB 706 enacted in 2024 established a Rural Scholarship at Marquette University School of Dentistry. The program provides up to $30,000 in scholarship funds annually to up to 15 students at a time. After graduation, recipients agree to work in a Dental Health Provider Shortage Area for 18 months for each year of scholarship, or are obliged to return the funds.

DENTAL HYGIENE CHAIRSIDE RECRUITMENT PROGRAM (PILOT STATES: AZ, AR, ID, IN, IA, MI AND MN)

The American Dental Hygienists' Association and the Delta Dental Foundation of Michigan, Ohio, and Indiana (DDF) announced the formation of "Hygienist Inspired," a chairside recruitment program designed to increase diversity and address workforce shortages in the dental hygiene profession and improve access to oral health care. The program was launched in March, 2025 in nine pilot states: Arizona, Arkansas, Idaho, Indiana, Iowa, Michigan, Minnesota, Ohio and Wisconsin, with plans for nationwide expansion over the next two years. The Foundations of Delta Dental in each pilot state are funding program ambassadors to lead recruiting in their states, following a successful ambassador training event, led in partnership by representatives from ADHA and the DDF. The Hygienist Inspired Ambassadors (three from each state) will lead outreach efforts in their respective states, conducting both chairside recruitment in their operatories and participating in community events to raise awareness about careers in dental hygiene.

FOREIGN-TRAINED DENTISTS (CALIFORNIA, MINNESOTA AND NEW YORK)

In California, AB 1307, which is currently pending, which would create a new Licensed Dentists from Mexico Pilot Program, repealing existing provisions in California statute. Under the new program, the Board will be required to issue a 3-year nonrenewable license to practice dentistry to an applicant that meets specified criteria and require participants in the program to comply with specified requirements. The bill would authorize participants to be employed only by federally qualified health centers that meet specified conditions, and would impose requirements on those centers. The legislation would require an evaluation of the program to begin one year after the program has commenced and would prescribe the information to be included in that evaluation. The bill would require the costs for the program to be fully paid for by funds provided by philanthropic foundations.

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Minnesota is currently the only state that may grant an internationally-educated practioner a general dentist license without further study. A person licensed under this subdivision must practice for three consecutive years in Minnesota pursuant to a written agreement, approved by the board, between the licensee and a Minnesota-licensed dentist. At the conclusion of the three-year period, the board may grant an unlimited license without further restrictions if all supervising dentists who had entered into written agreements with the licensee during any part of the three-year period recommend unlimited licensure, and if no corrective action or disciplinary action has been taken by the board against the licensee.

In New York, AB 3244, if enacted, would allow an internationally-educated dentist who has been licensed outside of the U.S. for at least 5 of the last 7 years to participate as a general practice dental preceptee in a preceptorship program under the supervision of a licensed dentist practicing in a federally- qualified health care facility or similar facility that primarily serves an underserved population. A dentist, upon satisfactory completion of five years of such practice, may apply for licensure as a dentist in New York.

FOREIGN-TRAINED DENTISTS AS HYGIENISTS (CONNECTICUT, FLORIDA, MASSACHUSETTS, MINNESOTA)

In Connecticut, HB 6562 and HB 6575 are currently pending, that would allow a dentist has been lawfully practicing for not less than five years in a foreign country or province of a foreign country to apply for licensure as a hygienist. HB 6562 would allow an internationally-trained dentists to be licensed in Connecticut, provided such dentist (1) possesses a degree of competency and has completed necessary examinations in subjects considered essential for a dental hygienist, as determined by the Commissioner of Public Health, and (2) passes written and practical examinations pursuant to state statute. HB 6575 would allow the same, provided that the dentist has practiced for at least five years in another country, and can provide documentation to that effect. The dentist must also meet any competency requirements determined by the Commissioner of Public Health.

For a dental hygiene license in Florida, a graduate of an unaccredited dental college or school, who has completed a minimum of 4 years of postsecondary dental education and received a dental school diploma which is comparable to a D.D.S. or D.M.D. can apply if they have completed the following examinations: the National Board Dental Examination or the Dental Hygiene National Board Examination; the ADEX Dental Hygiene Licensing Examination taken on or after June 1, 2010) and the Florida Laws and Rules Examination.

Massachusetts has enacted H4842 which allows internationally-trained dentists to perform dental hygiene in Massachusetts, provided they have been in practice for at least five years and can produce proof of clinical competency equivalent to what is required in Massachusetts. Legislation enacted in Virginia (SB1475) will mandate the Board of Dentistry to convene a working group to study the matter.

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In Minnesota, HF 1752/SF 1623 would allow for a dentist who completed a minimum of four years of postsecondary dental education and received a diploma comparable to a DDS or DMD in another country, to apply for licensure as a dental hygienist.

INCENTIVES TO PRACTICE IN CONNECTICUT, MAINE, AND NEW JERSEY

Connecticut Gov. Ned Lamont has put forward legislation to remove license application and renewal fees for certain occupations, including dental hygienists. SB 1246, which is currently pending, would eliminate occupational licensing fees, the state looks to encourage workers to join industries with in-demand jobs, such as dentistry. The fee range for dental hygienist licenses is $105 to $150, with nearly 4,000 payers in the state. Professions included in the proposal will still have to obtain and renew licenses, but there will be no fee.

Maine is considering a variety of incentives that would attract dentists to practice in the state. The initiatives under proposal include offering five years of tax incentives to dentists who practice in certain parts of the state, as well as malpractice insurance incentives tied to acceptance of Medicaid payments. As well, the Maine Dental Association is hoping to attract retired dentists to relocate and practice in the state, and is working with the Housing Authority to incentivize such moves.

In New Jersey, AB 2822, which is currently pending, would provide bonuses for certain essential healthcare workers. The bonuses are provided to individuals who receive an annualized base salary of $100,000 or less, who provide hands-on health or care services to individuals, or in-person support services to those providers, without regard to whether the person works full-time, part-time, on a salaried, hourly, or temporary basis, or as an independent contractor. This legislation provides for a bonus not to exceed $3,000 for Healthcare employees including dental hygienists, dental assistants who received an annualized base salary of $100,000 or less, from an employer who is enrolled in Medicaid.

S.M.I.L.E. HEALTHCARE PATHWAY PROGRAM (WASHINGTON DC AND TENNESSEE)

The S.M.I.L.E. (Student Mentoring with Immersive Learning and Enrichment) Healthcare Pathway Program is a partnership between Henry Schein, Inc., the National Dental Association, and other professional associations to help mentor future healthcare professionals, enhance health literacy, expand diversity in the healthcare workforce and ultimately improve health and overall outcomes in underserved communities nationwide. This summer program introduces students to careers in oral health, including: dentist, dental hygienist, dental assistant, or dental office administrators. The 2025 S.M.I.L.E. Healthcare Pathway Program will take place in two locations: Howard University in Washington, DC from June 28 – July 3, 2025 and Meharry Medical College in Nashville, TN from July 20-25, 2025.

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FLORIDA STATE COLLEGE AT JACKSONVILLE: DENTAL ASSISTING PROGRAM (FLORIDA)

Existing full-time 1230 clock hour to be replaced by two alternative programs:

- CWE (Continuing Workforce Education) Dental Assisting Program - a "hybrid" program that combines online and hands-on instruction, offers rapid entry into the profession for those students who need flexibility in scheduling to accommodate work or family obligations; not CODA-accredited

- ATD (Applied Technology Diploma) Dental Assisting Program - this for-credit program is designed for those students who wish to earn a degree and anticipate continuing their education; option for Associate's degree and facilitated entry into the Dental Hygiene Program, will be CODA-accredited.

SECURE LOAN ASSISTANCE FOR THE FULL DENTAL TEAM (FLORIDA, MAINE)

Florida's SB 7016 extended Florida's Dental Student Loan Repayment Program to hygienists.

In Maine, LD 1256 expanded the Maine Dental Education Loan Program to cover hygienists, therapists, EFDAs and assistants.

INCREASE TUITION WAIVERS (MARYLAND)

In April 2023, the Maryland Legislature passed HB 290, an Oral Health Task Force Bill that included improvements to the existing Maryland Dent-Care Loan Assistance Repayment Program. The tuition waiver increased from $23,740/year for three years up to $50,000/year for three years. The law also made qualifying dental hygienists eligible for $10,000/year for two years.

SB 456/HB 265, enacted in 2025, will alter the eligibility criteria for Higher Education Loan Assistance Grants under the Maryland Dent-Care Program to include part-time employment.

DISCOVERY DENTISTRY CAMP AND SYPOSIUM FOR 6TH-12TH GRADE (MARYLAND)

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University of Maryland School of Dentistry's *Planet Smilez* program hosts a week-long summer camp of immersive experiences for middle and high school students that emphasize oral and systemic health education and encourage pursuit of dental careers, including mentorship by current dental students. camp participants engaging in practical exercises designed to emulate real-world dental practices. From suturing to understanding how X-rays work, students gain hands-on experience that brings dental science to life. The program also offers a one-day pre-dental symposium that introduces the key components of the different dental professions.

GRANTS TO EDUCATION (MINNESOTA)

Minnesota has three bills pending (HB 1110, HB 1111 and SB 1325) that would make CODA-accredited dental assisting and dental hygiene programs eligible for grant programs. Eligible projects for the funding include: expanding or improving existing clinic physical infrastructure; creating and building new clinic physical infrastructure; improving classroom physical structure; creating student scholarships and improving faculty and staff salaries.

DENTAL HYGIENE APPRENTICESHIP PROGRAM (MONTANA, UTAH)

To help dentists build a dental assistant workforce through registered apprenticeships, Charter Apprentices administers an apprenticeship program that combine classroom education with on-the-job experiential learning. The program is competency-based (unlike the traditional time-based model) and utilizes national standards to ensure consistent training and competency from state to state and office to office.

Utilizing the program gives employers access to funding resources that offset the apprentices' wages, pay for the classroom learning and provide child-care and transportation support. Participants are paid using progressive wage scale based on competencies attained. An extended probationary period for apprenticeships serves to better evaluate technical and behavioral competencies and fit.

The apprenticeship program has received state approval in Montana and Utah. The state approval includes grant and workforce funding, including training wage offsets.

EXPANDING DENTAL TRAINING PROGRAMS ALONGSIDE OTHER HEALTH PROFESSIONS (NEW JERSEY)

In fall 2023, County College of Morris (CCM) announced the construction of a new facility that will function as the college's Center for Health Professions. The college will offer new programs in dental hygiene, dental assisting, surgical technology, diagnostic medical sonography and medical assistance and expanded programs in nursing, radiography, respiratory therapy, paramedic science and drug counseling.

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INTERSTATE DENTAL EDUCATION COLLABORATION BRINGING DENTISTS TO NEW MEXICO AND VERMONT

In September, 2024, Touro University broke ground on a clinical branch of Touro College of Dental Medicine (TCDM) in New Mexico. Students at Touro Dental Health New Mexico (TDHM) spend their first two years in the classroom studying basic biological sciences, and the last two years seeing patients in the clinics. Going forward, 100 students from each TCDM class of 200 will do the classroom portion of their training on TCDM's New York campus and spend their final two years treating patients from the Albuquerque community in the new clinical facility.

In April, 2025, TCDM announced that the Class of 2027 will be the first cohort of 100 students who will spend their final two years at Touro's newly opened state-of-the-art clinical campus in Albuquerque, New Mexico, located at the Lovelace Biomedical Research Institute. Under the supervision of expert faculty, these TCDM students will provide reduced-cost dental care to members of the Westchester and Albuquerque communities and surrounding counties.

In September, 2024, the Vermont State Dental Society (VSDS), University of Detroit Mercy (UDM), Sen. Bernie Sanders and Sen. Peter Welch announced a partnership to bring an innovative Dental Oral Health Education Center to Vermont in fall 2027. This new dental clinic and education program will bring UDM students to Vermont to complete their final years of training – strengthening the dental care provider pipeline and expanding access to much-needed care across the state.

Beginning in the fall of 2025, the partnership between VSDS and UDM will include two years of foundational and preclinical education at the UDM School of Dentistry Campus in Detroit, followed by two years of clinical and didactic education at a new dental clinic based in Colchester. The University of Detroit Mercy-Vermont dental program will offer DDS dental education in the state of Vermont, accredited by the Commission of Dental Accreditation (CODA).

ADVANCE A COORDINATED APPROACH TO PROMOTE HEALTH CARE CAREERS IN K-12 EDUCATIONAL SETTINGS, AND CREATE A PROGRAM TO ATTRACT STUDENTS TO THE STATE TO FINISH TRAINING (VERMONT)

Leverage AHEC, VSAC, Vermont After School, Vermont Career and Technical Education Centers and Vocational Rehab programs to clearly document and develop a plan to actively promote health care careers in K-12 educational settings. Ensure adequate funding for AHEC and other entities conducting middle and high school health careers outreach to develop health career pipelines are inclusive of dental careers including dentist, dental hygienist, dental therapy, and dental assisting. ("Health Care Workforce Development Strategic Plan", Vermont Agency of Human Services, October 2021.)

Vermont approved $100,000 in 2023 for its Dental Hygienist Forgivable Loan Program. Hygienists are eligible to apply for loan forgiveness if they practice in Vermont for the same number of years for which they received forgiveness and if they maintain enrollment at an eligible program.

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Vermont's $3.8 million appropriation for Critical Occupations Scholarships applies to dental hygienists, and provides funding for retraining and relocation incentives.

Additionally, Vermont is pursuing a program to attract dental students to the state to finish their training. Afterward, students are encouraged to stay and work in federally qualified health centers.

DENTAL ASSISTANT APPRENTICESHIP PROGRAM (WASHINGTON, IDAHO)

The dental assistant apprenticeship program is a one-year (2,000 hour) on-the-job training program facilitated by CHAS Health to train individuals to work as Registered Dental Assistants in the state of Washington and Idaho. Apprentices will be employed with CHAS Health full-time while simultaneously completing related coursework, which includes homework assignments and mandatory lab days. Following successful completion of the program, the dental assistant will be transitioned into a regular, full-time position. Throughout this program, the apprentice will be working hands-on in the dental clinic alongside a coach and team to practice clinical skills. The coach will support and guide the apprentice and ensure the mastery of each skill. In addition to working clinically, there will be 8 lab days, where the instructor will follow an agenda for lectures, reviewing practical skills, help with technique, and answer questions. Homework and lab obligations are unpaid.

The Dental Assistant Training Program is recognized by the state of Washington as a registered apprenticeship. This provides students with the assurance that they will receive a quality education that has met the qualifications set by the Washington State Department of Labor & Industries for training and instruction. Our program is governed by an Apprenticeship Committee of 50% employer and 50% journey-level dental assistant representatives. The curriculum is approved by the State Board for Community and Technical Colleges.

DENTAL ASSISTING TRAINING IN HIGH SCHOOL (WASHINGTON STATE)

Across Washington, eight skill centers have dental assisting training programs. Skill centers are regional secondary schools that serve high school students from multiple school districts. They provide instruction in preparatory programs that are either too expensive or too specialized for school districts to operate individually. The dental assisting programs are for juniors and seniors and are typically one school year long (9 months). Since the students are in high school the programs are free, with fees for supplies and equipment.

To standardize education and training, the Office of the Superintendent of Public Instruction adopted a dental assisting statewide framework in May 2022. The framework prepares students with an understanding of the roles and responsibilities of the dental health care profession within the application of dental care. Students are eligible to earn 1.0 lab science credit that counts for graduation requirements such as biology, chemistry, and other lab sciences. The framework is 540 hours long and requires students complete 55 hours of clinical practicum or clinical simulation.

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"INTRODUCTION TO DENTISTRY" PILOT PROGRAM (WASHINGTON STATE)

Delta Dental of Washington (DDWA) completed an "Introduction to Dentistry" pilot program at TAF Saghalie. TAF is a problem-based school in Federal Way for 6th-12th graders. The pilot program was 4 weeks long and students met one hour per week. The pilot cohort consisted of 8-12 students from a variety of grades. Students learned about different dental professions, dental basics, and local education programs. The program aims to educate students about dental careers early on. DDWA would like to expand this program throughout Washington. Funding for the pilot program came from DDWA and WSDA dentists donated dental supplies.

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DENTAL ACCESS MODEL ACT

ALEC MODEL LANGUAGE

Policy Status

Type: **Model Policy** Status: **Final** Date Introduced: **December 4, 2024** Date Finalized: **December 31, 2024**

Issues

- Health

Task Forces

- Health and Human Services

Tags

- SNPS 2024

Summary

This act supports the expansion of access to dental care by more efficiently utilizing existing members of the dental team and establishing teledentistry standards.

DENTAL ACCESS MODEL ACT

Certification of Expanded Function Dental Auxiliaries* (EFDA)

(1) In this section, "auxiliary" means an expanded function dental auxiliary*.

(2) A certification to practice as an EFDA granted under this chapter shall permit the holder to perform all of the following as delegated and supervised by a dentist:

(a) Placement and finishing of restoration material after the dentist prepares a tooth for restoration

(b) Application of sealants and silver diamine fluoride

(c) Coronal polishing

(d) Impressions and digital scans

(e) Temporizations

P288

(f) Placement of retraction cord and paste

(g) Removal of cement from crowns

(h) Adjustment of dentures and other removable oral appliances

(i) Removal of sutures and dressings

(k) Application of topical fluoride or other topical remineralizing agents

(l) The fitting and contouring of stainless-steel crowns

(3)

(a) The examining board shall promulgate rules for the certification and practice of an EFDA.

(b) The rules promulgated shall do all of the following:

(1) Require an applicant to the instructional program described in subd. 2. to demonstrate in his or her application that the individual satisfies one of the following criteria in order to be permitted to enroll in the instructional program:

(A) Has completed at least 1,000 hours practicing as a dental assistant and holds the certified dental assistant credential issued by the Dental Assisting National Board, Inc., or its successor.

(B) Has completed at least 2,000 hours practicing as a dental assistant, as verified by the supervising licensed dentist.

(2) Require an applicant for certification under this chapter to demonstrate to the satisfaction of the examining board that the applicant has successfully completed an instructional program that provides training in practice as an EFDA and requires at least 70 hours of classroom instruction.

(3) Require a dentist who delegates a procedure to an EFDA certified under this chapter to remain on the premises where the EFDA is performing the procedure until the procedure is complete and the dentist has verified that the procedure has been performed successfully.

(4) Require EFDAs to maintain current proficiency in cardiopulmonary resuscitation, including the use of an automated external defibrillator achieved through instruction provided by an individual, organization, or institution of higher education approved to provide such

instruction.

(c) The rules promulgated under (3)(a) may not permit an EFDA to perform any of the following:

(1) Diagnosis.

(2) Treatment planning.

(3) Irreversible procedures such as cutting of hard or soft tissue.

Certification of Oral Preventive Assistants (OPA)

(1) The scope of practice for an oral preventive assistant shall be limited to taking and recording periodontal probe readings, documenting areas of periodontal concern, and supragingival scaling and polishing. Oral preventive assistants shall be further limited to practicing on periodontally healthy patients or patients with reversible gingivitis. For the first five (5) years after certification of the OPA position in the state, oral preventive assistants shall be limited to practicing in federally designated Health Provider Shortage Areas (HPSAs) or in counties with a population of less than 100,000.

(2) Oral preventive assistants shall complete a dental board-approved oral preventive assistant expanded function training course, and apply for an expanded function permit issued by the board. Before taking an oral preventive assistant expanded functions training course, a dental assistant shall successfully complete a dental board-approved course containing the appropriate level of didactic and hand skills assessment or possess current certification as a Certified Dental Assistant from the Dental Assisting National Board.

Authorization of Teledentistry Services

Teledentistry. This rule establishes the standards of practice for teledentistry.

Definition. "Teledentistry" means a dentist is providing asynchronous or synchronous dental services or supervising dental services and education using technology when the patient is in another location. Teledentistry is not solely a response to a patient online inquiry consisting of a set of questions.

License or registration required. A dentist, dental hygienist, or expanded function dental auxiliary who uses teledentistry for a patient located in this state shall hold an active license in this state or registration issued by the board.

General requirements. The standard of dental care is the same whether a patient is seen in person or through a teledentistry encounter. The use of teledentistry is not an expansion of the scope of practice for dental hygienists or dental assistants. A dentist who uses teledentistry shall utilize evidence-based

standards of practice, appropriate delegation and supervision of appropriately trained dental hygienists or expanded function dental assistants, and practice guidelines to ensure patient safety, quality of care, and positive outcomes.

Informed consent. Informed consent must be obtained before the placement of interim therapeutic restorations or the application of silver diamine fluoride, when services are provided under a teledentistry permit and the patient is not examined in person by the authorizing dentist.

When teledentistry will be utilized, a dentist shall ensure informed consent covers the following additional information:

(a) A description of the types of dental care services provided via teledentistry, including limitations on services;

(b) The identity, contact information, practice location, licensure, credentials, and qualifications of all dentists, dental hygienists, and dental assistants involved in the patient's dental care, which must be publicly displayed on a website or provided in writing to the patient; and

(c) Precautions for technological failures or emergency situations.

Examination. A dentist may use teledentistry to conduct an examination for a new patient or for a new diagnosis if the examination is conducted in accordance with evidence-based standards of practice to sufficiently establish an informed diagnosis. A dentist shall not conduct a dental examination using teledentistry if the standard of care necessitates an in-person dental examination. Once an examination has been conducted, a dentist may determine a treatment plan and provide a referral. Delegation and supervision is determined with state statute.

Follow-up and emergency care. A dentist who uses teledentistry shall have adequate knowledge of the nature and availability of local dental resources to provide appropriate follow-up care to a patient following a teledentistry encounter. A dentist shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in the case of emergency.

Supervision. With the exception of administering local anesthesia or nitrous oxide inhalation analgesia, or performing expanded functions, a dentist may delegate to and supervise services to be performed by a dental hygienist or expanded function dental assistant. Delegation should conform to the applicable dental practice act in the state, territory or jurisdiction of the United States where the patient receives services and where the dentist is licensed. The dentist should be knowledgeable regarding the competence and qualifications of the allied personnel utilized, and should have the capability of immediately contacting both the allied dental personnel providing service and the patient receiving services.

(a) When general supervision of a dental hygienist or expanded function dental auxiliary is required, a dentist may utilize teledentistry.

(b) When public health supervision is utilized, a supervising dentist may authorize use of teledentistry.

Patient records. A teledentistry encounter shall be clearly characterized as such in a patient record.

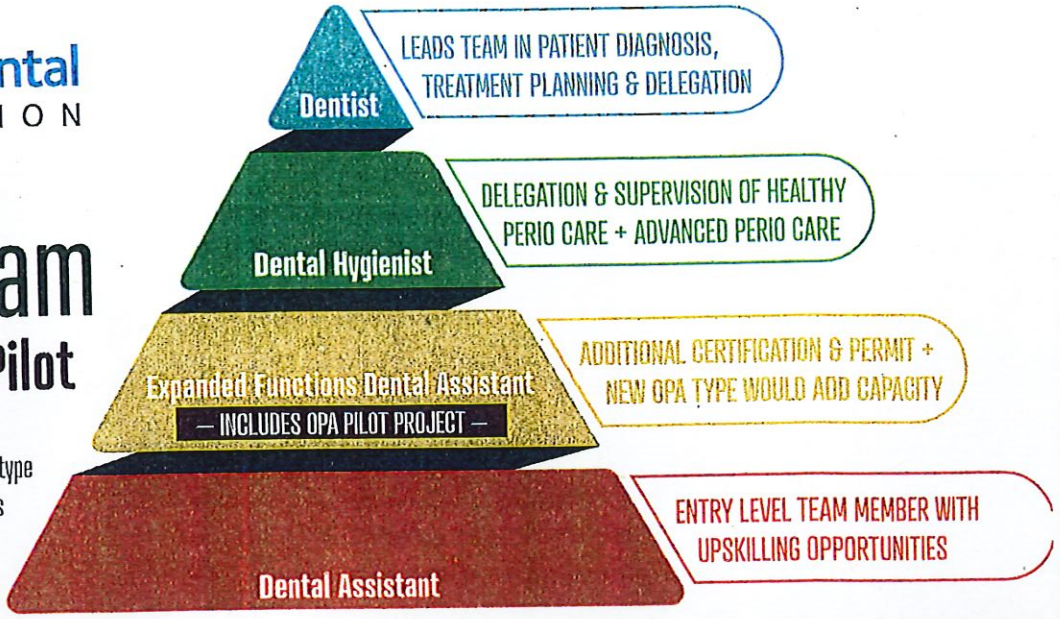
Privacy and security. All dentists, dental hygienists, and expanded function dental auxiliary shall ensure that the use of teledentistry complies with the privacy and security requirements of the Health Insurance Portability and Accountability Act.

Missouri Dental ASSOCIATION

The Dental Team

In Relation to the OPA Pilot

This is a basic hierarchal flow of dental team members in Missouri, including the Oral Preventive Assistant – a new type of Expanded Function Dental Assistant – whose creation is being proposed through a workforce pilot study. Below is more specific information about the dental team roles.



DENTIST

EDUCATION – Graduate of an accredited dental school; dental specialty degrees require additional education. Licensed to practice by the Missouri Dental Board.

ROLE – Provides diagnosis and treatment plan for a patient. A dentist can then delegate this treatment to other members of the team, depending on the type of treatment and supervision required. Delegation of treatment also depends on a team members' license or permit that specifies scope of practice (what they are allowed to do).

SUPERVISION – A dentist is not supervised but provides various types of supervision to others on the dental team.

CAREER – A dentist may have been a dental assistant and/or dental hygienist before receiving their dental degree.

DENTAL HYGIENIST

EDUCATION – Graduate of an accredited dental hygiene program. Licensed to practice by the Missouri Dental Board.

ROLE – Assists dentist to carry out treatment plan for patient, especially periodontal care.

SUPERVISION – May work under direct, indirect or general supervision of the dentist, depending on the treatment being delegated.

CAREER – Dental Hygienists sometimes become dentists. Dental Hygienists also can obtain one or more Expanded Functions permits to provide that specific type of care, in addition to their typical role in periodontal care.

EFDA (EXPANDED FUNCTIONS ASST)

EDUCATION – Pass an EFDA course for specific type of care and have Missouri Dental Board permit, plus dentist delegation to provide expanded functions. To attend any EFDA course, assistant must have passed a prerequisite exam.

ROLE – Assists dentist to carry out treatment plan for patient. An EFDA may have one or more permits for five types of care: Restorative I (basic fillings), Restorative II (advanced fillings), Removable Prosthetics (dentures), Fixed Prosthetics (crowns and bridges) and Orthodontics (braces).

SUPERVISION – May work only under the direct supervision of the dentist.

CAREER – EFDAs may become dental hygienists or dentists. Typically, an EFDA has one or more permits they use in a general dental practice, or they may use a specific permit in a specific practice type, such as those limited to Orthodontic or Prosthodontic specialties.

OPA (ORAL PREVENTIVE ASST)

EDUCATION – Because an OPA is a type of EFDA, completion of an Expanded Function course for this type of care. An OPA may or may not already hold other EFDA permits.

ROLE – Assists dentist AND hygienist to carry out treatment plan for patient, especially periodontal care.

SUPERVISION – May work under the direct supervision of the dentist OR hygienist.

CAREER – The OPA is a new type of EFDA who will focus on periodontal care. The OPA concept and pilot study is unique because it is suggested an OPA be able to work under the direct supervision of the dentist OR hygienist after a dentist has provided a treatment plan. Different from a hygienist who can care for patients with varying degrees of periodontal health, an OPA would be limited to assist in providing care to adults and children diagnosed as periodontally healthy or with gingivitis.

DENTAL ASSISTANT

EDUCATION – Formal education program or on-the-job training (OJT). Formal programs vary in length. Credentials may be obtained (such as Certified or Registered Dental Assistant) but neither ensures more dental care may be performed versus OJT.

ROLE – Assists dentist to carry out treatment plan for patient, but with the most limited scope.

SUPERVISION – May work only under the direct supervision of the dentist and may not be delegated care that requires an EFDA permit.

CAREER – Dental Assistants provide many valuable services. However, without EFDA upskilling a Dental Assistant is limited in the types of care they may assist with. This role is important as an entry into careers within the dental profession, and additional continuing education and certification opportunities are available.

DIRECT SUPERVISION – The dentist has authorized the procedure for a patient of record, remains in the treatment facility and evaluates the procedure prior to patient dismissal.

INDIRECT SUPERVISION – The dentist has authorized the procedure for a patient of record and remains in the treatment facility while the procedure is performed.

GENERAL SUPERVISION – The dentist has authorized the procedure for a patient of record and which does not require the physical presence of the dentist in the treatment facility during the performance of the procedure. The patient must be informed that the dentist is not in the treatment facility and the authorization is valid only 12 months from the most recent examination.

PATIENT OF RECORD – One for whom the dentist has obtained a relevant history, performed an examination and evaluated the condition to be treated

E|F|D|A
EXPANDED FUNCTIONS DENTAL ASSISTANT

MDA

Oral Preventive EFDA Pilot Study Final Report

What Problem Are We Trying to Solve

> **Workforce Shortages Cause Poor Access to Care**

Missouri has an oral healthcare workforce shortage that has most severely impact rural clinics and clinics serving Medicaid patients. This is a long-standing problem resulting in unacceptably long wait times for appointments and poor access to care.

The State Office of Dental Health (ODH) within the Missouri Department of Health and Senior Services used license and permit data to determine where providers are located and where they are needed, as indicated by these Missouri provider distribution maps demonstrating workforce shortage areas by county.

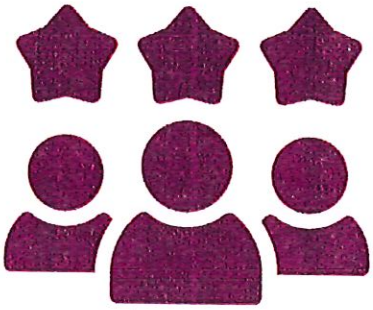
Pilot Study Explored Potential Workforce Solution

> To help address these challenges, the **Oral Preventive Expanded Function Dental Assistant (OPA EFDA) pilot project** — a collaboration of ODH, the Missouri Dental Board, and the Missouri Dental Association — was carefully designed to implement to evaluate how this healthcare worker might contribute in Missouri.

The **following sections summarize** what the study examined, what the evidence shows, and why the findings matter for Missouri patients, providers, and policymakers. You can **download the complete report** in the final section.



1600+
PATIENT VISITS



9.7
AVERAGE RATING FROM SUPERVISORS & PATIENTS



ZERO
SAFETY ISSUES OR COMPLAINTS

Results at a Glance >

Why This Matters for Missouri >

What This Study Did >

What the Study Found >

What This Means — and What It Doesn't >

Voices from the Pilot Project >

A Longstanding Commitment to Workforce Solutions >

Request Report >

OPA EFDA Summary

If you're looking for a brief overview of the OPA EFDA concept, including scope and curriculum, the information below provides that. The MDA has a page of extensive information on workforce issues, the OPA EFDA development and FAQs and more. Access it here.

OPA EFDA Overview >

OPA EFDA Scope >

ADVERTISEMENT

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EFDA Course Information

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Restorative II

Restorative II Remediation

Fixed Prosthodontics

Removable Prosthodontics

Orthodontics

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332.325. Medically underserved populations, pilot project — requirements — rulemaking authority — expiration date. — 1. The Missouri dental board may collaborate with the department of health and senior services and the office of dental health within the department of health and senior services to approve pilot projects designed to examine new methods of extending care to medically underserved populations, as defined in 42 U.S.C. Section 300e-1(7). These pilot projects may employ techniques or approaches to care that may necessitate a waiver of the requirements of this chapter and regulations promulgated thereunder; provided:

(1) The project plan has a clearly stated objective of serving a specific underserved population that warrants, in the opinion of a majority of the board, granting approval for a pilot project;

(2) The project has a finite start date and termination date;

(3) The project clearly defines the new techniques or approaches it intends to examine to determine if it results in an improvement in access or quality of care;

(4) The project plan identifies specific and limited locations and populations to participate in the pilot project;

(5) The project plan clearly establishes minimum guidelines and standards for the pilot project, including, but not limited to, provisions for protecting safety of participating patients;

(6) The project plan clearly defines the measurement criteria it will use to evaluate the outcomes of the pilot project on access and quality of care; and

(7) The project plan identifies reporting intervals to communicate interim and final outcomes to the board.

2. The board may promulgate rules and regulations to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of

rulemaking authority and any rule proposed or adopted after August 28, 2022, shall be invalid and void.

3. The provisions of this section shall expire on August 28, 2026. The board shall provide a final report on approved projects and related data or findings to the general assembly on or before December 31, 2025. The name, location, approval dates, and general description of an approved pilot project shall be deemed a public record pursuant to chapter 610.

(L. 2022 H.B. 2149)

Expires 8-28-26

---- end of effective 28 Aug 2022 ----

use this link to bookmark section 332.325

Click here for the **Reorganization Act of 1974 - or - Concurrent Resolutions Having Force & Effect of Law**

In accordance with Section **3.090**, the language of statutory sections enacted during a legislative session are updated and available on this website on the effective date of such enacted statutory section.

▶ **Other Information**

▶ **Other Links**

Missouri Senate **MO.gov** **Missouri House**

Errors / suggestions - WebMaster@LR.mo.gov

History and Fun Facts

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SHARE

An Overview of the Oral Preventive Assistant Pilot Project

Problem Statement: A conservative estimate is Missouri lost up to 10% of an already strained oral healthcare workforce during the COVID-19 pandemic years. The workforce shortage exists throughout the state, but data indicates the workforce shortage is most severely felt in rural and Medicaid clinics, where access to care may be delayed weeks to months before appropriate appointments are available[1]. The Office of Dental Health (ODH) workforce survey distributed in March and April of 2022 indicated doctors and staff are strained (more than 20% of both doctors and hygienists responded they are considering retirement in the next 5 years), and patient's needs may not be adequately served because of staff shortages and wait times for appointments. This comes at a time when approximately 170,000 newly eligible Missourians have registered for Medicaid benefits and FQHCs and clinics serving the Medicaid population will be expected to absorb the oral health care for this previously underserved population.

Oral Preventive Assistant: It has been proposed that a new oral healthcare worker, an Oral Preventive Assistant (OPA) Expanded Function Dental Assistant (EFDA), could help address access to care issues as an important part of a larger plan to better enable the oral healthcare workforce to meet the needs of Missouri citizens. The OPA-EFDA would work under the direct supervision of a hygienist or a dentist to collaborate in care for healthy children and adults, and patients with gingivitis, as defined by the American Academy of Periodontogly[2]. The premise is that OPA-EFDAs would contribute to access in two ways:

1. OPA-EFDAs increase the clinic's productive capacity for portal entry appointments to dental clinics by increasing the workforce available for initial examination and cleaning appointments for healthy children and adults and gingivitis patients. Gingivitis is defined as an inflammation of the gingiva most commonly caused by an accumulation of plaque/biofilm, that once biofilm is removed, demonstrates complete reversibility[2,4].

2. OPA-EFDAs increase the clinic's productive capacity to treat more advanced periodontal problems by freeing hygienists and dentists from the entirety of care responsibilities for the healthier segment of their patient population so hygienists and dentists can spend more clinic time operating at the top of their scopes treating more serious problems.

Since 1977, the Indian Health Service (IHS) has trained and employed Periodontal EFDAs like the OPA-EFDA being proposed in Missouri. IHS internal evaluations of the Periodontal EFDA have shown the IHS and tribal EFDAs have, in comparison with clinics of similar staffing stability and size, had an increase of 6.5% in preventive services rendered to patients[5]. An external evaluation conducted by the Johns Hopkins University Bloomberg School of Public Health in 2017 showed an increase of 12.1% in total services provided the following changes in programs with at least one Periodontal EFDA compared to clinics of similar size and staffing stability with a traditional (no EFDA) model.

1. Missouri Oral Healthcare Report of Covid-19 Impact on Workforce. Office of Dental Health, Missouri Department of Health and Senior Services. February, 2023.
2. https://members.perio.org/
3. Chappel, IL et al. Periodontal health and gingival diseases and conditions on an intact and a reduced periodontium: Consensus report. J Pero: Vol 89 Issue S1, 74-84
4. Trombelli, L, Farina, R, Silva, CO, Tatakis, DN. Plaque-induced gingivitis: Case definition and diagnostic considerations. J Periodontol. 2018; 89(Suppl 1): S46– S73.
5. Indian Health Services Periodontal EFDA Program data, Tim Ricks, DMD, MPH, US Public Health Service, April 2023

The IHS curriculum requires candidates to complete a training program that includes home-study, classroom instruction, hands-on clinical experience and a written exam. Currently there are over 1200 IHS Periodontal EFDAs who have been trained and are serving patients in 36 states. Illinois and Kansas have adopted periodontal EFDAs: Kansas already has implemented this type of EFDA, and Illinois passed the EFDA legislatively and now is preparing the educational courses for this type of oral healthcare worker.

OPA-EFDA Pilot Project: Under the provisions of 332.325 RSMo, the Office of Dental Health and the Missouri Dental Board were granted authority to approve and conduct pilot projects designed to examine new methods to extend care to medically underserved populations. The following is an explanation of how the OPA-EFDA Pilot Project specifically meets the seven provisions of 332.325 RSMo, the admission requirements for OPA-EFDA applicants, an overview of the OPA curriculum and testing, an overview of the OPA-EFDA Clinical Study design including collected metrics, a discussion about how the metrics will be analyzed and the reporting requirements to the Missouri Dental Board.

Seven Provisions of 332.325

1. **Clearly stated objective of serving a specific underserved population:** This OPA-EFDA Pilot Project is intended to increase access to oral healthcare to underserved populations in Missouri, especially rural and Medicaid clinics that currently have poor access due in part to a shortage of dental hygienists.

2. **Finite start date and termination date:** The OPA-EFDA Pilot Project will begin no later than January 1, 2024. The OPA online and hands-on educational components will be delivered January 1, 2024 through March 31, 2024. The OPA-EFDA Clinical Study will commence at the completion of the OPA educational curriculum and will terminate no later than June 30, 2025.

3. **Clearly define the new techniques or approaches it intends to examine to determine if it results in an improvement in access or quality of care:** The premise is that OPA-EFDAs would contribute to access in two ways:

    - OPA-EFDAs increase the clinic's productive capacity for portal entry appointments to dental clinics by increasing the workforce available for initial examination and cleaning appointments for healthy children and adults and gingivitis therapy appointments for gingivitis patients.

    - OPA-EFDAs increase the clinic's productive capacity to treat more advanced periodontal problems by freeing hygienists and dentists from the entirety of care responsibilities for the healthier segment of their patient population so hygienists and dentists can spend more clinic time operating at the top of their scopes treating more serious problems.

4. **Identify specific and limited locations and populations to participate in the pilot project:** To generate enough data to validly assess the OPA-EFDAs impact on clinic's productive capacity and access to care, there needs to be 2-3 trained OPA-EFDAs, in a minimum of five participating clinics for a period long enough to minimize confounding

factors like seasonal variation in missed appointment rates. (Missed appointment rates in Medicaid clinics may vary as much as 10% depending on prevailing weather patterns.) Otherwise, the sample size is too small to accurately draw conclusions.

Participating clinics selection criteria may include:

- Location in a county designated as a Dental Healthcare Provider Shortage Area by HRSA; and,
- A patient population that is comprised of at least 25% Medicaid-eligible patients in the previous year; or,
- Located in a county designated as a dental hygienist shortage area by the Missouri Office of Dental Health; and,
- Attest they understand their role in the clinical portion of the OPA-EFDA curriculum and commit to fulfilling that role; and,
- Attest they understand the data collection and reporting requirements of the OPA-EFDA Clinical Study and commit to fulfill that requirement; and,
- The sum of the participating clinics adequately samples the geographical and population diversity in Missouri.

5. **Establish minimum guidelines and standards for the pilot project including, but not limited to, provisions for protecting the safety of participating patients:** OPA-EFDA candidates must have satisfied the current prerequisites as required for the Missouri EFDA programs (Missouri Dental Assisting Skills Exam passage or be a Certified Dental Assistant (CDA)) before being admitted to the program; must take a structured curriculum modeled after the long-standing, successful Indian Health Service Periodontal EFDA program (see OPA-EFDA Curriculum section); and, must pass both hands-on and written competency exams before they participate in the clinical study portion of this pilot project. This project will be guided by written protocols that clearly define the scope of an OPA-EFDA, patient eligibility, data collection requirements, treatment outcome reporting and the standards of patient record documentation. OPA-EFDAs will operate under the direct supervision of either a hygienist or a dentist, which means the patient will be evaluated before and after the OPA-EFDA portion of care delivery. Any additional care required for the patient will be completed by the supervising hygienist and/or the dentist before the patient's dismissal. Patient reported outcome experiences also will be collected and reported. Participating clinics will be required to attend monthly quality assurance meetings to document, discuss and resolve any obstacles encountered in the study.

6. **Project plan must clearly define the measurement criteria it will use to evaluate the outcomes of the pilot project on access and quality of care:** The purpose of the measurement metrics is to determine if an OPA-EFDA improves access to care and or quality of care in clinics serving Medicaid patients or in clinics serving hinterlands with a significant shortage of hygienists. There are 3 primary investigational outcomes of the Oral Preventive Assistant (OPA-EFDA) Pilot Study. They are:

A. **To determine if the addition of OPA-EFDAs to the oral healthcare workforce can improve access to care** due to the OPA-EFDA assuming some care responsibilities for healthy and gingivitis patients thereby creating more portal entry appointment opportunities for patients. This part of the study will be an internal comparison study comparing the number of new patients and type of patients seen in each clinic during the OPA-EFDA study compared to a similar period prior to the study. The metrics used to assess the impact of OPA-EFDAs on patient access to clinics are:

- # of new patients examined (by all providers) in clinic during OPA-EFDA Pilot Project period:
  - # of patients seen in each age grouping (child <17; adult >18)
  - # of patients in each periodontal diagnostic categories (health, gingivitis, periodontitis as diagnosed by the supervising dentist)
- # of patients seen by OPA-EFDAs during the OPA-EFDA Pilot Project period:
  - # of patients seen by OPA-EFDAs in each age grouping (child <17; adult >18)
  - # of patients seen by OPA-EFDAs in each eligible periodontal diagnostic categories (health, gingivitis as diagnosed by supervising dentist)
- # of new patients examined (by all providers) in clinic during a similar period prior to the OPA-EFDA Pilot Project period:
  - # of patients seen in each age grouping (child <17; adult >18)
  - # of patients in each periodontal diagnostic categories (health, gingivitis, periodontitis as diagnosed by the supervising dentist)

B. **To assess the treatment outcomes of OPA-EFDAs for healthy and gingivitis patients from a clinical and patient perspective.** The included patients in this arm of the study will be healthy and gingivitis patients as diagnosed by the supervising dentist using the 2017 American Academy of Periodontology Diagnostic Classification System. This will be an internal cohort study comparing treatment outcomes of OPA-EFDA healthy and gingivitis patients for a finite period to treatment outcomes of hygienists and dentists in the same clinic for same patient categories and the same finite period. The re-evaluation period will be 2-4 weeks post treatment. 100% of the gingivitis patients will be appointed for re-evaluation. 20% of the healthy patients will be requested to return for re-evaluation. Re-evaluations will be conducted by a hygienist or dentist assisted by the OPA-EFDA to facilitate periodontal data collection. Patient outcomes will be categorized as Healthy, Improved-Not Resolved, Not Significantly Improved-Localized problems, Not Significantly Improved or Declined-Generalized problems. All patients will be requested to complete a Patient-Centered Evaluation. The metrics used to assess the quality of OPA-EFDAs treatment outcomes are:

- Clinical Outcome Assessment (cites: Chappel Table 1[3] and Trombelli Table 6[4])
  - % Healthy: Treatment outcome is healthy patient (<10% sites demonstrate inflammation)

- % Patient Improved: Patient with inflammation improves after treatment w/o complete resolution (5%-15% reduction in bleeding points)
- % Patient Status Not Significantly Improved with Localized Problems: Patient presented w/localized inflammation (10-30% of sites still inflamed at re-evaluation)
- % Patient Status Not Significantly Improved or Declined with Generalized Problems with Generalized Inflammation: Patient's generalized inflammation did not resolve (>30% sites still inflamed at re-evaluation)

- Patient-Centered Evaluation: Each re-evaluation patient will complete a brief evaluation of treatment including a 1-5 Likert scale and comment section. *Metric: Average Patient Likert Evaluation.*

C. **To determine if the addition of OPA-EFDAs to the oral healthcare workforce can improve access to care for patients with more serious periodontal problems** by freeing hygienists and dentists to use some time previously devoted to healthy patients to serve patients with more serious or urgent periodontal needs. This is an internal comparison study comparing the number of periodontitis related procedures performed by dentists and hygienists during a finite period of the OPA-EFDA study to the number of periodontitis procedures performed by dentists and hygienists during the same finite period before the OPA-EFDA study. The metrics used to assess OPA-EFDAs impact on access for patients with more serious periodontal problems are:
   - # Patients Diagnosed with Periodontitis
   - # Gross Debridement appointments
   - # Scale and Root Plane appointments
   - # Periodontal Surgeries
   - # Periodontal Maintenance appointments

7. **Identifies reporting intervals to communicate interim and final outcomes to the Missouri Dental Board:** ODH will provide interim reports to the Missouri Dental Board every three months and within two months after the termination of the OPA-EFDA Pilot Study. When enough data has been generated to validly assess the OPA-EFDAs impact on clinics productive capacity and access to care, a final report will be submitted.

Oral Preventive Assistant Curriculum: The curriculum for the OPA-EFDA has been modeled after the curriculum used by the Indian Health Service (IHS) for its certification process for the Periodontal Expanded Function Dental Assistant 1 program (IHS Perio EFDA 1). The scope of practice of the IHS EFDA 1 closely mirrors the scope of practice proposed for the Missouri OPA-EFDA.

The training and certification program for the IHS Perio EFDA 1 has been in place since 1977 and has trained, certified, and successfully deployed more than 1200 Perio EFDA 1 providers in 36 states. The IHS curriculum provides for home study curriculum, followed by 35 hours of in-person training, and culminates in the execution of a minimum of 20 satisfactory supragingival

debridement, prophylaxis and oral hygiene consultation visits supervised and graded by a dentist or hygienist.

Rear Admiral Tim Ricks, DDS, Chief Dental Officer for the U.S. Public Health Service and IHS Continuing Dental Education Coordinator, has indicated that IHS and tribal dental programs with Periodontal EFDAs have, in comparison with clinics similar staffing stability and size, an:

i. increase of 0.7% per year in clinic utilization
ii. increase of 5.1% in total dental services rendered to patients
iii. increase of 6.5% in preventive services rendered to patients
iv. increase of 7.5% in total services per patient visit[5]

E|F|D|A

EXPANDED FUNCTIONS DENTAL ASSISTANT

This special section provides information on the MDA Expanded Function Dental Assistant program, an important component of a strong dental team and workforce in our state that has successfully operated in Missouri for 25 years! It strives to bring awareness to existing courses and processes, but also highlight the OPA EFDA Pilot. Visit MOEFDA.ORG for information.

A SUCCESSFUL HISTORY

The Expanded Function Dental Assistant (EFDA) program became a reality with the passage of the Dental Board Rule in September 1994, which allowed dentists to delegate 19 specific expanded functions to dental assistants who have approved training and have successfully passed competency testing.

Over a four-year period prior to 1994, the MDA Council on Professional Affairs and Laboratory Relations worked extensively to develop a master plan to not only bring about a rule change, but also, to provide the educational piece to make the program a reality. The Council spent numerous hours conducting focus groups with dental assistants, dental hygienists, dentists and others to listen to all viewpoints about dental manpower shortages. A master plan was identified to proactively approach the problem before there was a crisis.

With approval and support from the MDA House of Delegates, the rules and the Expanded Function Dental Assisting programs offered by the MDA were born. Program modules developed included orthodontic, restorative, periodontic and prosthodontic. The first MDA EFDA courses were held beginning in 1998.

COURSES & DELEGABLE FUNCTIONS

Functions delegable to a dental assistant possessing a Missouri Dental Board-issued permit to perform expanded functions are divided into five categories: Restorative I, Restorative II, Removable Prosthodontics, Fixed Prosthodontics and Orthodontics.

On September 30, 2022, there were slight changes to some of the categories and functions. The list below shows the current Missouri Dental Board General Rules (see link at the end of the article).

Restorative I

- Sizing and cementing of prefabricated crowns;
- Placing, condensing, carving and finishing amalgam for Class I, V and VI restorations;
- Placing and finishing composite for Class I, V and VI restorations;
- Minor palliative care of dental emergencies (place sedative filling)

Restorative II

- Sizing and cementing of prefabricated crowns;
- Placing, condensing, carving and finishing amalgam for Class I, II, III, IV, V and VI restorations;
- Placing and finishing composite for Class I, II, III, IV, V and VI restorations;
- Minor palliative care of dental emergencies (place sedative filling)

Orthodontics

- Preliminary bending of archwire;
- Removal of orthodontic bands and bonds;
- Final cementation of any permanent orthodontic or prosthesis;
- Making impressions for the fabrication of any orthodontic prosthesis/appliance;
- Placement and cementation of orthodontic brackets and/or bands

Prosthodontics (Fixed)

- Apply ties retracting material prior to impression of a fixed prosthesis;
- Extra-oral adjustments of fixed prosthesis;
- Final cementation of any permanent appliance or prosthesis;
- Making impressions for the fabrication of any removable or fixed prosthesis/appliance;
- Sizing and cementing of prefabricated crowns

Prosthodontics (Removable)

- Placement of temporary soft liners in a removable prosthesis;
- Extra-oral adjustments of removable prosthesis during and after insertion;
- Making impressions for the fabrication of any removable or fixed prosthesis/appliance

Expanded Function courses, whether provided by the MDA or by a CODA-accredited dental assisting program, must provide teaching on the skills listed for each of the five categories. Five total courses are offered according to the category.

PREPARATION = SUCCESS

Missouri rule states that to be eligible to take Expanded Function courses, assistants must have proof of certification as a Certified Dental Assistant (CDA) or a Certified Orthodontics Assistant (COA) or proof of passing the Missouri Dental Assisting Skills (MDAS) exam.

The Dental Assisting National Board (DANB) offers testing and certification

for the three pathways for EFDA course eligibility. Go to moefda.org for information about these certifications and examinations. While DANB has specific study guides and recommendations for the CDA/COA exams, there is no specific study guide for the Missouri Dental Assisting Skills exam. Fortunately, the MDA has an in-person Basic Skills Review course that assistants can attend to assist in successfully passing the Exam (see page 32 for more details).

Once a candidate has successfully passed one of these required exams, they may register for course. Specific to the Restorative II Course, MDA requires assistants have a Restorative I Permit as an additional prerequisite for registration.

While these prerequisites are required, there are other things dentists and assistants can do to help ensure success at the course and to ensure the assistant is better prepared to begin being delegated expanded functions safely, efficiently and effectively.

As best practice, the MDA recommends assistants considering attending EFDA courses have at least one to two years on-the-job training. EFDA training begins with understanding the terminology of clinical dentistry. Words are the key to how we effectively relate to one another professionally, and the best preparation and coaching involves bringing the EFDA candidates (and new EFDA graduates) fully into the conversation of the ideals of the delegated procedures and how their product either meets or falls short of those ideals.

DENTISTS HELPING ASSISTANTS

As the supervising doctor for an EFDA candidate, you play an important role of engaging with your assistants as they progress through the online learning process and coaching them through pre-clinical exercises, such as restoring preps for Restorative courses and fabricating custom trays for Removable Prosthetics.

Supervising dentists should begin their participation at or before the time a team member registers for an EFDA course. MDA suggests dentists become familiar with the EFDA course content, including online review materials and the clinical skills that will be taught and tested. Have your assistant observe these procedures in practice and ask questions and discuss the skills standards to ensure confidence in the assistant's readiness for the EFDA course.

BY THE NUMBERS

For more than 25 years, the MDA has offered EFDA training. In the early years, we would hold six to eight courses annually, typically certifying between 75 to 100 auxiliaries per year. In 2022, the MDA held 25 courses and certified 195 auxiliaries. This year, as of September 1, we have scheduled 22 courses and registered 202 auxiliaries, with more courses planned. The demand for EFDA training continues and the MDA is working to meet that demand with excellence! Learn about EFDA today!

EXPECTATIONS OF A NEW EFDA

EFDA training is designed to bring participants to pre-clinical competence in performing dental procedures. Through the courses, assistants will be practicing skills on models, with their performance evaluated accordingly. Upon completion of the training, assistants will be minimally competent in performing expanded function skills and must demonstrate the ability in practice to successfully perform these same procedures on patients, under the supervision of their dentist.

EFDA training gives assistants a fundamental knowledge of the procedures that they will be performing. A doctor shouldn't expect that the assistant will come back ready for full speed the first day. In fact, EFDAs aren't allowed to legally perform the functions they have just been certified on until they receive their permit from the Missouri Dental Board. Doctors must realize the main part of the EFDA training will be in their offices after the course. Take your time; explain to your assistants why they do each step that they are doing. A good idea for the first several patients for each procedure is to act as an assistant to the new EFDA.

Be a positive coach during the learning process. Speak your vision for the future team functioning and indicate your confidence in the skills of your new EFDA. Positive coaching enrolls the team and patients in welcoming the advancement in provision of care.

PROFESSIONAL RESPONSIBILITY

Since the inception of the EFDA curriculum in 1998 — and especially since Restorative II was passed by the Dental Board in 2014 — the MDA EFDA Committee has as its primary concern protecting the public through proper delegation of the EFDA duties. It is the responsibility of the supervising dentist to determine if an EFDA in their practice can successfully complete, to the standard of care, the procedure being delegated. This ensures the safety and care of the patient and the quality of the procedure provided by the EFDA. Regarding all Expanded Function certifications, it is important to note:

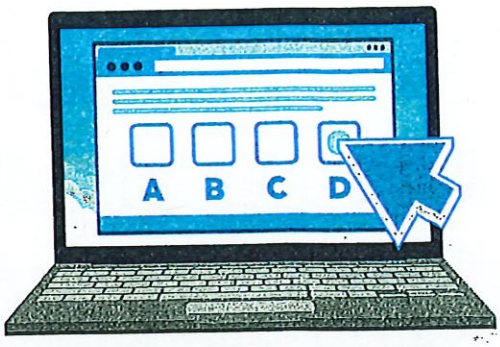
- A dentist is NOT required to delegate any expanded functions.
- Supervising dentists (under their professional license) are responsible for all patient care, whether rendered by the dentist or by an EFDA under direct supervision.
- Supervising dentists are responsible for determining the appropriateness of delegation, as the dentist considers the EFDA's skill level, task difficulty, and nature and condition of the patient.
- Supervising dentists should always check the work of the EFDA before releasing the patient. Therefore, it is highly recommended doctors continue working with an EFDA after the clinical course completion and only delegate procedures when the EFDA's delivery and standard of care matches that of the dentist.

Access EFDA Rules at modental.org/practiceact or pr.mo.gov/dental-rules-statutes.asp (the EFDA Rule begins on page 10; the list of functions on page 11).

P308

E|F|D|A
EXPANDED FUNCTIONS DENTAL ASSISTANT

MDA In-Person Basic Skills Review Helps Assistants Get EFDA Ready



Last fall the MDA launched an in-person Basic Skills review course. For some time, dentists and assistants had asked for an in-person review course where students could ask questions, get feedback and deepen their knowledge so they have a better chance of successfully passing the Missouri Dental Assisting Skills (MDAS) Exam (commonly referred to as the Basic Skills Exam) and going on to take EFDA courses.

Since beginning in October 2022, the MDA has hosted five review courses, with 125 assistants attending. We consistently follow up with attendees to track their progress and success. To date, 30 percent of those attendees have responded to our inquiries, and of those, 100 percent have passed the Exam.

The MDA is pleased to be working with Linda Twehous CDA, EFDA, BS who has extensive knowledge as a dental assistant and dental assisting educator. She is a true asset to this program, and a significant reason for attendees' success. "I have a passion for dental assistant education and was excited to work with the MDA to create this course," she said. "I am very satisfied with our first year and enjoyed the questions and comments from participants." Linda said she believes for students to be successful they must be able to take the course information and review it and make it part of themselves. "Their feedback makes me believe we are making a positive impact on successful exam pass rates."

Dentists sending their assistants to participate also feel positively about the course and its outcome. "We are delighted with your improved and updated Basic Skills Review course," said Dr. M. Conrad Journée, a partner and general practitioner at Shoal Valley Dental in Kansas City. Dr. Journée states they had several dental assistants in the past three-four years who were working on either receiving their CDA or EFDA certificates; two took the Basic Skill Exam and did not pass, even though they had been in the dental field for more than four years. He said when they saw the In-Person Basic Skills Review course, they agreed this course was exactly what they needed. Two of them signed up for the course and began studying immediately afterwards. "The review cards and their notes were enough to help them pass the Basic Skills Exam without a doubt," he said. "They both were so confident upon entering the exam they believed they would pass after only the first few questions."

Not only did these assistants pass, Dr. Journée said they came back prepared and ready to take the CDA/EFDA courses. As of today, two have been awarded their EFDA in Restorative I. "They both are happy the Basic Skills Review course was updated and geared to what we are learning currently in our office," said Dr. Journée. "I extend a big thanks to the MDA for wanting to help the dental assistant workforce progress here in Missouri. We are lucky to work so closely with the MDA."

Paige Houser, one of Dr. Journée's assistants, agrees with his sentiments. She said after working at Shoal Valley Dental for more than three years, she was challenged to take the Basic Skills Exam and began studying for a couple months. "I took it but didn't have the success I had hoped for. I was then informed about the study course the MDA offers to help dental assistants pass the Basic Skills Exam," she said. She was hesitant due to finances and travel, but once she took the onsite course and started studying the flashcards provided, she realized the great benefit of studying specific topics provided by this course. "I not only passed the Exam, but feel the course is money well spent. I realize now if it was not for the study course, I would not have been as well prepared." Paige is now on her way to becoming an EFDA and said she is grateful for the opportunity and wants to encourage other assistants who may be struggling with the same decision she faced.

REVIEW COURSE QUICK FACTS

- ✓ Held at MDA Office in Jefferson City, every two to three months, on Friday from 8:30am-1pm.
- ✓ Instructor Linda Twehous teaches topics from the DANB exam outline.
- ✓ Interactive discussion and Q&A paired with flashcard study aids.
- ✓ The next review course is November 17. Visit moefda.org to register.

ADVOCACY TO IMPROVE THE EXAM

For several years, members have expressed frustration concerning the Basic Skills Exam and the bottleneck it was creating for their dental assistants who want to pursue EFDA certification. Common concerns expressed included issues with the Exam itself, as well as the lack of relevant study materials available to help prepare assistants to take the exam. The MDA took this issue to task. In February 2022, the MDA sent a letter to the Missouri Dental Board articulating concerns with the Exam, including consistent complaints from MDA members and assistants indicating questions were outdated, irrelevant or confusing. In turn, that same fall, the Missouri Dental Board took great steps to address problems the MDA identified with the current Exam, including:

- A review of each question on the Exam, with some reworded and some removed. Going forward, the Board will review the Exam on an annual basis.
- The Exam passage percentage was lowered to 75 percent. The Board indicated many test takers were scoring in the higher 70th percentile on the Exam.
- A remote proctored Exam is now available through Pearson Vue, so students don't have to go to a testing center.

MDA Establishing Clinical Training Center at MDA Executive Office

Buildout will allow improvements and consistency in EFDA courses; ease burden on individual dental practices

For more than 25 years, the MDA has partnered with our dentist members to host EFDA courses at their offices in various locations around the state. In the early years, we would hold six to eight courses annually, typically certifying between 75-100 auxiliaries per year. In 2022, the MDA held 25 courses and certified 195 auxiliaries. This year, as of September 1, we have scheduled 22 courses and registered 202 auxiliaries, with more courses to come. You can see the demand for the EFDA certification continues and the MDA does its best to ensure we can meet that demand.

We are so thankful for our EFDA leads and trainers, who often host two, three, four and sometimes even more courses a year, as they are ensuring all auxiliaries can begin the EFDA certification process when they are ready. But it certainly is a labor of love. These trainers are committed to the EFDA program because they see its value. They know the training and upskilling of the auxiliaries enhances their career goals and makes them feel like a more essential member of the team, and as well, creates a positive impact on the overall efficiency in dental practices.

Over the years, the methods for hosting courses in our member offices has become more streamlined and efficient, but the basic process has remained the same.

- MDA finds and schedules an available date with the dentist/host office;
- MDA opens course registration and manages and monitors each auxiliary's prework and coursework;
- MDA prepares course kits for upcoming courses (preps typodonts, orders and restocks materials, sterilize instruments); and,
- MDA ships or delivers kits to the host office for the upcoming course.

While our goal was always to make it easy for our member dentists to host MDA EFDA courses, it still takes a good deal of preparation and planning on their end: unpacking course kits (often having their staff complete this); using their operatory rooms to train during the clinical session; cleanup after the course which can be time consuming (and again, delegated to a staff member); and, packing up the kits to ship back to the MDA.

In recent years, we've encountered some difficulties with our usual process, such as:

- More offices are providing regular appointments or treating more difficult cases on Fridays and Saturdays, making it harder to schedule courses.
- There is more demand than available space; smaller offices with fewer operatories means smaller courses (and the need for additional courses).
- If the office is closed on a course day, ensuring (and paying) office staff are available to manage the set up and breakdown of course kits.
- When shipping kits, increasingly lost kits, delayed delivery, and broken, mishandled shipments that equate to increased replacement costs.
- An overlap in timing with returning kits and restocking materials, making it difficult, logistically, to host more than two or three courses each month.

While it's been a system that has served us, we needed to make it better. Enter the MDA Clinical Training Center.

The MDA Executive Office in Jefferson City has always had a large classroom and catering kitchen facility in the lower level, which the MDA uses (such as, for its Basic Skills Review and the MERIT meeting) and rents to various groups for meetings. There also is existing office space that has been vacant for some time, due in part to the great amount of rental property available in Jefferson City.

The MDA Board and staff began to discuss the benefits of turning this unused space into a clinical dental training center that could host EFDA courses (including Restorative II exams and remediation), but also other possible dental team training events like nitrous monitoring training, radiography, sedation and other courses with a hands-on clinical component.

In early May 2023, the MDA Executive Committee recommended to the Board to fund the building and creation of this MDA Educational Center. This plan was approved and since, many Board members have been involved in the design and planning of the space, along with the help of Chad Wind of Burkhart Dental.

"I'm genuinely excited about collaborating with the MDA and eagerly anticipating the expansion of dental education, said Chad. "I've had a great experience working alongside the board members to formulate a comprehensive plan for a space that will serve the dental profession well.

The renovated space will include an open clinical training space with eight fully functioning dental chairs, which will allow the MDA to host up to 16 auxiliaries at a time for the majority of our EFDA courses (or 8 for Restorative II courses). With the central location and adjusting course start times for some courses, we hope to allow auxiliaries to drive in the morning of the course and lessen the travel time and expense that is often encountered. In addition, there will be adjacent space for sterilization and lab equipment, as well as materials and instrument storage.

CONTINUED NEXT PAGE

E|F|D|A
EXPANDED FUNCTIONS DENTAL ASSISTANT

Training Center

CONTINUED FROM PREVIOUS PAGE

"As we continue to evaluate the needs of our members and workforce shortages, it became clear that building an education center at the MDA headquarters in Jefferson City would be a perfect central location for clinical training," said Dr. Jon Copeland, MDA president-elect and immediate past treasurer.

"We are constantly evaluating our EFDA programs to stay current — to provide the fundamentals to assistants while incorporating modern techniques and technology. The training center is going to give us a location that can adapt to changes and modernize into the future and provides a new benefit to our members and their dental teams."

The MDA expects this change to also benefit our dedicated trainers, too, including:

- Trainers will now travel to the Clinical Training Center on specific training days, instead of the burden to host a course in their office.
- Course equipment and materials will be preset and ready to go when they arrive.
- Better training setup with all students in one space with screens and AV for viewing training modules.
- No after-course clean up or office wear and tear, nor having to pay additional staff to assist in course provision.
- No interruptions to patient care.

We also will be increasing trainer stipends to $1,000 per course. This is feasible, in part, to the savings the MDA will experience from not having to ship kits (or, in many circumstances, drive the kits to an office).

BECOME AN EFDA TRAINER

Do you want to learn more about Expanded Functions? Do you want to help dental auxiliaries become a more integral part of the team? Do you enjoy teaching? Why not become an EFDA trainer! As we prepare to begin hosting EFDA courses at the beginning of 2024, the MDA is asking our member dentists to consider getting involved with our EFDA programs and become a trainer.

Your commitment to supporting continued education of the dental team is valued. The insight and practical experiences and knowledge of a passionate dentist is integral to help teach dental auxiliaries to enhance their skills in the dental practice. But what else is in it for you?

- **Income:** $1,000 for each course you attend and train.
- **CE:** Trainers receive eight hours of free CE credits at each course they attend.
- **Ease:** Just show up, do what you do best (teach), evaluate competencies and return home.
- **Reward:** Take pride knowing you're helping upskill Missouri's dental workforce, which in turn creates practice efficiency and patient access to care!

Dr. Rolfe McCoy, MDA EFDA Committee Chair and long-time trainer can attest to the reward factor.

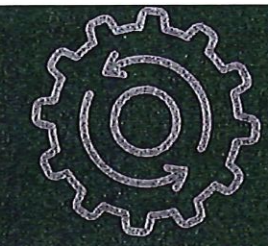
"Over the years, I have had the privilege of meeting and teaching many wonderful dental assistants throughout our state. What keeps me motivated to continue in the program are the assistants I meet and their enthusiasm. It never ceases to amaze me how excited these assistants to attend the courses to further their knowledge and technical training."

Dr. McCoy is also a long-time Dental Board Examiner, and in his travels and conversations, witnesses firsthand how unique the MDA EFDA program is and the privilege it is to have it in our state.

"I am lucky to examine at schools all over the country with other dentist examiners from many states. When discussing trends in our respective states, I am always presented with many questions about the evolution of the MDA EFDA program and its viability. I enjoy discussing it and the value EFDAs bring to our practices."



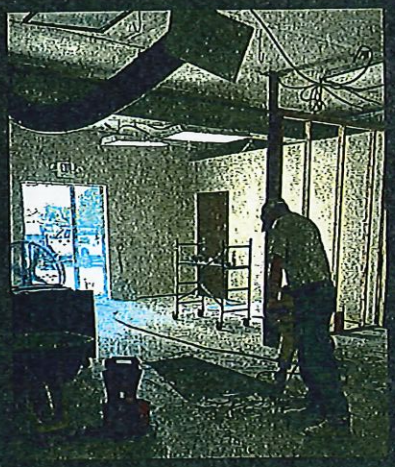
To inquire about becoming an EFDA trainer, contact Mandy Lewis at mandy@modentalmail.org.

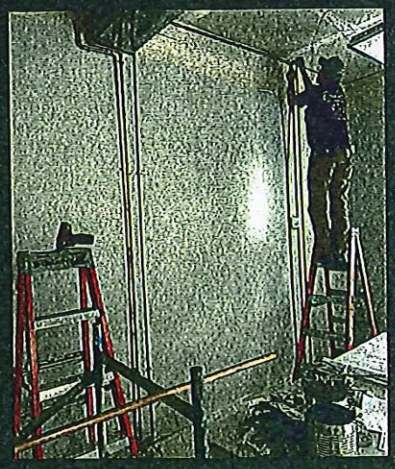


PROGRESS UNDERWAY









The MDA Board toured the training center renovation at its meeting August 25. Since then, demo, plumbing and painting have commenced toward the goal of fully functioning operatories. The MDA anticipates holding courses in the new space after the New Year.

Exploring a New OPA EFDA Through a Pilot Project

In April 2023, the Missouri Dental Board passed the allowance of an Oral Preventive Assistant Pilot Project coordinated by the Missouri Department of Health and Senior Services (DHSS) Office of Dental Health (ODH). The pilot project will examine the use of an Oral Preventive Assistant (OPA) Expanded Function Dental Assistant (EFDA) (herein referred to as OPA EFDA) to deliver preventive care, including supragingival scaling limited to patients who are diagnosed as periodontally healthy or with gingivitis. The results of the pilot project will be reported to DHSS through ODH and other oral healthcare stakeholders in the state, and with proven safety and efficacy, will be offered for subsequent rule promulgation to allow new delegable duties. Creating an OPA EFDA position would build on the proven approach of allowing dental assistants, under direct supervision, to assist with restorative, orthodontic, and fixed prosthetic and removable prosthetic care. All OPA EFDA candidates would be required to satisfy the same prerequisite as other assistants wanting to pursue EFDA certification, and must successfully complete all online learning, including module quizzes, prior to matriculation into clinical training.

WHAT WOULD THE OPA EFDA DO?

Dental assistants who successfully complete all parts of the OPA EFDA curriculum and training (including prework, hands-on clinical sessions and competency exams) will be eligible (within the pilot program at approved clinical sites) to assist dentists and hygienists (under direct supervision) with:

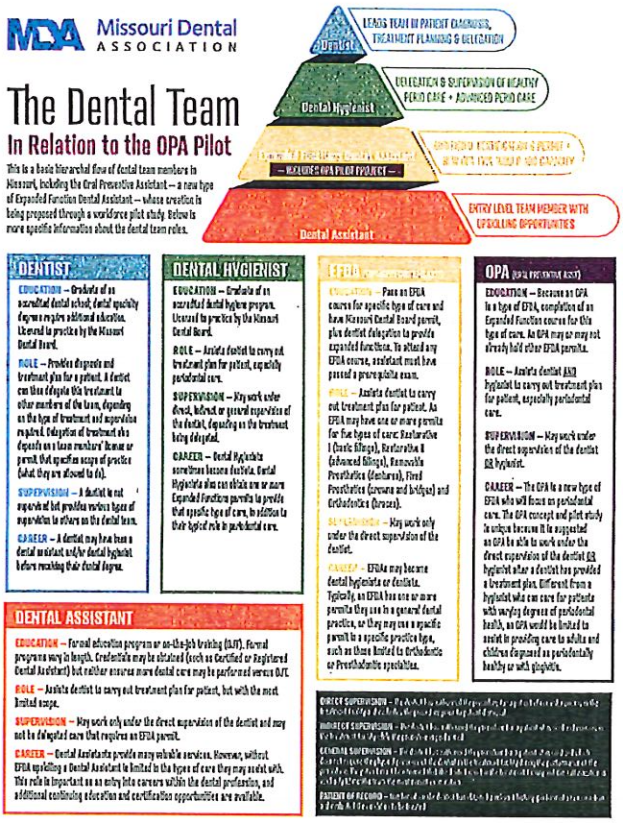
- Documenting periodontal probe readings and bleeding spots.
- Supragingival scaling, limited to patients diagnosed as periodontally healthy or with gingivitis.

By performing these and other clinical skills that alleviate the simpler but time-consuming tasks typically associated with a hygienist's daily workflow, we hope this will allow dental hygienists (and dentists) the time necessary to practice at the top of their scopes to provide care. It should be noted that if a patient is diagnosed as outside of periodontally healthy or with gingivitis, they can only be seen for the initial diagnostic exam and no proposed delegated functions can be performed by an OPA for that patient thereafter.

OVERVIEW OF OPA EFDA MODULES

The OPA EFDA curriculum is a comprehensive suite of educational modules. The opening modules will require assistants to review and reacquaint themselves with fundamental principles. The subsequent modules will prepare assistants for the delegable functions with required hands-on clinical sessions and competency exams. Some modules (such as Modules 10-11) offer additional education and training on procedures already delegable to all dental assistants (no EFDA certification required).

The curriculum workgroup, comprised of practicing dentists and dental faculty, has consulted existing, similar curriculum from Indian Health Services, among other texts and sources. The curriculum will be presented to the Missouri Dental Board at its October meeting, for review and approval to formally commence the pilot. As with all EFDA curriculum, the workgroup will continue to review and update the curriculum, especially as the pilot provides information and feedback.



- **Introductory Modules** – Overview/Introduction; Infection Control; Positioning
- **Module 1** – Anatomy, Physiology and Morphology
- **Module 2** – Periodontal Etiology and Classification
- **Module 3** – Armamentarium
- **Module 4** – Maintenance and Sterilization
- **Module 5** – Oral Hygiene Instructions
- **Module 6** – Patient Assessment and Data Collection
- **Module 7** – Imaging & Evaluation
- **Module 8** – Using a Periodontal Probe, Principles & Techniques (proposed delegable functions)
  - Initial diagnostic periodontal probing depth and bleeding spot recording.
  - Recall periodontal probing depth and bleeding spot recording on patients who have been classified healthy or with gingivitis.
- **Module 9** – Supragingival Scaling (proposed delegable functions)
  - Use supragingival hand and ultrasonic scalers on healthy or gingivitis patients.
  - Initial supragingival gross debridement in preparation for periodontal evaluation.
- **Module 10** – Coronal Polishing
- **Module 11** – Placement of Sealants, Fluoride Varnish and Silver Diamine Fluoride

Find a full size version of the above chart and additional information about the OPA EFDA Pilot Project at modental.org/opa.

P312

OPA EFDA Pilot Project Update

by VICKI WILBERS, EXECUTIVE DIRECTOR

"Build it and they will come" seems to be the mantra for this project. It's appropriate for the work effort from those participating in the Oral Preventive Assistant (OPA) Expanded Function Dental Assistant (EFDA) Pilot Project — dentists, trained OPAs, hygienists, front office administrators and more — and for the other many dentists supporting this effort in multiple ways.

It's been since last fall that a formal update was given on the OPA Pilot project — though each week we respond to emails from doctors asking us when the OPA will be available to help with the critical workforce need in their offices, which impacts patient care. The purpose of the article is to refresh you with an outline of the project, give a status update and, most critically, request your continued support.

REVIEWING THE WORKFORCE ISSUE

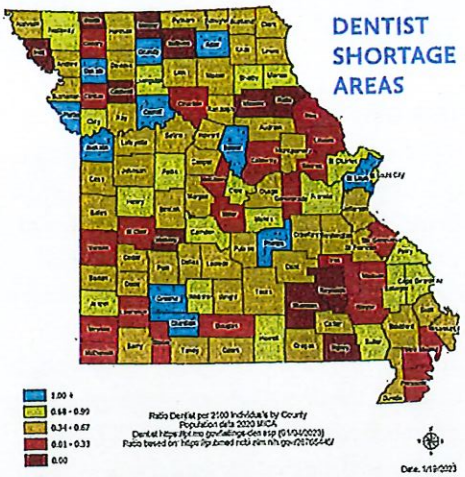
Since 2023 when we first began to address workforce issues, not much has statistically changed in the shortage of the oral healthcare workforce. Like all healthcare sectors, the oral healthcare workforce is critically shorthanded and the period affected by COVID exacerbated the issue. In a 2023 report, the Missouri Office of Dental Health (ODH) indicated that approximately 10 percent of the oral healthcare workforce exited healthcare during COVID. A survey by ODH also revealed that 20 percent of the workforce were considering retirement in the next five years due to age or job stress.

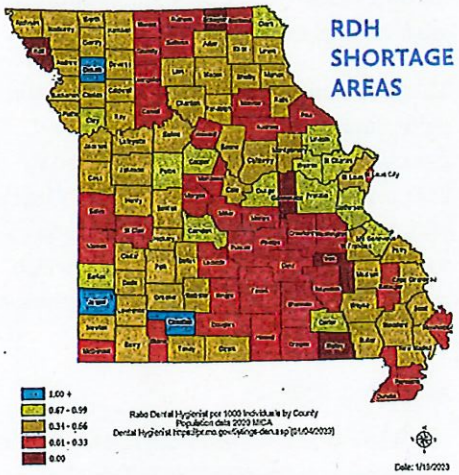
The result is significantly understaffed clinics operating at 60 to 80 percent of capacity.

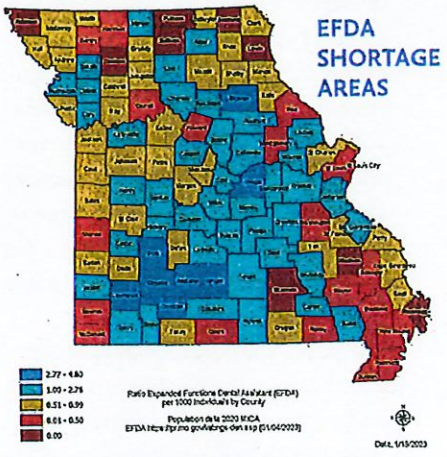
Workforce shortages have had a more severe impact on rural clinics and those serving the eligible Medicaid population, with appointment wait times in many Federally Qualified Health Centers and clinics serving Medicaid patients lasting weeks or even months. The ODH used license and permit data to determine provider locations and identify areas where more providers are needed.

When you look at these maps (with all counties not colored in blue considered shortage areas), you can note the following:

- All but a few metropolitan counties have significant oral healthcare workforce shortages. Rural areas are the most severely impacted.
- There is a shortage of dentists and dental hygienists in rural Missouri: 44 percent of clinics that had an opening for a dental hygienist were unable to fill that opening.
- You will see that EFDAs are distributed more evenly throughout the state, especially in rural areas where hygienists are scarce. The relative scarcity of hygienists in rural areas hasn't changed significantly since 1990, despite nearly 2,200 additional hygienists being licensed and residing in Missouri. The training centers are in metropolitan areas, and most graduates find employment within a 50-mile radius of the school they attended. In fact, when comparing 2022 maps with 2023 maps, EFDA distribution was the only category showing improvement, in that three fewer counties were among shortage areas, whereas an additional county for RDH was added to the designation for shortage areas.







Missouri Dental Workforce Distribution Maps, provided by the Missouri Office of Dental Health. **For all maps, all counties not colored in blue are considered shortage areas.** These are the most recent maps, dated January 19, 2023.

MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES
Office of Dental Health

TAKE NOTE! Two years ago, the MDA published a workforce issue with information on the OPA Pilot Project, the MDA EFDA program, other workforce initiatives happening across our state and expanding dental hygiene programs. Those programs have provided updates we're sharing with you in this issue. You can read those starting on page 29 of this issue.

OPA OFFERS A SOLUTION

The OPA is one solution and is proving that this upskilled worker is a valuable part of the dental team. With the final promulgation of rules towards the end of 2024, the trained OPAs began to work within the seven clinical pilot sites providing supragingival scaling and care on healthy and gingivitis patients. In doing so, the dental offices — through a team effort between the dentist, the RDH, the 16 OPAs and the office administrators — began to collect data to conform with the outlined specifications of the project.

The pilot clinical study, which measures the performance of OPA EFDAs, has demonstrated excellent outcomes as evaluated by both patients and clinical supervisors. Details of the performance evaluations are reported to the Missouri Dental Board (MDB), which can be found online, but some key takeaways are as follows:

As of July 3, 2025:

- 440 evaluations had been collected from patients treated by OPA EFDAs. The average evaluation of OPA EFDA care by patients was 9.7/10.
- Supervising dentists were required to submit a performance review of OPA EFDAs using eight scales that mirror the educational objectives of their curriculum. The performance evaluation scores average for all OPAs ranged from 8.3 to 10, with an average global score of 9.3/10.
- The study will conclude in October 2025 with final reporting to the MDB and a full analysis conducted by the ADA Health Policy Institute.

Additionally, some of the comments from OPA sites include:

- "We are excited to integrate OPAs into our team. We've had trouble recruiting hygienists to our location. Our plan is to pair an OPA with every hygienist to serve more patients better." — *Dr. Robert Thompson* (Chief Operating Officer, Pine Lawn Dental Management LLC, St. Louis)
- "The OPA has been an invaluable addition to our clinic, particularly in supporting our hygienists and expanding patient access to care. By assisting with tasks such as periodontal charting, patient education and preventative procedures, the OPA enables our hygienists to concentrate on delivering specialized clinical care for patients with more complex periodontal needs. This collaborative model improves workflow, allows our hygienists to practice at the top of their scope and increases the number of patients we can serve. Because the OPA works directly alongside a hygienist or dentist, this approach enhances access without compromising the quality of care." — *Shannon Covington, RDH* (Director of Dental Training and Development, Compass Health Network, Wentzville)



IRB: PATIENT PROTECTION, DATA INTEGRITY, BIAS CONTROL

Prior to the clinical trial, the MDA submitted the entire OPA EFDA study protocol to an **Institutional Review Board** registered with the U.S. Department of Health and Human Services Office for Human Research Protections. Registered IRBs are mandated to review human study constructs, ensure adequate safety protocols are in place to protect participants, review the study hypotheses and metrics to ensure there is a high likelihood the study will collect data necessary to confirm or deny hypotheses, examine for and recommend corrections for study biases if they exist, and determine if the study meets all federal guidelines applicable to human studies. The OPA study was reviewed and approved by the IRB as safe, soundly constructed and in compliance with all federal regulations. The MDA felt it was important this pilot project have IRB approval to remove the concern of any bias within the project and protect the patients served through it.

CONTINUING MOMENTUM

The MDA will work to codify this into law, allowing dentists to delegate care to this oral health care worker as a part of their dental team. While we have had naysayers, more so, we have had overwhelming support for the OPA. We also continue to receive comments from doctors expressing their dire need for this and their confidence in the EFDA program: that the OPA, as a type of EFDA, can be integrated as a valuable, critical member of their teams.

For those who are skeptical, I will restate that we absolutely can't sit back and not create a pathway for communities and dental teams to progress toward bringing more access to oral healthcare for Missourians. For those who are critical, just look at the pilot reporting currently: It's working! It is being shown an OPA EFDA can provide great care under direct supervision and be an asset to their team — not only to the approval of their supervising dentists and hygienists, but to the patients for whom they are providing care. Is the OPA the only solution to workforce issues? Absolutely not. Yet it is clear and proven that EFDA training is the most cost-effective way to leverage the existing dental workforce and increase productive capacity and access. One EFDA can increase the productive capacity of a dentist or hygienist by 15 to 25 percent.

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P314

It costs $1,500-$7,500 to educate an EFDA; $30,000-$60,000 to educate a hygienist; and $350,000-$500,000 to educate a dentist.

It is also clear that support from organizations such as the American Legislative Exchange Council (ALEC) who adopted the OPA into their model oral healthcare policy, indicates the need for changes in the oral healthcare delivery system. This adoption has brought forth applications of the OPA EFDA into other states: In 2025 Arizona placed the OPA into law, Illinois has created a type of scaling assistant, and scaling assistants have existed in Kansas for decades — with no adverse effects being reported. The MDA has had several other states inquiring about the pilot and licensing the OPA curriculum. The question remains: Will Missouri, with the support of its dental profession, have the courage and fortitude to make this a law in our very own state?

Other possibilities to decrease shortages certainly exist. Enhancing the role of the hygienist is important. The MDA worked heavily with its own membership to address its policies and make changes to move forward with support for RDHs to provide local anesthesia under general supervision. That rule has been fully promulgated into law and serves the ODH Nursing Home Care Project. Allowing more spots for hygienists in schools is another way to address the shortage and bringing more programs for exploration of interest into dental careers is yet another element to help build a pipeline of people for the dental profession. Dr. Megan Krohn, the new State of Missouri Dental Consultant, is committed to this issue and has brought together a group of stakeholders to continue to discuss the myriad opportunities to address oral healthcare workforce shortages in our state (see the ODH and other workforce updates starting on page 29).

WHAT YOU CAN DO

I had said previously that we receive comments from doctors expressing their support for the OPA — and often, asking what they can do to help bring its passage to our state. For any dentist or supporter reading this and wondering what they might be able to do to build up this program, it's simple: Build a relationship with your state senator and representative and give to MODentPAC. For us to accomplish our goal, we need you to build new or enhance current relationships to help us bring this successfully to the finish line. There is a great article on page 16 about this very topic! Contact our office; our lobbying team will walk you through how to make these relationships and be a leader for this important advocacy work!

In retrospect, the challenges we have faced with the enormity of the OPA Pilot Project seem minimal compared to the care being given to patients by the OPAs and overall work being conducted by the sites. Their enthusiasm for this model and the hope for it to become available for the entire dental profession in Missouri is palpable. Their work is outstanding, reflecting their extreme dedication to the project because of its value for their patients, team and the provision of dental care in our state. We cannot thank them enough for their incredible role. I cannot give enough praise for their ongoing efforts; I am humbled by their commitment to this project.

MISSOURI ACADEMY of GENERAL DENTISTRY

UPCOMING CE COURSES

register today

MOAGD.NET



HANDS-ON FIXED PROSTHETICS COURSE

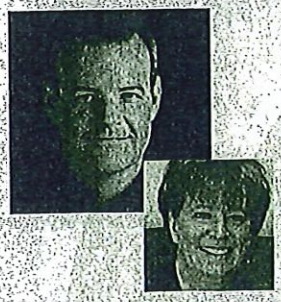
October 3-4, 2025 | Held in St. Louis

Presented by Dr. Todd Snyder | 2 Day Hands-On

16 CE CREDITS

Fixed Pros 2 Day Mastery Course: Transform Your Practice, Your Skills and Your Life

This course includes 2.5 hours of hands on each day; 16 credit hours with an option to get up to 34 credit hours if protocol presentation is given after the course.



The Dental Practice Prison Boot Camp and Preventing Practice Embezzlement

January 17, 2026 | Held in Branson

Presented by Matt Kennedy, CPA & Cindy Day

8 CE CREDITS

Each speaker will present a half day course. Learn how to breakout of the dental office prison and prevent practice embezzlement.

Scan code to learn more about speakers and to registers!

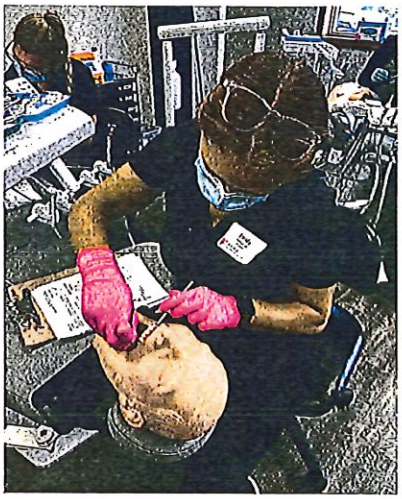
P315

In addition to all the dentists, OPAs, RDHs and office administrators doing exceptional work within this project, we (the MDA Board and the MDA team) also especially thank Dr. Guy Deyton, the Office of Dental Health and the Missouri Dental Board. We thank every person who has in some way provided the pilot project and entire EFDA program support. And we again call on the dentists of this state — the members of this association — to continue to stack the blocks and help us build upon what has already been accomplished.



Visit modental.org/opapilot for Missouri workforce distribution maps, pilot project reports and more. For questions, email Vicki at vicki@modentalmail.org. Below are a few pictures from courses we've hosted in our wonderful Clinical Training Center. Read an update on pages 32-331







MDA Governance Task Force Begins Its Work

The assembly and activities of the MDA Governance Task Force has begun, with its goal to increase participatory governance and explore alternatives to the MDA House of Delegates. This past June, the MDA House of Delegates adopted Resolution 2025H-7 that directed this effort. Since then, considerable work has been done to adhere to its directives, including the assembly of the task force by Dr. Amanda Fitzpatrick, MDA Speaker. The process allowed self-nominations from which a 15-member taskforce was established.

Dr. Fitzpatrick reported to the MDA Board during its September meeting. She outlined the taskforce structure, explaining her goal to bring together members with new and historical perspectives to discuss changes to create more participatory governance and increased membership engagement.

To show its commitment to this process and its goals, the Board agreed to hire a facilitator to lead and navigate the governance discussion. The MDA has spent years addressing overarching governance structure matters and felt strongly that a consultant would benefit the work of the group. MDA has chosen Vista Cova, which brings extensive background in this type of facilitation. Vista Cova will engage members, ask difficult questions, listen deeply to varied perspectives, identify points of insight and consensus, and craft a shared vision. This type of focus ensures the members of this task force will know it is their perspective, expertise and passion that are represented.

The process of this work will be led by Lowell Aplebaum, Vista COVA CEO, and will be aided by a team that includes a researcher, and a client experience and program expert. Lowell's clients number in the hundreds. His work with healthcare associations includes recent and ongoing work with the Georgia Dental Association and the Society of Hospital Medicine. We are excited to bring him onboard to help lead this exploration, along with Dr. Aaron Bumann, who will aptly serve as task force chair.

We'll continue to keep members informed of task force outcomes. MDA appreciates all who submitted their name for consideration, with the following chosen for this important work:

- Central: Phil Batson, Chris Kollath, JC Standlee
- Greater Kansas City: Aaron Bumann (Chair), Garret Cochran, Wendy Weimer
- Greater St. Louis: Bob Butler, Emily Hahn, Robyn Hayes, Megan Lenahan, Danielle Riordan, Robby Thompson
- Greater Springfield: Ahad Saqib
- Southeast: Dennis Nguyen
- Southwest: Aldo Del Sol Martinez
- Non-Voting Members: Rachael Parker (New Dentist Committee Liaison), Amanda Fitzpatrick (Speaker)
- Staff Liaisons: Margie Kunze (Governance Manager), Vicki Wilbers (Executive Director)

RESOLUTION 2025H-7

RESOLVED, that a task force, whose composition is representative of the percentage of active membership by component society, be appointed by the Speaker of the House in consultation with the Board of Trustees to be charged with increasing participatory governance and exploring alternatives to the MDA House of Delegates; and be it further,

RESOLVED, that the taskforce shall identify a structure or process to ensure continued membership engagement and input on policy matters; and be it further,

RESOLVED, that the task force through the Board of Trustees provides an interim report back to the 2026 MDA House of Delegates.

For questions, email Dr. Fitzpatrick at amandafitzpatrick613@gmail.com or Vicki at vicki@modentalmail.org.

2020

COVID-19 Escalates Existing Dental Workforce Issues

MDA-HPI Dental Team Scope of Practice Survey — *November 2020*

2021

Workforce Executive Session at MDA House
MDA House Passes 2021H-9
MDA Exploratory Committee on Workforce Established
November 2021

- *Focus Area A* — RDH Scope & Delegation
- *Focus Area B* — DA/RDH Schools
- *Focus Area C* — EFDA Scope & Delegation

2022

MO Office of Dental Health Workforce Survey *Spring 2022*

MDHA Hygiene Workforce Survey *Spring 2022*

Dr. Guy Deyton, then State Dental Director, convenes small group of oral health stakeholders to consider all recent available data to address shortages and make recommendations
May 2022

Educational articles in *MDA Focus* relaying findings and recommendations of oral health group *Summer 2022*

HB2149 "Missouri Dental Board Pilot Project" passes, giving statutory authority to develop pilot projects to extend dental care to underserved populations
May 2022

MDA Exploratory Committee Presents Report to MDA House
November 2022

Severity of the workforce issues should be addressed immediately

Support dental team scopes to work at top of education

Support RDH local anesthesia under general supervision policy change

Support EFDA Oral Preventive Assistant

MDA House of Delegates changes policy on **RDH Local Anesthesia Delegation**
November 2022

MDA Board **supports pursuing Oral Preventive Assistant EFDA** (regulatory) as part of legislative agenda
November 2022

Missouri Dental Board Authorizes Nursing Home Pilot Project coordinated by Office of Dental Health
December 2022

MDA creates workgroup to pursue Oral Preventive Assistant EFDA Pilot Concept
December 2022

2023

Missouri Dental Board prepares to promulgate rule for RDH Local Anesthesia under General Supervision
January 2023

- Full promulgation of Rules for local anesthesia under general supervision *Presently progressing through MDB*
- Waiver of Rules approval for OPA EFDA Pilot *July 2023*

OPA EFDA Workgroup continues to develop focus areas of a potential pilot project
January 2023

- OPA RFA Site Application & Selection Process Begins *October 2023*

OPA EFDA Curriculum Workgroup creating course content and standards
January 2023 to Present

- OPA Didactic & Hands-On Training & Clinicals to Follow in Selected Sites *Anticipated to Begin January 2024*

2024

Training of OPA Candidates Commences and is Completed
January – March 2024

OPA EFDA & Local Anesthesia Under General Supervision Rules Posted in Missouri Register, *May 2024*

Final Order of Rulemaking Posted in Missouri Register
October 2024

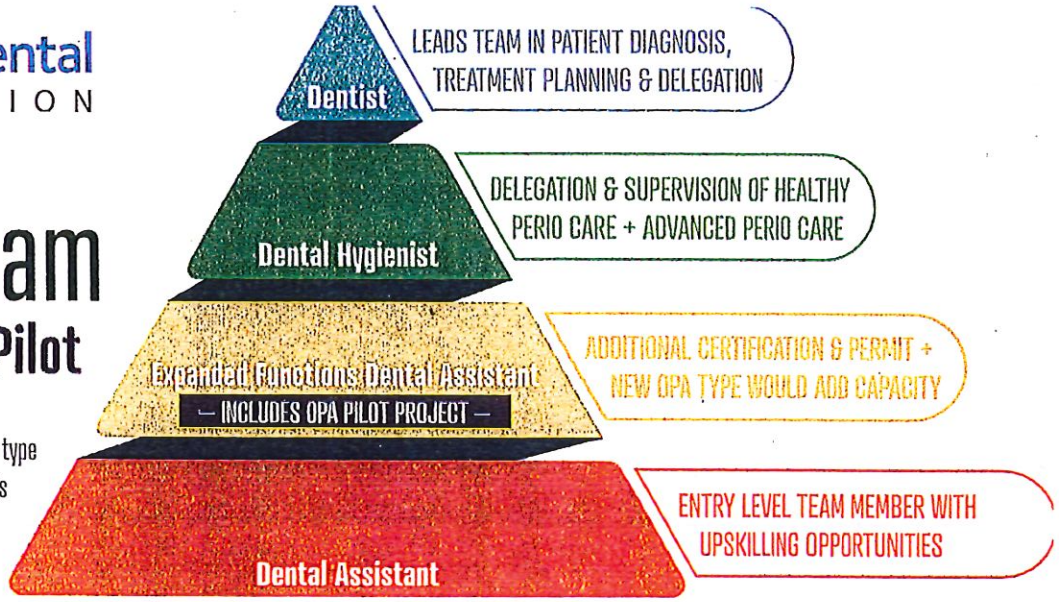
Official OPA EFDA Pilot Project Begins
December 2024

Missouri Dental ASSOCIATION

The Dental Team

In Relation to the OPA Pilot

This is a basic hierarchal flow of dental team members in Missouri, including the Oral Preventive Assistant – a new type of Expanded Function Dental Assistant – whose creation is being proposed through a workforce pilot study. Below is more specific information about the dental team roles.



DENTIST

EDUCATION – Graduate of an accredited dental school; dental specialty degrees require additional education. Licensed to practice by the Missouri Dental Board.

ROLE – Provides diagnosis and treatment plan for a patient. A dentist can then delegate this treatment to other members of the team, depending on the type of treatment and supervision required. Delegation of treatment also depends on a team members' license or permit that specifies scope of practice (what they are allowed to do).

SUPERVISION – A dentist is not supervised but provides various types of supervision to others on the dental team.

CAREER – A dentist may have been a dental assistant and/or dental hygienist before receiving their dental degree.

DENTAL HYGIENIST

EDUCATION – Graduate of an accredited dental hygiene program. Licensed to practice by the Missouri Dental Board.

ROLE – Assists dentist to carry out treatment plan for patient, especially periodontal care.

SUPERVISION – May work under direct, indirect or general supervision of the dentist, depending on the treatment being delegated.

CAREER – Dental Hygienists sometimes become dentists. Dental Hygienists also can obtain one or more Expanded Functions permits to provide that specific type of care, in addition to their typical role in periodontal care.

EFDA (EXPANDED FUNCTIONS ASST)

EDUCATION – Pass an EFDA course for specific type of care and have Missouri Dental Board permit, plus dentist delegation to provide expanded functions. To attend any EFDA course, assistant must have passed a prerequisite exam.

ROLE – Assists dentist to carry out treatment plan for patient. An EFDA may have one or more permits for five types of care: Restorative I (basic fillings), Restorative II (advanced fillings), Removable Prosthetics (dentures), Fixed Prosthetics (crowns and bridges) and Orthodontics (braces).

SUPERVISION – May work only under the direct supervision of the dentist.

CAREER – EFDAs may become dental hygienists or dentists. Typically, an EFDA has one or more permits they use in a general dental practice, or they may use a specific permit in a specific practice type, such as those limited to Orthodontic or Prosthodontic specialties.

OPA (ORAL PREVENTIVE ASST)

EDUCATION – Because an OPA is a type of EFDA, completion of an Expanded Function course for this type of care. An OPA may or may not already hold other EFDA permits.

ROLE – Assists dentist AND hygienist to carry out treatment plan for patient, especially periodontal care.

SUPERVISION – May work under the direct supervision of the dentist OR hygienist.

CAREER – The OPA is a new type of EFDA who will focus on periodontal care. The OPA concept and pilot study is unique because it is suggested an OPA be able to work under the direct supervision of the dentist OR hygienist after a dentist has provided a treatment plan. Different from a hygienist who can care for patients with varying degrees of periodontal health, an OPA would be limited to assist in providing care to adults and children diagnosed as periodontally healthy or with gingivitis.

DENTAL ASSISTANT

EDUCATION – Formal education program or on-the-job training (OJT). Formal programs vary in length. Credentials may be obtained (such as Certified or Registered Dental Assistant) but neither ensures more dental care may be performed versus OJT.

ROLE – Assists dentist to carry out treatment plan for patient, but with the most limited scope.

SUPERVISION – May work only under the direct supervision of the dentist and may not be delegated care that requires an EFDA permit.

CAREER – Dental Assistants provide many valuable services. However, without EFDA upskilling a Dental Assistant is limited in the types of care they may assist with. This role is important as an entry into careers within the dental profession, and additional continuing education and certification opportunities are available.

DIRECT SUPERVISION – The dentist has authorized the procedure for a patient of record, remains in the treatment facility and evaluates the procedure prior to patient dismissal.

INDIRECT SUPERVISION – The dentist has authorized the procedure for a patient of record and remains in the treatment facility while the procedure is performed.

GENERAL SUPERVISION – The dentist has authorized the procedure for a patient of record and which does not require the physical presence of the dentist in the treatment facility during the performance of the procedure. The patient must be informed that the dentist is not in the treatment facility and the authorization is valid only 12 months from the most recent examination.

PATIENT OF RECORD – One for whom the dentist has obtained a relevant history, performed an examination and evaluated the condition to be treated.

MY VIEW

Workforce Issues: Present Both Challenges and Opportunities



by GUY DEYTON, DDS

For reasons I don't fully understand, Dr. Dean Patzman, a prosthodontist close to retirement, professionally adopted me and mentored me starting at my first Greater Kansas City Dental Society meeting 38 years ago. I suspect that after listening to a still wet-behind-the ears dentist, freshly out of a residency program, he was concerned about my future and the future of my patients. As closely as I can remember, this is what he said:

"I envy the opportunities you will explore in dentistry. Your professional future will be exciting and challenging. I suspect the landscape will change more quickly than you imagine. Those with curiosity, energy and enthusiasm to explore new ways to deliver care will be successful. Of course, some things won't change, like the value of kindness and respect."

Now I pass his words on to you, especially as it relates to the challenges that lie ahead in maintaining an adequate workforce to assist you in delivering care to the increasing population that needs your services.

WHAT IS THE CURRENT STATUS OF THE ORAL HEALTHCARE WORKFORCE AND HOW DID WE GET HERE?

- Our oral healthcare workforce is currently 10 to 15 percent understaffed. To give you a numerical context, Missouri is approximately 1,000 to 1,500 oral healthcare workers short of what is necessary to adequately provide access to care.
- Our workforce was short and stressed before the COVID-19 Pandemic, due to closure of dental schools at St. Louis University and Washington University. Then it got much worse quickly during the Pandemic.
- Understaffing cuts across all roles: doctors, hygienists, EFDAs and assistants, leaving many providers overworked, stressed and hovering dangerously close to burnout.
- Workforce surveys conducted in 2022 by the Missouri Office of Dental Health indicate that slightly more than 20 percent of our workforce is considering retirement in the next five years. To give you context, that is an additional 2,000 oral healthcare workers who may exit soon.
- The need for new doctors, hygienists, EFDAs and assistants far outstrips the capacity of our existing educational infrastructure to prepare replacements. Given our current educational capacity, it will take two to three decades to restore a provider-to-population ratio to provide adequate access to care to Missouri's population.
- The workforce shortage disproportionately affects clinics serving rural and Medicaid populations. Considering workforce solutions for these populations must be a priority.

WHAT OPTIONS AND OPPORTUNITIES LIE AHEAD?

1. **Listen to Dr. Patzman's advice.** Our professional landscape is changing more rapidly than we imagined and more rapidly than we like. We are going to be forced to creatively search for new ways to educate a workforce and new ways to deliver care.
2. **Expand the use of EFDAs.** This should be job No. 1! EFDAs are a proven way to increase access to care in times of workforce shortages. In the early 1990s, when Missouri began to feel the impact of the dental school closures, we developed the Missouri Expanded Function Dental Assistant program. It has been a resounding success, increasing the productive capacity of clinics that employ EFDAs by 15 to 20 percent. EFDAs have helped to preserve access to care even during the period of 1990-2022 when the population-to-dentist ratio in Missouri increased each dentist's workload by 33 percent.
3. **Create and promote accessible entry level opportunities in dentistry.** We are 1,000 to 1,500 oral healthcare workers short now with the prospect of greater workforce shortages in the future. The Missouri Office of Dental Health's brilliant pilot project (see update on page 25) identifying partners for dental assistant training programs in high schools and in rural areas is a great start. If we hope to replenish our future workforce, we need to add promotion of dental career opportunities to our strategic plan on every level: national, state, local and especially chairside.
4. **Employ distance learning educational modalities** to keep prospective healthcare providers in rural areas in place, rather than uprooting them to metro-

politan areas where schools are located. Few uprooted, formerly rural healthcare workers return to rural settings.

5. **Shorten the professional educational development cycle.** In his book, *The Soul of a New Machine*, Tracy Kidder chronicles Hewlett Packard's successful effort to shorten the development cycle for bringing new computers to the market from years to months. HP's culture had equated time with "doing it right". Tom West, the leader of the HP project, was quoted as saying "The world is moving faster than we are. We need to keep up." Dentistry needs to do the same thing in professional education. Given the future workforce implications, we can't afford to wait eight years for new dentists to join the workforce, or three to four years for hygienists, or one to three years for EFDAs. There are many people who are not being cared for, and we need to change so the future looks better!
6. **Lobby for increased funds for dental education.** Just because our educational infrastructure is behind the demand curve doesn't mean we shouldn't invest to increase its capacity. Increasing the capacity of our educational programs is critically important. It just can't be the only solution.
7. **Expand use of telehealth modalities to leverage existing workforce.** Modern technology has enabled us to reach out to patients from a distance. We are discovering new ways almost daily to use computers, phones, cameras and now integrate AI to help patients. Embrace telehealth. It will be an essential tool to help during times when there are too few healthcare providers and too many patients.
8. **Integrate AI.** Like it or not, the use of artificial intelligence interfacing and assisting in patient interactions is a foregone conclusion in healthcare. Mayo Clinic communicated in July that it has trained and implemented an AI patient interface to facilitate care. AI assisted procedures will be a fee-linked procedure, much like a problem-oriented exam. Using AI to assist in distant patient interactions allows a stressed healthcare workforce to use more time for face-to-face patient encounters.
9. **Remember kindness and respect.** If you want to have people continue to help you deliver care to your patients, take Dr. Patzman's advice. Treat your staff and colleagues kindly and with respect. You have a choice: you can make staff want to stay or want to leave.

I will never fully understand why Dr. Patzman chose to adopt and mentor me at our first meeting 38 years ago. Now that I am approximately the age he was at the time, I have a better idea. With each passing day, I appreciate his wisdom. Like Dr. Patzman, I envy the opportunities you will explore!



Dr. Guy Deyton is a former MDA President and Missouri Dental Board member, and is immediate past Missouri Director of Oral Health, Office of Dental Health. Contact him at guydeyton@gmail.com.

P320

High School DA Program

CONTINUED FROM PAGE 25



The Pike/Lincoln Technical Career Center in Eolia (Pike County) is one of three that will be working with ODH. Others include Clinton Technical School in Clinton (Henry County) and Lewis & Clark Career Center in St. Charles (St. Charles County).

These schools will be working with ODH, and private dental offices, Compass Health Network and other FQHCs to make this dental assisting program a reality in Missouri.

To start the programs, we would hire instructor(s) to teach the didactic portion of dental assisting in the classroom. Instructors would demonstrate techniques within the individual classrooms and organize the intern opportunities for the students. The first year would include purchasing equipment and getting instructor(s) in place. The following years, the career centers would receive tuition funding from their sending districts and state grants to cover the costs. Our plan is to film all the classes and make a repository so future districts can utilize the curriculum materials. The individual school districts also can apply for federal grants to establish new dental assisting programs across the state.

Our goal is to have 12 students each in the morning and afternoon in each of the three schools. Current student enrollment in Clinton is 500+, Pike-Lincoln is 300+, and Lewis & Clark is 500+. Both Pike-Lincoln and Clinton also serve area adults. In addition to their area public schools, all three career centers also serve some of the local private schools. If the project provides a well-trained dental assistant educated in their own hometowns, they are likely to stay and address the need for trained dental assistants in rural areas. This dental team member also can receive a higher salary to reflect their EFDA certification. More importantly, the development of this educational program can be duplicated across Missouri, allowing both individuals and communities to thrive. This program would impact the equity of care when a trained dental assistant is able to assist the dentist in providing more efficient dental care. We also hope to train ethnically diverse populations to become part of the dental team, thus improving access to well-paying jobs as soon as the student graduates with their dental assisting certificate and diploma.

In a 2022 Dental Assisting National Board *Dental Assistants Salary and Satisfaction Survey*, it was reported three out of four dental assistants agree dental assisting is a career, not a job. We look forward to this program exposing more students, earlier, to becoming a valued dental team member in the great profession of dentistry.



Dr. Jackie Miller is the Missouri Director of Oral Health, Office of Dental Health. Contact her at jacqueline.miller@health.mo.gov.

State Fair Community College RDH Program: Expanding & Innovating

by ANDRA FERGUSON, PHD

State Fair Community College (SFCC) has been working to expand its dental hygiene program. Recently, SFCC applied for two grants: one was not received, while the other (through the MOExcels program) we anticipate hearing about in September. Plans for the grant funding are to assist with the renovation of a current building on the SFCC campus into a multi-purpose health science building which would include an expanded dental hygiene facility. This grant funding would allow the college to establish an advanced dental training facility that will provide a centralized training center supporting SFCC's service region.

Though the college's main campus is in Sedalia, the college's 14-county region in mid-Missouri is an area roughly the size of the state of Vermont. This region of west-central Missouri is an aging, medically underserved region. According to the U.S. Department of Health and Human Services, Health Resources and Services Administration, nine of the 14 counties have Medically Underserved Area designations either as a full county or a subdivision, and all 14 counties have Health Professional Shortage Area designations.

With the multi-purpose health center, the dental hygiene clinic will allow for more than double the enrollment of students and number of community patients able to be served in the on-campus clinic, thereby increasing dental services provided to the underserved population of the SFCC service area. It's obvious this expansion would be a great benefit to the entire community.

SFCC's proposal is aimed at providing students access to high-quality health science education opportunities and boosting enrollment in programs with significant labor market demand. The health science occupations are listed as high-demand occupations, identified using long-term occupational projections developed by the Missouri Economic Research and Information Center (MERIC). MERIC's projections assign career grades based on projected openings, growth and wages.

The Missouri Department of Health and Human Service's Health Workforce Strategic Plan focuses on recruiting and training health professionals from underserved communities to build a diverse representative health workforce, ensuring equitable distribution of the workforce across geographic areas and health professions, and using evidence and data to make better decisions about our health workforce education and training investments. With that in mind, 67 percent of SFCC's Dental Hygiene students and 83 percent of the Occupational Therapy Assistants students come from rural counties, which are nearly all considered Health Professional Shortage Areas.



Additionally, following graduation from SFCC, for the past three years, 93 percent of SFCC dental hygiene graduates work in Missouri with 65 percent of those working in rural Missouri counties. We believe this investment of funds for a health education center serving rural Missouri makes good sense.

In addition to the above exciting opportunities for the SFCC healthcare education programs, we also are working with community partners to adapt current dental hygiene curriculum to support online didactic learning and face-to-face clinical and lab courses. This is a new, hybrid option to deliver education, which will allow SFCC to take on more students to meet the workforce needs. This is something we have considered to meet demands of Missourians and the workforce demand. Currently, clinical and lab portions of training are taught by adjunct bachelor-level hygienists, within the requirements of the Commission on Dental Accreditation (CODA). We also have current clinical rotations in dental offices during the second year of the DH program. SFCC would like to expand the clinical training to include first-year students. However, this change to the program must first be CODA approved.

Communication and support from MDA, Missouri Dental Hygienists' Association, Office of Dental Health and many community health partners has been encouraging and will hopefully continue to bring the best health outcomes to Missourians. We are very grateful for the support of the physical expansion on campus and of new educational methods to address workforce issues.



Dr. Andra Ferguson is the Director of Dental Hygiene at State Fair Community College. Headquartered in Sedalia, SFCC serves a 14-county region in west central Missouri, including the following counties: Benton, Camden, Carroll, Cole, Cooper, Henry, Hickory, Johnson, Miller, Moniteau, Morgan, Pettis, Saline and St. Clair.

Assistant Apprenticeship, Career Education: MPCA Workforce Grant Focus

by KAREN DENT, CDA, EFDA

Delta Dental of Missouri has funded an application recently submitted by the Missouri Primary Care Association (MPCA) to help address oral health workforce shortages in rural areas of Missouri. MPCA will take a two-pronged approach to execution of the grant as described below.

IMPLEMENT A DENTAL ASSISTANT APPRENTICESHIP TRAINING PROGRAM IN 4 RURAL MISSOURI COMMUNITY HEALTH CENTERS

Four rural health centers will be chosen to establish a pilot dental assistant training program designed to recruit dental assisting staff members who live in communities served by each participating health center. Upon completion of the apprenticeship, students will be employed by the health center in which they received their training. A total of 16 students across four rural health centers will spend part of each workweek engaged in didactic education, while learning clinical skills in the training facility's dental clinic for the remainder of the week.

The curriculum was developed by the Washington Association for Community Health; it has been used to train more than 800 dental assistants in 10 states. The curriculum also aligns with ADA Commission on Dental Accreditation (CODA) standards for dental assistant training and includes guidance for mentor/instructors to facilitate the training program. The apprenticeship pilot is slated to last four to six months in each training facility, culminating in students sitting for the Missouri Test of Basic Dental Assisting Skills. MPCA anticipates that student apprenticeship programs will commence in early 2024. MPCA will work with participating health centers to determine sustainability of the training program beyond 2024.

DEVELOP AND DISSEMINATE AN ORAL HEALTH CAREERS RECRUITMENT PLATFORM FOR MISSOURI HIGH SCHOOLS

MPCA will create recruitment materials to be disseminated to Missouri high school health education programs. The recruitment platform may be presented in person, remotely or through blended learning. The oral health career information will include descriptions of various dental career options, responsibilities of each dental team member, educational requirements, employment/salary outlooks for each oral health career classification, and a list of educational entities offering dental education. MPCA will begin sharing the recruitment materials with high schools in the fall of 2023.

Karen Dent has served as Director of Oral Health Network of Missouri for MPCA since 2003. Prior to this role, she was a dental assisting education for 19 years. Contact her at kdent@mo-pca.org.

Surge in RDH Applicants Pushes STLCC to Expand Program Campuses

by KIM POLK, RDH, MEd

The future is bright for the Dental Hygiene Program at St. Louis Community College (STLCC). The program moved into the college's new Center for Nursing and Health Sciences building on the Forest Park Campus in fall 2019 after a more than 50-year stint at its previous location. The new facility, characterized by its brightness and beauty, is equipped with cutting-edge technology to offer students and patients an exceptional experience.

Positioned on the first floor, the STLCC Dental Hygiene Program features a 30-unit clinic, sterilization room, five radiology rooms, a reception area and waiting room, a dental lab, two classrooms, a student locker room, a faculty locker room/lunchroom and an office suite housing seven spaces capable of accommodating up to 12 faculty members.

After four years in this facility, interest in the program has surged beyond its capacity. In fact, the post-pandemic wait list for enrolling 32 students annually has expanded to nearly 150 students. STLCC is an open access college. This means that all students who meet the minimum requirements are placed on the wait list. Even after increasing enrollment to 40 students this fall, 110 students remain on the wait list.

Recognizing the pressing need for licensed dental hygienists within the greater St. Louis dental community, STLCC is responding by constructing a new Center for Nursing and Health Sciences on the Florissant Valley Campus. Just like on the Forest Park Campus, this expanded dental hygiene program will occupy the entire first floor and adopt a similar layout. The new educational facility, set to open in 2025, will also be capable of enrolling 32 students. Once the new facility opens, Forest Park will go back to enrolling 32 students annually.

Dental Hygiene Program Director Kim Polk has submitted multiple reports to the Commission on Dental Accreditation documenting the process and plans for this expansion. As the program grows, additional teaching opportunities for adjunct and full-time faculty are being added.

As the only dental hygiene program in the eastern half of the state, STLCC is leading the way in graduating professionally qualified dental hygienists who will be on the forefront of providing preventive care to the citizens of Missouri and beyond.

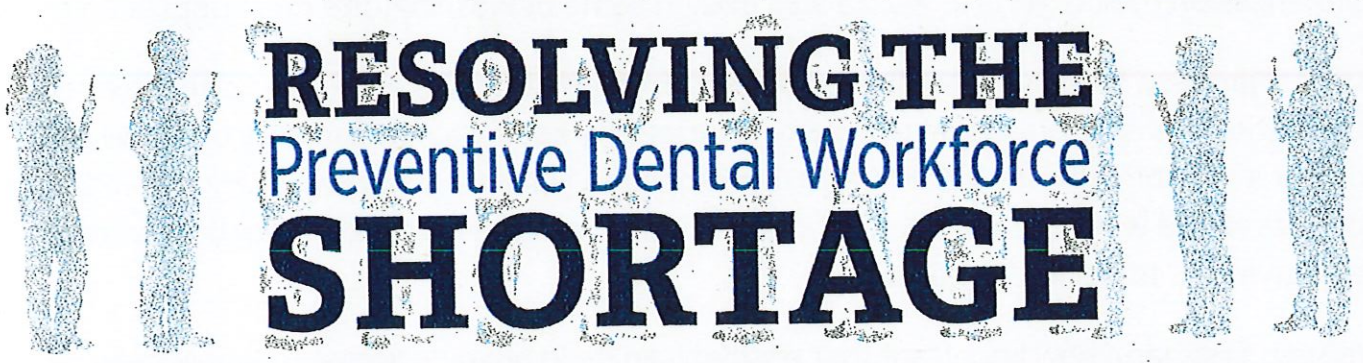
This article was published on adea.org on September 13, 2023. Courtesy of Kim K. Polk, RDH, MEd, Dental Hygiene Program Director, St. Louis Community College Center for Nursing and Health Sciences (source bit.ly/46lrqGg). Learn more about the STLCC Dental Hygiene Program at stlcc.edu/programs-academics/pathways/health-professions/dental-hygiene.

Blog

Resolving the Preventive Dental Workforce Shortage

Jun 4, 2026

Reducing the dental workforce backlog in Washington requires a multi-pronged approach. WSDA hopes a new category of dental care provider will offer another avenue for relief.



Quick Bites:

- WSDA members consistently list the dental workforce shortage as one of the biggest challenges facing dental practices.
- These shortages have prompted exploration of a new category of dental care provider: the

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For almost seven years now, Dr. Brittany Dean has traveled to Alaska once a month to spend a week treating pediatric patients in that state's most rural and underserved communities.

Working in remote villages and towns like Kake and Sitka, Dean has seen patients face practical and geographic challenges in accessing routine oral health care services. Resources are limited, and care is often delayed simply because there are not enough providers to see patients on a regular basis.

To meet the dental workforce shortage in the state, Alaska allows what are known as Preventive Dental Health Aides (PDHAs) to offer limited care and treatment until a dentist or hygienist is available locally. As a locum tenens to the Southeast Alaska Regional Health Consortium or SEARHC, Dean is often partnered with a PDHA who performs a limited array of dental work, including cleanings above the gumline with scalers and polishers.

"I've been lucky to have those assistants with me on my visits. I think it's nice because the alternative is waiting to see a hygienist," said Dean, WSDA's president-elect. "There can be care delays when providers must travel to remote areas. Preventive Dental Health Aides can boost what dentists are able to complete."

When she returns to Seattle, Dean resumes her work locally, splitting time between Bellevue Pediatric and Seattle Special Care Dentistry. Surprisingly, the same workforce challenges she experiences on the outskirts of Alaska also exist in some of Washington's most populated cities.

This past January, Dean testified before the Senate Health & Long-Term Care Committee regarding the benefits of easing the dental workforce shortage by adding a new category of dental care provider in Washington state: the Preventive Expanded Function Dental Auxiliary or P-EFDA. These providers would work under a dentist's supervision to increase office efficiency by providing preventive care to healthy patients.

"I've seen first-hand how important that position can be in building access to timely preventive care," said Dean. "In my experience, many Alaskans enjoy better oral health than they would otherwise because PDHAs are available to deliver timely preventive care. I'd like to see those same benefits accrue to adults and children here in Washington. While those benefits would be felt statewide, I believe they would be felt most prominently in some of the more remote areas and in underserved, low-income, and diverse communities of Washington," she added.

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Next Up: The P-EFDA

In the 2026 legislative session, Senate Bill 6146 was introduced to authorize the P-EFDA in Washington state. Under the proposal, P-EFDAs would be licensed to provide "dental prophylaxis for patients in a healthy oral state" as defined by the dental commission with consultation from the dental hygiene examining committee.

A December 2025 study from the University of Washington Center for Health Workforce Studies [see callout] lends strong support for the addition of P-EFDAs. The research examined the potential for what the study referred to as perio EFDAs — a preventive EFDA, as opposed to the restorative EFDA that already exist in our state — to improve preventive care at Indian Health Service (IHS) Facilities. In the IHS model, perio EFDAs can scale teeth to remove all visible plaque and calculus. The study included a review of academic research literature as well as interviews with dental professionals familiar with the model in other states.

Among the study's key findings: authorizing this new type of provider could serve as an effective strategy for reducing workforce shortages, increasing access to care and avoiding the serious problems that result from delays in preventive care. Their conclusion was clear: "Employing perio EFDAs helped to increase patient access to routine preventive services and allowed dentists, dental hygienists, and dental therapists (where applicable) to deliver more services at the top of their scope of practice."

During the Senate work session this past January, Dean emphasized the benefits this new position could generate for patients in Washington state. She also emphasized what the position would not do: supplant the work of dental hygienists.

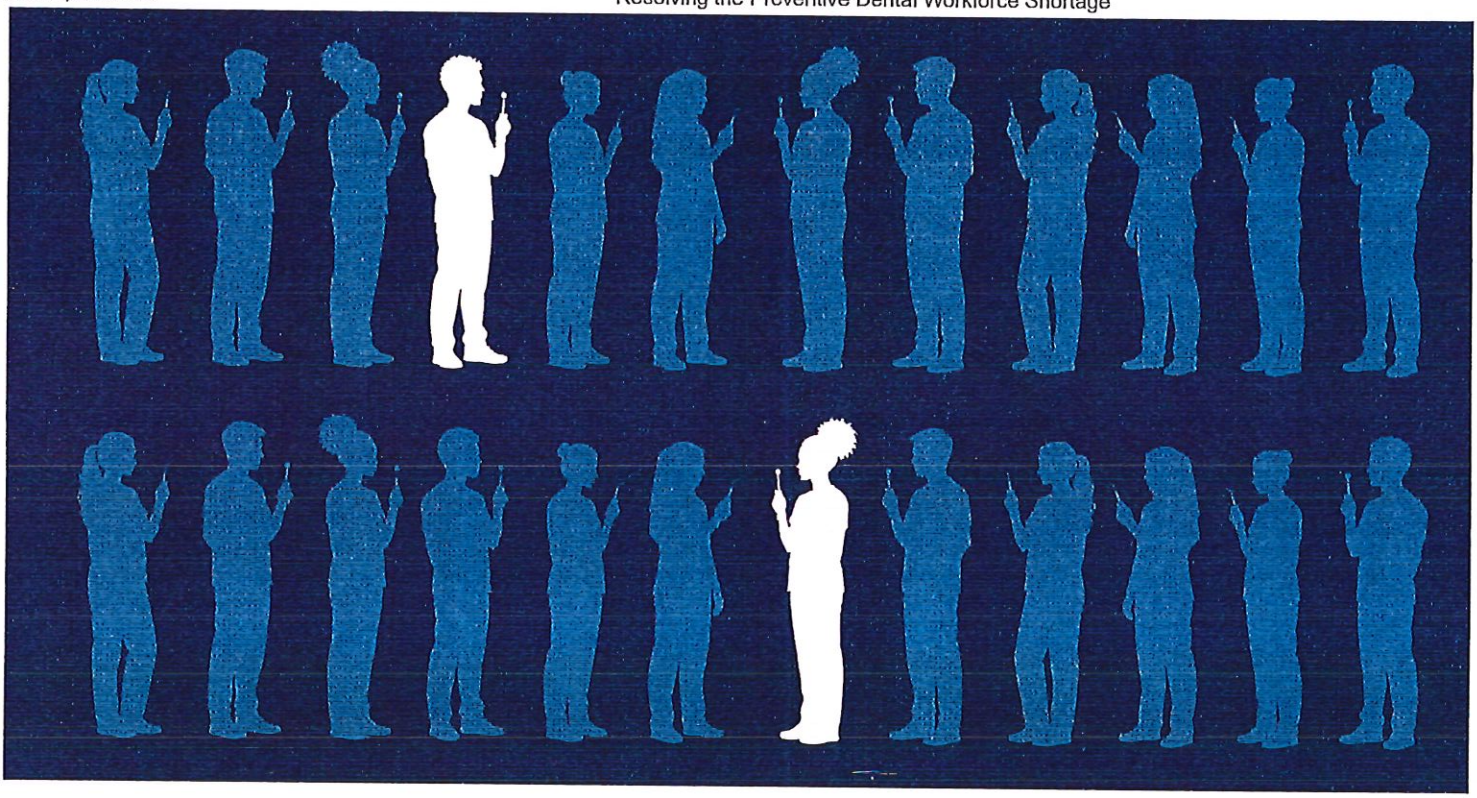
"[The P-EFDA position] is intended to expand access to routine preventive care services so that hygienists may focus a greater percentage of their time on the more complex care they have been trained to provide," she said.

P-EFDA discussions will continue in the next legislative session.

"We are trying to tackle this problem from every angle. It's frustrating and it's been a major pain point for dentists and patients for a long time," said Dean.

"We are working to increase programs. We are part of the compact to make it easier for hygienists to relocate to our state. And it does make a difference when our members speak to their

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Addressing Dental Workforce Shortages

WSDA Advocacy Director Kevin Schilling emphasized that the proposal to create the P-EFDA position in Washington is not intended to supplant the important contributions made by dental hygienists.

"Dental hygienists are essential providers of preventive care, and WSDA has a long track record of working towards consensus on dental hygiene scope expansion when it makes sense. For example, Washington was one of the first states in the nation to enable dental hygienists to administer local anesthesia — something that has been a legislative battle in some other states for more than 50 years after it was adopted here," said Schilling. "But the state simply doesn't have and isn't producing enough hygienists to meet patients' needs. So, the P-EFDA model that's used in other states, as well as in military and tribal care systems, can help address access gaps, especially among Medicaid and rural patients. This is about expanding capacity, not about redefining existing roles."

Even before COVID, dentistry faced preventive workforce shortages that impacted oral health care for thousands of Washingtonians and providers.

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It is a problem dentists know all-too-well.

WSDA members consistently list the dental workforce shortage as one of the biggest challenges facing dental practices. According to surveys of WSDA and Washington Dental Hygienists' Association members in 2021, there were more than four open hygiene positions for every hygienist that reported looking for a position — and the discrepancies were even more dire in rural areas of the state.

WSDA has been battling workforce issues on many fronts. In 2023, WSDA was successful in advancing a pair of bills designed to immediately address the shortages. House Bill 1466 extended the initial license period for hygienists moving into the state to complete Washington's additional educational requirements. The law extends the previous licensing period from 18 months to five years, giving hygienists the opportunity to begin providing care to patients while they obtain additional education that Washington requires to obtain licensure.

That same year, a second measure was signed into law. House Bill 1287 removes the requirement that a hygienist in another state or Canadian province be actively practicing in order to qualify for an initial limited license when coming to Washington state.

"P-EFDAs help meet the immediate need for high quality, routine preventive care for some of our vulnerable populations."

The Dentist and Dental Hygienist Compact created through a third measure, House Bill 1576, enhances licensure portability, making it easier for dental professionals moving to Washington to begin practicing in the state. As of March 2026, nine states have enacted legislation to join Washington in the compact, including Colorado, Iowa, Kansas, Maine, Massachusetts, Ohio, Tennessee, Virginia and Wisconsin.

And while the compact and new Washington state laws will eventually help reduce the workforce shortage, patients are still in dire need of preventive care now, particularly in more rural corners of the state.

"We continue to make good progress on the workforce shortage, especially in the Legislature," said WSDA President Dr. Lisa Egbert. "The Dentist and Dental Hygienist Compact, along with the hygienist licensing bills passed in 2023, are having a positive impact in terms of providing more opportunities for hygienists to enter the workforce in our state. But we know more must be done

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pipeline in our state. But we're still not keeping pace, and we need to take additional steps to improve patient access to preventive care services."

"Creating a new category of dental provider — the Preventive Expanded Function Dental Auxiliary — is a proven way to meet that goal," added Schilling. "P-EFDAs help meet the immediate need for high quality, routine preventive care for some of our vulnerable populations. They also free up hygienists to spend time on more complex care, which they have been trained to provide."

What's Happening in Other States

The dental workforce shortage is a national challenge. Like Washington, other states are piloting ideas to create new dental care providers aimed at expanding access to services and easing the stress on busy hygienists.

In 2025, the Missouri Dental Association completed a pilot project of placing Oral Preventive Expanded Function Dental Assistants (OPA-EFDAs) in seven dental clinics around the state. The goal of the program was to see if OPA-EFDAs would create more appointment opportunities, improve access and reduce appointment wait times, especially in rural areas and in clinics that serve Medicaid-eligible patients. OPA-EFDAs in the Missouri pilot could remove supragingival calculus and perform coronal polish, oral hygiene instruction, and fluoride applications. The study found these EFDAs were well-trained, and their work was overseen by clinical supervisors.

By the conclusion of the pilot, OPA-EFDAs had delivered care to 1,626 healthy and gingivitis patients, earning stellar ratings. The clinical supervisors rated OPA-EFDA performance at 9.6 out of 10, which was interpreted as "excellent, strongly exceeds expectations." More importantly, nearly 1,000 of the participating patients evaluated the care they received, and their average rating was even higher, at 9.7 out of 10. There were no reported adverse incidents, patient injuries, or patient complaints during the eight-month pilot project.

Missouri estimates that OPA-EFDAs would be eligible to help hygienists and dentists in treating healthy and gingivitis patients in somewhere between 21% and 33% of all clinic appointments, a significant improvement in access to preventive care.

Given that potential and the results of the pilot project, Missouri concluded that OPA-EFDAs practicing under the direct supervision of dentists and hygienists are a safe addition to the oral healthcare workforce. Their contributions will create more available appointments in dental clinics and significantly improve access to care.

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further underscores the goal of adding P-EFDAs here in Washington: A State of Kansas audit found that their "scaling assistants" were augmenting the dental team, not replacing hygienists.

The Path to P-EFDAs

The creation of the Preventive Expanded Function Dental Auxiliary will take more than just legislative approval. If legislation is enacted, it would direct the Dental Commission to develop specific education and licensing requirements for assistants looking to move up the career ladder into a P-EFDA position. Rules will need to be developed for oversight of the care provided by P-EFDAs. Additional training resources may have to be created so that assistants can develop the skills they will need to safely deliver this care.

WSDA leaders like Dean believe it will be worth the effort. If created, the position stands to have a significant positive impact on underserved communities around Washington state.

She says that WSDA has done a good job conveying the message that there are persistent workforce shortages among hygiene and assistants, and that it's affecting patient care.

Still, more work remains to be done.

"In my mind, there's only so many things you can do to address this problem, and we are trying all of them," said Dean.

"Some things take a long time, like establishing a new hygiene program. This, on the other hand, could have a positive impact relatively quickly. And if we aren't doing anything, people aren't getting the care they need."

Studying the Impact of EFDAs

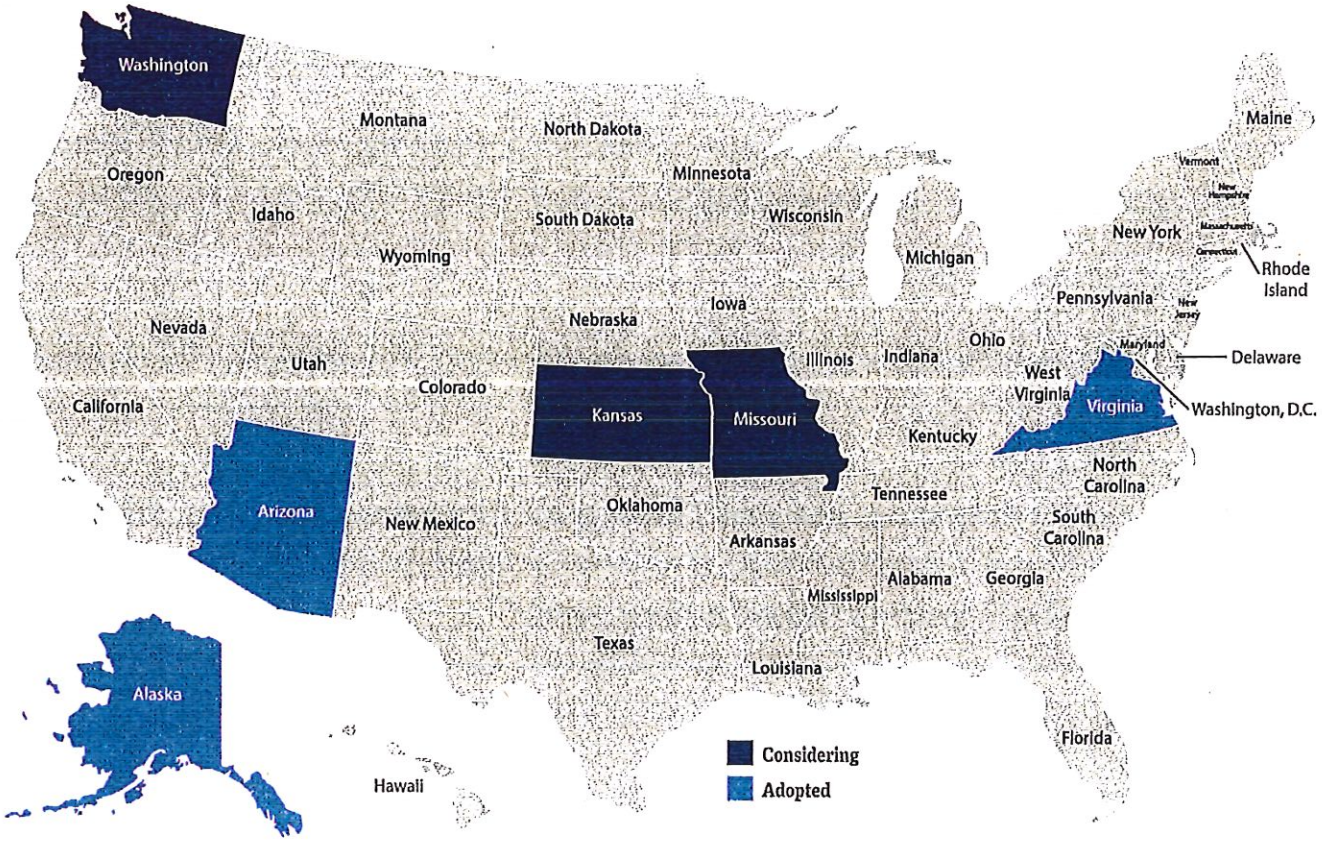
A December 2025 study from the UW Center for Health Workforce, funded with the assistance of WSDA, examines the potential impact of the Expanded Function Dental Assistant-1, also referred to as the perio EFDA. The study yielded several key findings, including:

- Employing perio EFDAs helped to increase patient access to routine preventive services and allowed dentists, dental hygienists, and dental therapists (where employed) to deliver more services at the top of their scope of practice.
- Clinic motivations to employ perio EFDAs included mitigating dental hygienist shortages

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- The success of perio EFDA training, according to interviewees, often depends on identifying candidate dental assistants who are self-motivated and eager for professional growth.
- Demand for dental hygienists and dental assistants in Washington remains high. In addition to expanding education programs, exploring the use of additional dental workforce roles may help address the state's workforce gaps.

Read the full study here.



This spring, Virginia joined Alaska and Arizona in adopting a form of EFDAs to address their dental workforce shortages. States considering similar actions include Missouri and Kansas. In 2027, Washington lawmakers will have an opportunity to join this trend by adding the Preventive Expanded Function Dental Auxiliary or P-EFDA position.

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HOW ARE ORAL PREVENTIVE ASSISTANTS IMPACTING ACCESS TO DENTAL CARE IN OTHER STATES?

Paul Logan
Virginia Dental Association

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HOW ARE ORAL PREVENTIVE ASSISTANTS IMPACTING ACCESS TO DENTAL CARE IN OTHER STATES?

Paul Logan, Director of Strategic Initiatives/Innovation

As a dentist, you're likely familiar with statistics on the prevalence of periodontal disease. About 42 percent of dentate adults over 30 years old in the U.S. have advanced gum disease (periodontitis)[1]. It can lead to the loss of tissue and bone that support the teeth, and it may become more severe over time. A chief barrier in patients receiving timely preventative dental care today in Virginia is the availability of pathways to enter into the workforce that supports the delivery of that care.

An Oral Preventive Assistant (OPA) is a type of Expanded Function Dental Assistant (EFDA) who has taken the required education and completed training to provide patients with additional preventive services. Services typically include the removal of supragingival calculus, coronal polishing, providing oral hygiene instructions, and applying fluoride.

The Virginia Dental Association's House of Delegates, since 2006 and reaffirmed in 2025[2], has supported the creation of a specialized dental assistant permitted to perform limited scaling services as part of a dental team to help increase access to preventive care. The United States Armed Forces, the Indian Health Service, and other states have deployed preventive assistants and have also had an opportunity to study the impact of these professionals educated in expanded duties on access to dental care.

Indian Health Service Periodontal Expanded Functions Dental Assistant

The Indian Health Service has been a pioneer in deploying new dental access models, including the periodontal expanded functions dental assistant (perio EFDA). From 2016 to 2017, the Johns Hopkins University Bloomberg School of Public Health conducted a study[3] comparing the effectiveness of sites using perio EFDAs vs. a traditional workforce model. The study found that compared to a traditional model, sites with perio EFDAs saw increased access to dental care, more dental sealants placed, more fluoride varnish applications, and more total services provided.

In comparing services offered prior to perio EFDA certification and post-EFDA certification, the analysis found a twenty-five percent increase in the provision of services within the scope of a perio EFDA. Additionally, they noticed an increase in periodontal procedures typically performed by dental hygienists and dentists. This is presumably because periodontal EFDAs were providing services to allow more time for dental hygienists and dentists to perform these advanced services..

"The United States Armed Forces, the Indian Health Service, and other states have deployed preventive assistants and have also had an opportunity to study the impact of these professionals educated in expanded duties on access to dental care."

Kansas Scaling Assistant

In 1998, the Kansas Dental Practice Act was changed to allow a specially trained dental assistant to polish and scale the visible (or supragingival) part of the tooth, while specifying that a licensed dentist or hygienist is required to complete the rest of the routine cleaning. The state conducted a performance audit[4] in 2007. The audit found that two-thirds of dentists who employed scaling assistants reported an increase in patient access to care.

When asked why offices were incorporating scaling assistants into their practice teams, the audit collected verbatim responses, including:

"We see many pediatric patients that don't always need to see the hygienist."

"Large number of children in practice. Children generally only have supragingival calculus."

"Helps with workload of dentist."

"To allow the hygienist to treat more challenging and periodontal patients and thereby increase her income and job satisfaction."

The state audit also found that these assistants were augmenting the dental team, not replacing hygienists. In response to inquiries posed to dental hygiene education programs in Kansas, all of the officials said placement rates of dental hygiene graduatess hadn't been affected by the existence of dental scaling assistants and that nearly all graduates have a job in their field within six months of graduation.

Missouri Oral Preventive Assistant

The Missouri Dental Association recently established a pilot program[5] for Oral Preventive Assistants. Didactic training of OPA pilot participants commenced in early 2024, with the clinical phase beginning in December 2024 after the promulgation of related rules. As of this publishing, the final report for the pilot program has not yet been released, but an interim report[6] released in July 2025 gives an indication of the impact preventive assistants can have.

The interim report found high marks from both patients reporting their experience of care from OPAs as well as from dentists evaluating their skills. The average evaluation of OPA EFDA care by patients was 9.7/10 – higher than the patient score for dentists or hygienists –, and the average performance evaluation score from supervising dentists was 9.3/10.

The pilot also collected verbatim responses from participants and found that hygienists working alongside OPAs found value in the collaborative model. "The OPA has been an invaluable addition to our clinic, particularly in supporting our hygienists and expanding patient access to care," reported Shannon Covington, RDH, Director of Dental Training and Development, Compass Health Network, Wentzville. "By assisting with tasks such as periodontal charting, patient education, and preventative procedures, the OPA enables our hygienists to concentrate on delivering specialized clinical care for patients with more complex periodontal needs. This collaborative model improves workflow, allows our hygienists to practice at the top of their scope, and increases the number of patients we can serve. Because the OPA works directly alongside a hygienist or dentist, this approach enhances access without compromising the quality of care."

Virginia

The Virginia Dental Association will continue to closely follow workforce developments in other states as we move forward to address bottlenecks in allied dental education and workforce gaps in the Commonwealth. The impact of preventive assistants in other states up to this point has aligned with the aspirations expressed by VDA members in a spring 2025 survey on workforce models.

"I meet too many wonderful, talented, smart, motivated people in the dental profession who cannot get into dental hygiene school after years of applying simply because the program sizes are so limited," shared one member dentist.

"I currently work with an expanded function assistant who places restorations for me daily. It allows me to be more productive and also to be able to complete quadrant dentistry on patients when that is a need. My assistant takes pride in her work and seeks to always do the best possible work for our patients. I believe another pathway for assistants to expand their services would help the entire practice and patients."

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Expanded Function Dental Assistants & OPAs: Understanding the Emerging Roles in Dental Care



Tina Clarke, RDH
Posted June 20, 2025

As the dental workforce continues to evolve in response to provider shortages, access issues, and growing demand for preventive care, a number of states have introduced or expanded roles for dental assistants. These include Expanded Function Dental Assistants (EFDAs) and, most recently, Oral Preventive Assistants (OPAs), a new category officially recognized in Arizona in 2025. While these developments aim to support patient care, they've also sparked valid concerns,

especially among dental hygienists—about regulation, training standards, and scope of practice.

Let's explore what these roles entail, how they differ from dental hygiene, and what this means for the future of collaborative care.

What Is an EFDA or OPA?

EFDA roles vary by state but generally allow dental assistants to perform additional tasks—such as coronal polishing, taking impressions, removing cement from crowns, and in some states, placing restorations and administering local anesthesia—under supervision of a dentist and in many cases a dental hygienist as well. In many cases, these professionals are trained through state-specific, board-approved programs, some of which are accredited, while others are not.

The Oral Preventive Assistant (OPA), introduced in Arizona, is a newer preventive-focused model. OPAs are trained to provide basic hygiene services to patients who are periodontally healthy or exhibit only mild gingival inflammation. Their scope includes:

- Supragingival scaling
- Coronal polishing
- Fluoride application
- Oral hygiene instruction
- Visual assessment of gingival health (not probing or full charting)

To qualify, OPAs must complete a 120-hour training program after proving they hold certifications in radiology, coronal polishing, and CPR, and are either CODA graduates or DANB-certified.

How Does EFDA/OPA Education Compare to Dental Hygiene Education?

Below is a general chart overview of the educational and scope of practice differences between these professions.

Category	EFDA / OPA (Varies by State)	Dental Hygienist
Training	120–300 hours (varies by program/state)	2–4 years (associate or bachelor's Degree)
Credentialing	State certification specific certification. May or may not require additional examination. Board supervision limited if at all present	State licensure-oversight by the board of dentistry or board of dental hygiene (California)
Scope of Practice	Assist dental practice with restorative and/or preventive duties under supervision. In some states, place restorations and administer local anesthesia.	Full preventive and periodontal care, restorative functions in some states
Assessment Skills	Visual exam, basic charting, patient education	Full charting, probing, diagnosis, treatment planning
Supervision	Direct supervision usually required	Often general supervision in many states. May have independent practice in some states

States with EFDA or OPA Models

Several states have developed EFDA models, each with unique scope and training requirements. States with active programs include:

- Minnesota
- Illinois
- Kansas
- Alaska
- Wisconsin
- Maryland
- Missouri

- Oregon
- Arizona (OPA model)

In Oregon, for example, EFDAs are trained in both restorative and preventive procedures, and many programs meet the highest educational standards—despite a lack of national accreditation requirements. Still, the variability between programs and the reliance of on-the-job training remain legitimate concerns, as does the lack of regulatory oversight regarding licensure/certification and continuing education requirements.

Pay Equity

As these roles for dental assistants evolve, questions about pay equity are rising. Many assistants argue that if their responsibilities shift toward more direct patient care, their compensation should reflect that.

Dental hygienists have concerns on both sides of the spectrum. Some worry that the growing role of the EFDA or OPA could lower hygienists' pay, while others argue they should be compensated for supervisory responsibilities—especially when those duties are tied to their professional licensure.

Balancing the Benefits and Risks

These roles bring both promise and complexity to the dental profession. Here is a breakdown of both sides:

Potential Benefits:

- **Improved Access to Care:** In underserved or rural areas, expanded roles allow practices to reach more patients.
- **Efficiency and Team-Based Care:** Dentists and hygienists can focus on higher-level care while EFDAs/OPAs manage supportive tasks.
- **Career Pathways for Assistants:** These roles offer growth for assistants who may not pursue full hygiene degrees.**Key Concerns:**
- **Inconsistent Educational Standards:** Without CODA accreditation across the board, quality varies.
- **Lack of Regulatory Oversight**
- **Pay Disparities:** Will assistants who receive this training be

paid more? Will these lower wages for dental hygienists?

- **Patient Safety and Overlap:** Inadequate training or supervision could lead to improper care or scope creep.
- **Professional Tension:** Hygienists—rightfully—worry that these roles blur the lines of clinical responsibility and quality patient care.

A Path Forward

As someone who teaches independent anesthesia certification courses for dental hygienists and dental assistants—and is also an educator for dental hygiene schools, I've seen firsthand how high-quality education and appropriate supervision can empower dental assistants to support preventive care without compromising safety or undermining hygiene's role.

But I also understand the hesitation from many dental professionals—especially when oversight is inconsistent, or programs aren't held to the same standards.

It's time for collaborative dialogue, clear role definitions, and transparent training standards to ensure that patients, practitioners, and the profession all benefit from innovation—without sacrificing quality.

Final Thoughts

Expanded function roles like EFDAs and OPAs look like they are here to stay. These professions are shaped by workforce demands and access challenges across the country. The challenge now is ensuring that the education, scope, and supervision of these providers are up to the task—and that hygienists remain a vital, central part of the care team.

Let's advocate for high standards across all roles and stay engaged in the policy decisions that will define the future of our profession.

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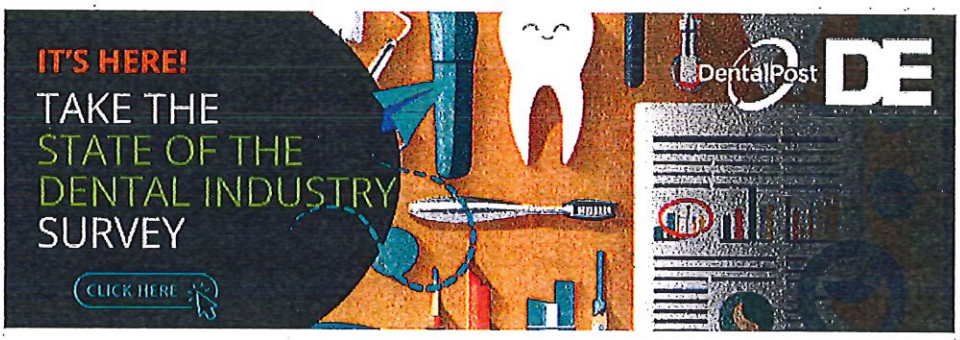
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Posted September 10, 2025

Recommendations for a Dental Assisting Professional Model



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Recommendations for a Dental Assisting Professional Model

JULY 18, 2025

A Path Forward for the Dental Assisting Profession 2
About the Dental Assisting Professional Model Workgroup 3
Guiding Principles & Approach 4
The Recommended Model 5
- Model Snapshot 5
- Level 1: Entry Level 5
- Infection Control 9
- Radiography 11
- Level 2: Intermediate Intraoral Functions 12
- Level 3: Expanded Restorative Functions 14
- Nitrous Oxide Monitoring 16

Designations for Each Dental Assisting Level 17
Emerging Functions 18
Guidance for Implementation 21
Model Statutory and Regulatory Language 23
Phase 2: Orthodontic and Anesthesia Functions 23
Appendix A: Dental Assisting Professional Model Workgroup Members 26
Appendix B: Supplemental List of Functions 28

A Path Forward for the Dental Assisting Profession

Dentistry is experiencing significant challenges related to the workforce, including an insufficient number of qualified dental assistants. The workforce shortage impacts practice capacity, efficiency, productivity, patient access, and quality of care.

The dental assisting workforce shortage was already a problem before the start of the COVID-19 pandemic, but the pandemic both exacerbated the shortage and delayed progress on solutions. In a 2022 stakeholder forum that included executives and strategists from more than 20 organizations, participants consistently returned to the observation that the lack of uniformity in the dental assisting profession across states was an important factor impeding meaningful progress in alleviating the shortage. Increasing uniformity and establishing standards was a key theme underlying the most important initiatives identified by forum participants.

A shared understanding of what dental assistants do and how they can advance will greatly improve dentistry's ability to recruit and retain qualified personnel, as well as to develop pipelines for the future workforce. Without a shared understanding, dentistry will continue to see:

- Challenges in attracting and educating dental assisting candidates
- Loss of qualified dental assisting personnel from the field
- Reduced capacity of the oral healthcare infrastructure and diminished access to care
- Unclear understanding of minimum requirements for patient safety
- Duplication of effort in developing mid- and long-term solutions to address the workforce shortage
- Inefficiency, frustration, and confusion

Whether intended or not, state legislation and regulation of the dental assisting profession shape the careers of dental assistants because they determine the frameworks within which dental assistants may advance. Significant differences in these frameworks have prevented the formation of a shared national understanding of the dental assisting profession. Bringing uniformity to dental assistants' scope of practice and exam, education, and credential requirements can help lay out a consistent path for the profession that offers a long-term career journey. Providing a clear road map for that journey will assist with both recruitment and retention of assistants. And those who move between states or work in multiple states over the course of their careers will be able to continue to work without significant pause.

There is overwhelming support in dentistry for uniform national standards. A 2023 survey of dental assistants, dentists and employers, and educators showed 83% supported this idea.

The Dental Assisting Professional Model Workgroup was established to address the wide variation in how states regulate dental assisting, with a focus on recommending a model that could be used as the basis for state-to-state uniformity. The Workgroup developed a model that offers multiple pathways into the profession and a framework for professional advancement, supporting the recruitment and retention of dental assistants.

About the Dental Assisting Professional Model Workgroup

The Dental Assisting Professional Model Workgroup consists of 20 members, including dental assistants, dentists, educators, dental hygienists, and regulators. The Workgroup, formed in early 2024, sought to help address the shortage by creating a national model that:

- Elevates the dental assisting profession and attracts more candidates to the field
- Provides a road map for career growth that can support recruitment and retention of dental assistants over the long term
- Improves professional mobility of dental assistants from state to state
- Increases practice efficiency and enhances access to care
- Provides states with a straightforward framework for regulation that reflects the needs of dentistry

Nominating organizations included:

- American Association of Dental Administrators
- American Association of Dental Boards
- American Dental Assistants Association
- American Dental Association
- American Dental Education Association
- American Dental Hygienists' Association
- Association of Dental Support Organizations
- Dental Assisting National Board
- Hispanic Dental Association
- National Network for Oral Health Access

Six additional members were invited to participate for their expertise and perspective gained in specific roles and to broaden geographic diversity.

Two co-chairs provided leadership to the Workgroup:

- Dolores Cottrell, D.D.S., Executive Secretary, New York State Board for Dentistry (New York)
- Helen Sublette, B.S., CDA, COA, CDIPC, FADAA, Owner, Coastal Dental Professionals Consulting (North Carolina)

Workgroup meetings were led by third-party facilitators, with the Dental Assisting National Board (DANB) staff leading workgroup coordination and contributing subject matter expertise. A full list of Workgroup members, including credentials, affiliation, and nominating organization, can be found in Appendix A.

The framework outlined in this document is the product of 12 months' work by the Dental Assisting Professional Model Workgroup, reflecting the Workgroup's consensus and incorporating the Workgroup's response to feedback from external stakeholders received during the stakeholder comment period.

Guiding Principles & Approach

The Workgroup prioritized a national model that supports:

- **Public protection**, including patient safety and occupational safety
- **Uniformity**, with an effort to build upon existing commonalities among states' scopes of practice and requirements
- **Road map for advancement**, which sets a clear path for dental assistants to grow
- **Implementation feasibility**, for a model embraced nationwide



To support these priorities, the Workgroup's deliberations were informed by the following sources of data:

- Survey research revealing broad stakeholder perspectives
- Clinical data, derived from a job task analysis survey, about frequency of tasks performed by dental assistants
- Data about commonalities among states related to dental assisting regulation
- Subject matter expertise provided by Workgroup members themselves

In the spirit of the guiding principles, the recommendations that follow are for national minimum standards. Each dental assistant level offers multiple pathways that are as equivalent as possible, ensuring they do not create further barriers for states, employers, or dental assistants. The levels consist of both on-the-job and formal education options that offer third-party validation.

The Workgroup's approach has been informed by the following factors:

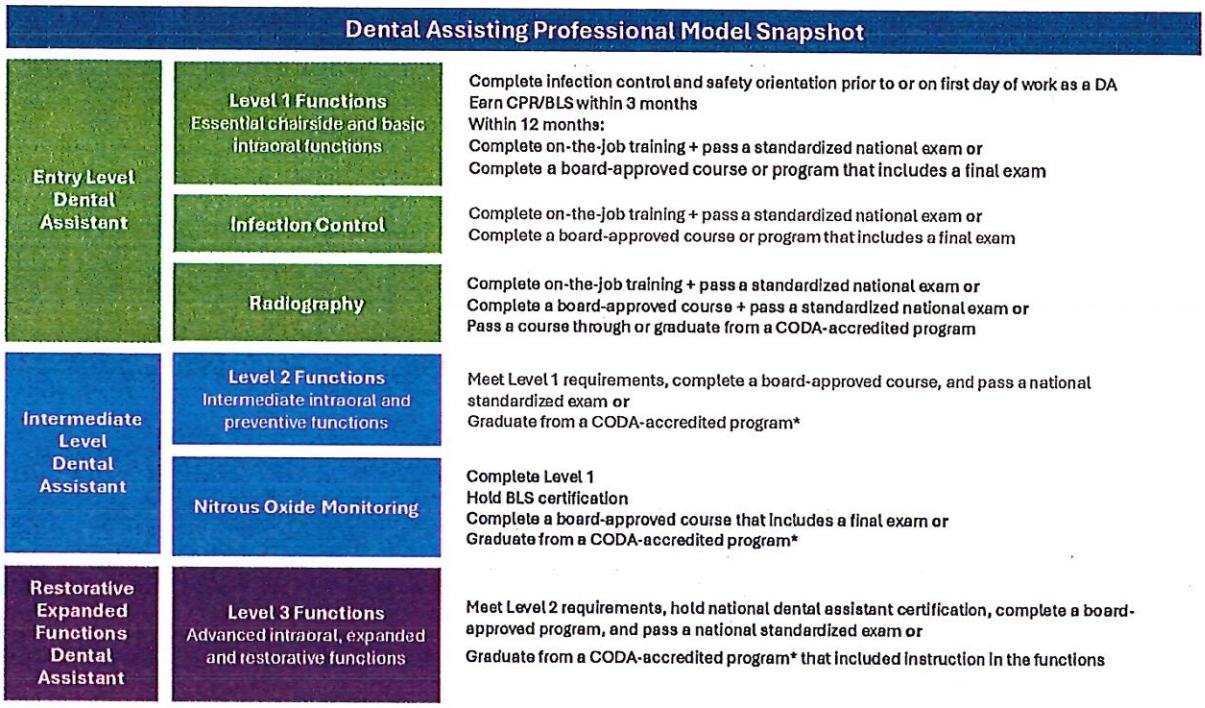
- Dental assisting education that is accredited by the Commission on Dental Accreditation (CODA) provides excellent preparation for dental assistants, but programs collectively do not have the capacity to supply all the dental assistants that are needed, and their capacity is declining; the collective annual enrollment of CODA-accredited dental assistant programs has decreased by almost half in the last decade
- There are other sources of high-quality education for dental assistants, including some community college programs and public career and technical education (CTE) programs, and some for-profit education sources might also provide quality instruction; uniform objective criteria are needed for states to evaluate offerings from all of these sources
- In many states, hiring individuals with no dental assisting experience and training them on the job is the predominant mode of entry into the dental assisting profession; however, this trend is associated with poor retention, inconsistencies in training, high turnover, and frequent vacancies that diminish the capacity of dental offices to see patients

The Workgroup's recommendations seek to balance the need to train some dental assistants on the job with the need to protect the public. The recommendations also seek to provide adequate training and education at each level to provide a foundation for advancement to the next level and enhance the ability of employers to recruit and retain dental assistants; elevating dental assisting as a rewarding career will also help dental assisting education programs recruit students.

The Recommended Model

Model Snapshot

The Workgroup's recommendations for a professional model for dental assisting is summarized in brief in the following graphic. Additional details for each element of the model are contained in the sections that follow.



A note about completion of CODA-accredited dental assisting programs: A dental assistant who has completed a dental assisting program accredited by CODA will have met educational requirements for both Level 1 and Level 2.

If a CODA-accredited dental assisting program included the required instruction in restorative functions, a dental assistant completing such a program will also have met educational requirements for Level 3.

Level 1: Entry Level

Overview

Level 1 dental assistants have foundational dental knowledge and perform essential chairside and basic intraoral functions.

Supervision

Tasks are performed under the dentist's personal and direct supervision, until the dental assistant has met established requirements. Then, the dental assistant may work under indirect supervision.

Personal Supervision: The dentist is personally operating on a patient and authorizes the dental assistant to aid in treatment by concurrently performing supportive procedures.

Direct Supervision: The dentist is on the premises while work is performed by dental assistants; the dentist directs dental assistants' activities and verifies that functions have been performed correctly.

Indirect Supervision: The dentist is in the office, authorizes the procedures, and remains in the office while the procedures are being performed.

Description

Level 1 dental assistants support the dentist, the dental team, and the dental office's clinical operations. Their primary role is to assist dentists as they perform dental procedures on patients, under the dentist's personal supervision, and to execute supportive tasks before, during and after such procedures. Level 1 dental assistants also perform duties under the direct supervision of dentists.

Delegable Tasks

- Administrative, non-clinical tasks
- Clinical extraoral tasks
- Fundamental patient appointment support tasks
- Tasks that support diagnosis of the patient's condition
- Tasks that are reversible and pose a minimal risk of patient pain, injury or long-term ill effects
- Tasks that address or assist in addressing dental and medical emergencies

Examples of Level 1 tasks are:

- Maintain field of operation during dental procedures by retraction, suction, irrigation, drying, placing and removing cotton rolls, etc.
- Provide patient preventive education and oral hygiene instruction
- Take and record vital signs
- Apply topical anesthetic
- Apply topical fluoride
- Make impressions for study models and fabrication of such appliances as allowed under state regulations, including digital impressions
- Place and remove dental dam
- Remove temporary crowns and cements

Other tasks appropriate for Level 1 are listed in Appendix B.

Note on radiography and infection control: Radiography and infection control tasks, such as sterilizing instruments, are fundamental to the job of dental assistants and are performed by dental assistants at all levels. However, incorrect performance of these tasks carries the risk of irreversible harm to patients and personnel; therefore, special consideration has been given to addressing patient and occupational safety concerns related to these functions. Accordingly, apart from a first-day orientation required to begin working as a Level 1 dental assistant, these functions will be addressed separately.

Entry-Level Orientation

Prior to beginning work in a dental setting, a dental assistant should be provided with an infection control and safety orientation that covers essential topics, including the following:

- Fundamentals of Infection Prevention and Control: Personnel role in preventing infections; standard and transmission-based precautions; CDC resources
- Patient Protection and Occupational Safety: Hand hygiene; PPE; respiratory illness precautions; sharps safety and percutaneous injury response; work practice and engineering controls; safe injection practices; hepatitis B immunization
- Sterilization and Disinfection: Sterilization of a variety of patient care items; instrument sterilization process; sterilizer monitoring; disinfecting environmental surfaces; waste disposal; dental unit water quality monitoring/management
- Basic Radiation Safety: Occupational safety for those working in a setting where x-rays are used

The first-day safety orientation is an important element in the model that allows a dental office to bring dental assistants on board quickly while ensuring they have received critical information to perform assigned duties safely while working under personal or direct supervision.

Training Period

A dental assistant may work in a dental office while receiving training in Level 1 functions for up to 12 months prior to meeting the pathway requirements.

Allowing 12 months for completion of requirements provides employers with time to determine if a new dental assistant is likely to succeed and continue in their role and to deploy training resources appropriately.

CPR/BLS

A dental assistant must hold current CPR/BLS certification within three months of beginning work in a dental office and keep CPR/BLS certification current during employment. CPR/BLS certification must meet either American Heart Association or American Red Cross guidelines.

Pathways

	Training/Education	Assessment
Pathway 1	**On-the-job training** Receive in-office training that follows a standardized content outline or training manual *(See required training/course content outline below.)*	Standardized nationally recognized exam approved by the dental board
Pathway 2	**Course or program** Complete a course or dental assisting program that is either approved by the state dental board or CODA accredited	End-of-course exam

These pathways provide flexibility when dental offices must hire individuals with no prior experience to work as dental assistants, in that they give the employer time and multiple options for providing structured training and education to dental assistants.

In each pathway, one element of the pathway — either the education or the exam — is verified against a set of objective criteria, which supports uniformity and consistency of quality. At the same time, structured and standardized training provides the foundation for advancement to higher levels, which fosters long-term retention and promotes increased productivity for dental offices.

Required training or course content
The training or course should cover:

Foundational Knowledge

- Principles of four-handed dentistry
- Treatment documentation and charting
- Universal tooth numbering system
- Tooth names, anatomy and morphology
- Oral anatomical landmarks
- Dental terminology
- Management of hazardous waste (transport, disposal, documentation)
- Patient privacy laws (HIPAA)
- Recognition of and response to dental and medical emergencies
- Any occupational safety training required under state or federal law, including but not limited to training in hazard communication and respiratory protection

Essential Chairside Functions

- Review and update patient medical history, including identifying contraindications for treatment
- Perform preliminary patient examination
- Prepare patients and operatory for treatment
- Assisting in explaining and obtaining patient consent for procedure
- Discuss risks, benefits and alternative treatments with patient
- Set up instrument trays
- Set up anesthetic syringe
- Prepare and deliver dental materials for procedure
- Maintain field of operation during dental procedures by retraction, suction, irrigation, drying, placing and removing cotton rolls, etc.
- Observe patient during procedure
- Provide patient preventive education and oral hygiene instruction
- Take and record vital signs

Basic Intraoral Functions

- Apply topical anesthetic
- Apply topical fluoride
- Remove temporary crowns and cements
- Take impressions for study models and fabrication of appliances, including digital impressions
- Place and remove dental dam

Board approval criteria
For board approval, the course must address the required content shown above and meet one of these criteria:

- Offered by a provider that is either PACE- or ADA CERP-approved
- Offered by a provider accredited by an agency recognized by the U.S. Department of Education
- A public high school or adult CTE program approved by the state department of education

(PACE or Program Approval for Continuing Education is a continuing education provider approval program operated by the Academy for General Dentistry. ADA CERP or Continuing Education Recognition Program is a continuing education provider recognition program operated by the American Dental Association.)

Increasing approved education channels expands avenues into the profession, which increases the number of educated dental assistants for the workforce. At the same time, ensuring that such education is verified against an objective set of criteria in accordance with agreed standards supports both uniformity and advancement to higher levels of responsibility, fostering long-term retention.

Infection Control

Description

The dental assistant performs infection prevention and control tasks, including processing instruments and devices, preventing cross-contamination, and following OSHA protocols.

Training Period

After orientation, a dental assistant may work in a dental office for a training period of up to 90 days before completing infection control requirements. During the training period, the dental assistant should receive instruction and training in infection control and should be monitored by a team member who has demonstrated knowledge of infection control through licensure, registration, or assessment and who maintains infection control knowledge through continuing education.

The first-day orientation for entry-level dental assistants allows employers flexibility to begin training dental assistants right away and to provide the necessary infection control training to ensure public protection and provider safety over a longer, 90-day training period. The Workgroup's first priority was public and provider safety, but Workgroup members remained cognizant of and concerned about introducing requirements that would make it more difficult to hire and onboard dental assistants. The combination of these two elements — the first-day safety orientation and the 90-day infection control training period — accounts for both the operational need to allow newly hired dental assistants to begin working immediately and the employer's obligation to ensure all staff have the knowledge they need to protect themselves and patients from infection.

Pathways

	Training/Education	Assessment
Pathway 1	**On-the-job training** Receive in-office training that follows a standardized content outline or training manual *(See required training/course content outline below.)*	Standardized nationally recognized exam approved by the dental board
Pathway 2	**Course or program** Complete an infection control course or dental assisting program that is either approved by the state dental board or CODA accredited	End-of-course exam

These pathways for infection control preparation reflect the principles noted earlier: There are multiple options for a dental assistant to meet requirements, providing flexibility for onboarding of candidates; and, one element in each pathway — either the education or the exam — is verified against a set of objective criteria, supporting uniformity and consistency of quality.

Required training or course content

The training or course should cover:

- CDC's Guidelines for Infection Control in Dental Health-Care Settings
- CDC's Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care
    - Transmission and prevention of infectious diseases
    - Overview of laws and guidelines applicable to oral healthcare settings
    - Personnel health elements of an infection control program
    - Preventing transmission of bloodborne pathogens
    - Hand hygiene
    - Personal protective equipment (PPE)
    - Respiratory hygiene/cough etiquette
    - Contact dermatitis and latex hypersensitivity
    - Sharps Safety and the Needlestick Prevention Act
    - Safe injection practices
    - Sterilization and disinfection of patient-care items and devices
    - Environmental infection control
    - Dental unit waterlines, biofilm and water quality
- OSHA Bloodborne Pathogens Standards
    - Exposure control
    - Methods of compliance
    - Special practices
    - Hepatitis B vaccination and post-exposure evaluation and follow-up
    - Communication of hazards to employees
    - Recordkeeping

Board approval criteria

For board approval, the course must address the required content shown above and meet one of these criteria:

- Offered by a provider that is either PACE- or CERP-approved
- Offered by a provider accredited by an agency recognized by the U.S. Department of Education
- A public high school or adult CTE program approved by the state department of education

Radiography

Description

The dental assistant performs dental radiography tasks, including seating and positioning the patient, positioning the x-ray equipment, and taking images.

Pathways

A dental assistant must meet radiography training and assessment requirements before exposing radiographs.

	Training/Education	Assessment
Pathway 1	**On-the-job training** Receive in-office training from a dentist, registered dental hygienist, dental therapist, or a dental assistant who has completed the state's radiography requirements *(See required training/course content outline below.)*	Standardized nationally recognized exam approved by the dental board
Pathway 2	**Board-approved course** Complete a course or CTE program approved by the state dental board or other state agency regulating use of x-rays	Standardized nationally recognized exam approved by the dental board
Pathway 3	**CODA-accredited course or program** Complete a dental radiography course or graduate from a CODA-accredited program	End-of-course exam

As with every element of the model, dental assistants have multiple options to qualify in radiography, and those options provide flexibility in hiring and training along with assurance of quality and support for uniformity.

Training and course content criteria

The training or course should cover:

Radiography Technique

- Review health and dental history for indications/contraindications for exposure to radiation
- How to seat patient based on technique
- Purpose of dental images
- Techniques to acquire dental images
- Identify anatomical variations that require a technique modification to acquire images
- Identify and correct technique errors to obtain a diagnostic image
- Identify what should appear in a diagnostic dental image
- Identify orientation landmarks in a dental image
- Identify dental materials in dental images
- Identify, understand purpose of and how to handle radiographic equipment
- Legal requirements

Radiation Protection

- Factors affecting x-ray production
- Protocols to ensure minimum radiation dose
- Monitor for x-ray unit malfunctions
- Potential negative health effects of radiation
- Operator safety
- Patient safety
- Addressing patient concerns regarding risks associated with exposure to radiation
- State regulatory requirements for radiation exposure

Board approval criteria

For board approval, the course must address the required content shown above and meet one of these criteria:

- Offered by a provider that is either PACE- or CERP-approved
- Offered by a provider accredited by an agency recognized by the U.S. Department of Education
- A public high school or adult CTE program approved by the state department of education

Level 2: Intermediate Intraoral Functions

Overview

Level 2 dental assistants perform intermediate intraoral and preventive functions.

Supervision

Tasks are performed under the dentist's direct and indirect supervision.

Description

Level 2 dental assistants perform intraoral functions of intermediate complexity that carry a higher level of risk for injury or pain for the patient than those included in Level 1. These functions are reversible intraoral functions delegated by the dentist under direct or indirect supervision. Safe and effective performance of these functions requires knowledge of oral anatomy, hand skills, and mastery of specific operational techniques beyond those required for Level 1.

The purpose of delegating Level 2 functions to dental assistants is to improve efficiency of the dental office and allow dental hygienists and dentists to spend more time on procedures requiring the professional skill and judgment commensurate with their education and training.

Delegable Tasks

- Intermediate tasks that are reversible
- May carry an increased risk of pain or injury for the patient
- Can be delegated to a dental assistant while a dentist is on the premises but may be working in another operatory

Examples of Level 2 tasks are:

- Coronal polishing
- Place sealants

- Place and remove retraction materials
- Fabricate and place temporary crowns
- Cement temporary crowns
- Place and remove matrix band and wedge
- Remove periodontal dressings
- Place post-extraction dressings
- Remove sutures

Other tasks appropriate for Level 2 are listed in Appendix B.

Pathways

	Education	Assessment
Pathway 1	**Board-approved course** Meet Level 1 requirements. Then, complete a course approved by the state dental board that addresses Level 2 functions	Standardized nationally recognized exam approved by the dental board
Pathway 2	**CODA-accredited program** Graduate from a CODA-accredited program that covers Level 2 functions	End-of-course exam

Pathway 1 for Level 2 allows any person who has met Level 1 requirements, including those who received in-office training, to grow their career and advance to Level 2 by receiving additional training in Level 2 functions. Advancement opportunities are a key element in mitigating workforce shortages: they support retention of qualified and experienced personnel over the long term, which will reduce the recurrent vacancies that hinder dental office productivity, and they make the profession more attractive to those considering entering the profession at the first level, which supports recruitment of new candidates.

Pathway 2 for Level 2 takes advantage of the high-quality education provided by CODA-accredited dental assisting programs by allowing graduates of those programs to enter the field as Level 2 dental assistants and to begin contributing to the dental office productivity and efficiency immediately upon completion of their education.

Required course content
The course should cover Level 2 functions:

- Coronal polishing
- Place sealants
- Place and remove retraction materials
- Fabricate and place temporary crowns
- Cement temporary crowns
- Place and remove matrix band and wedge
- Remove periodontal dressings
- Place post-extraction dressings

Board approval criteria
For board approval, the course must address the required content shown above and meet one of these criteria:

- Offered by a provider that is either PACE- or CERP-approved
- Offered by a provider accredited by an agency recognized by the U.S. Department of Education
- A public high school or adult CTE program approved by the state department of education

Note in Response to Stakeholder Feedback

The Workgroup received questions from stakeholders related to flexibility in education requirements for Level 2. The Workgroup believes that the recommended course approval criteria are appropriately flexible to allow for the development of structured training experiences. Examples include hybrid programs that could potentially include remote or asynchronous didactic education coupled with work-based learning for which the supervising dentist serves as preceptor, in situations or areas where traditional courses are scarce or insufficiently available. The workgroup encourages stakeholders to commit resources to the development of solutions that meet the recommended content requirements and ensure patient protection.

Level 3: Expanded Restorative Functions

Overview

Level 3 dental assistants perform advanced intraoral restorative functions.

Supervision

Tasks are performed under the dentist's direct and indirect supervision.

Description

Level 3 dental assistants perform intraoral restorative functions of advanced complexity that carry a higher level of risk for injury or pain for the patient than those included in Level 2. These functions are reversible intraoral restorative functions delegated by the dentist under direct or indirect supervision. Safe and effective performance of these functions requires more advanced knowledge of oral anatomy, hand skills, and mastery of specific operational techniques beyond those required for Level 2.

The purpose of delegating Level 3 functions to dental assistants is to improve efficiency of the dental office and allow dental hygienists and dentists to spend more time on procedures requiring the professional skill and judgment commensurate with their education and training, which helps increase the capacity of dental offices to see patients and improves access to dental care.

Delegable Tasks

- Expanded restorative functions that are reversible, not including cavity or crown preparation or the cutting or removal of hard or soft tissue
- May carry an increased risk of pain or injury for the patient
- Can be delegated to a dental assistant while a dentist is on the premises but may be working in another operatory

Examples of Level 3 tasks are:

- Place liners and bases

- Place, contour, finish, and adjust direct restorations in a cavity prepared by the dentist or dental therapist
- Final impressions
- Place and cement prefabricated crowns (such as stainless steel crowns) on a tooth prepared by the dentist or dental therapist
- Interim therapeutic restorations
- Cementation of a permanent indirect restoration (crown) on a tooth prepared by the dentist or dental therapist

Other tasks appropriate for Level 1 are listed in Appendix B.

Pathways

	Education	Assessment
Pathway 1	**Board-approved Restorative EFDA program** Meet Level 2 requirements and earn national accredited dental assistant certification recognized by the state board. Then, complete a restorative EFDA program approved by the state dental board that addresses Level 3 functions	Standardized nationally recognized written and/or hands-on exam approved by the dental board
Pathway 2	**CODA-accredited program** Graduate from a CODA-accredited program that covers Level 3 functions	Standardized nationally recognized written and/or hands-on exam approved by the dental board

The pathways for Level 3 continue to conform to the Workgroup's principles of providing multiple options to qualify while also supporting uniform standards, allowing dental assistants to grow their careers by building on training, education, and experience acquired at earlier levels, and taking advantage of the high-quality education available in CODA-accredited programs.

Program criteria
The program should cover:

- Dental anatomy and physiology
- Place, contour, finish, and adjust direct restoration
- Final impressions
- Place and cement fabricated crowns
- Interim therapeutic restorations
- Cementation of permanent indirect restorations

For board approval, the course must be offered by a provider that is accredited by an agency recognized by the U.S. Department of Education, including CODA.

Nitrous Oxide Monitoring

Pathway

Prerequisite	Education	Assessment
Meet Level 1 requirements Hold BLS certification	**Course or program** Complete a board-approved course or graduate from a CODA-accredited program that covers nitrous oxide monitoring	End-of-course exam

Required course content

The course should cover:

- Advantages and contraindications of nitrous oxide
    - Advantages: Discuss the safety, rapid recovery, minimal side effects, and suitability for various patients.
    - Contraindications: Cover conditions such as COPD, pregnancy, psychiatric conditions, and immune disorders. Focus on pre-sedation patient screening and ensuring proper patient selection.
- Inhalation sedation equipment
    - Overview of equipment: Review nitrous oxide delivery systems, how to adjust concentrations, and ensure proper equipment function.
    - Hands-on training: Practice setting up and operating the equipment, including how to monitor oxygen levels.
- Sedation procedure and patient monitoring
    - Chemical makeup of nitrous oxide: Overview of nitrous oxide pharmacology and how it works in the body.
    - Patient education: Train dental assistants on how to explain the procedure, effects, and what patients should expect before and after sedation.
    - Steps of sedation:
        - Patient positioning
        - Administration of nitrous oxide/oxygen
        - Monitoring patient response and adjusting gas flow
        - Pediatric sedation considerations
        - Patient Monitoring: Focus on continuous monitoring of respiration, responsiveness, and any signs of oversedation.
- Emergencies and complications
    - Common complications:
        - Oversedation
        - Nausea and vomiting
        - Airway obstruction
        - Vertigo or disorientation
    - Emergency management: Apply BLS skills in case of respiratory depression or unconsciousness. Briefly review the recognition of these emergencies, but rely on participants' existing knowledge of CPR, airway management, and AED use.
- Post-sedation care and documentation

- Post-sedation recovery: Emphasize how to monitor patients during recovery from nitrous oxide sedation, focusing on re-establishing full awareness and checking for any delayed reactions.
- Patient communication: Train on discussing post-sedation instructions with patients or caregivers, including any risks of driving or returning to regular activities.
- Documentation: Review the legal and procedural documentation for sedation events, focusing on how to record sedation dosages, patient reactions, and any interventions performed.

Board approval criteria
For board approval, the course must address the required content shown above and meet one of these criteria:

- Offered by a provider that is either PACE- or CERP-approved
- Offered by a provider accredited by an agency recognized by the U.S. Department of Education
- A public high school or adult CTE program approved by the state department of education

Note: There are 13 states that allow dental assistants who have met specified requirements to administer nitrous oxide in addition to monitoring. The Workgroup's recommendations do not address administration of nitrous oxide by dental assistants and also do not recommend against allowing dental assistants who have met appropriate requirements conforming to sound public protection principles from performing this function.

Designations for Each Dental Assisting Level

One of the factors contributing to the lack of uniformity across states affecting the dental assisting profession is the inconsistent use of designations and titles in different states. The meaning of the term "registered dental assistant" varies greatly in the states that use it; it may mean:

- An entry-level dental assistant
- An assistant who has met radiography requirements or requirements to perform other individual functions (like coronal polishing)
- An intermediate level between the entry level and the restorative expanded functions level
- The highest level of dental assistant in the state, but not authorized to perform restorative functions
- A restorative expanded functions assistant

Similarly, in some states, the term "EFDA" or "EDDA" is roughly equivalent to the intermediate level in other states, and a different designation is used for the restorative expanded functions level.

The most uniformity of titles is seen at the entry level, where 30 states simply call this level "dental assistant." However, there are still 20 states and DC that use a different term to refer to these assistants.

While it is not essential for states to use the same terms to achieve greater uniformity of scope of practice and requirements for dental assistants, the Workgroup believes that adopting more uniform designations for dental assistants at each tier will reduce confusion and support the objective of achieving an understandable road map for dental assistants to navigate their careers.

The Workgroup recommends these designations for dental assistants at each level described in the model:

Level as Outlined Above	Recommended Designation
Level 1	Dental Assistant 1
Level 2	Dental Assistant 2
Level 3: Restorative EFDA	Dental Assistant 3 — Restorative EFDA

Rationale

These designations:

- Help demonstrate a clear progression from the first tier to the highest tier
- Are easy to understand and do not use terms that are new or unfamiliar in the dental field
- Provide flexibility for states to credential or not credential each of the levels

We recognize that in states that are already using these designations, the adoption of different meanings for these terms could cause temporary confusion during a transition period, or states could continue to use these terms in a way that is out of alignment with the model. To completely avoid creating conflict with any existing state designations, it would be necessary to recommend terms that are not currently in use in any state, and doing so would introduce a different set of drawbacks, in that the terms would likely be unfamiliar, unintuitive, and not aligned with general naming conventions for allied health personnel.

While there is no perfect solution, the Workgroup has determined that recommending terms that are clear, easy to understand, and familiar will support the goal of uniformity more than inventing new, unfamiliar terms.

Emerging Functions

How states choose to address new dental assisting functions that emerge over time, because of new technology or efforts to expand dental assisting scope of practice, is an area where the best efforts to move toward a more uniform model for the dental assisting profession may encounter challenges.

Our intention has been to describe each level using objective criteria, including the underlying principles that govern decision-making for each level, to create a framework that will allow states and employers to determine whether a function may be delegated to dental assistants meeting the requirements of one of the defined levels or whether additional new knowledge and skills are required.

New or "emerging" functions may come under discussion when new technology creates new functions or alters the skill level needed to perform existing functions — for example, digital imaging technology has changed the skill level needed for making impressions. In addition, stakeholders may propose expanding the scope of practice for dental assistants to include functions not previously performed by assistants, such as administration of local anesthetic, blood draws (phlebotomy), application of silver diamine fluoride, scaling/prophylaxis, or periodontal probing.

Because one of our guiding principles has been to build on commonalities that already exist among states, we have not included in the model functions that have only recently come under discussion but have not been authorized or addressed in more than a few states. However, we believe that the model provides a framework for consideration of how to treat these functions and encourages states, as they engage in these discussions, to ask the following questions:

- What is the rationale for considering adding a new function to dental assistants' scope or recategorizing an existing function?
- Is adoption of new technology occurring rapidly, and are employers seeking guidance around delegation?
- Will the public benefit from authorization of new functions for dental assistants, such as through increases in access to care?
- Will dental offices benefit through increasing their capacity to see patients?
- Will the addition of new functions support retention and recruitment of dental assistants?

If the function is worth additional consideration, the following questions can provide a framework for categorizing the function into an existing level or developing pathways for a separate new level or category:

- Is the function intraoral?
- Is the function reversible?
- Is the function invasive? Does it penetrate hard or soft tissue?
- Will the function result in the placement of a permanent restoration or appliance?
- What is the risk of pain or injury to the patient?
- Does the function require advanced hand skills or mastery of advanced operational techniques?
- Does any existing level have the knowledge needed, or is new knowledge required?

It may also be important to consider whether the function overlaps with any other healthcare professions' scope of practice and whether laws and regulations governing those professions address the performance of that function by those outside the profession. For example, is starting IV lines or doing blood draws prohibited for those not licensed as a nurse or phlebotomist?

If new knowledge is required, developing a set of requirements that includes education from an accredited source and/or assessment from a national organization offering accredited exams/certifications would support future uniformity as the function is adopted in additional states.

Registration

An important question that states must consider when determining how best to regulate dental assistants is whether to require registration for some or all levels of assistant.

"Registration" is a broad term signifying varying levels of rigor and continued oversight over a profession, depending on the state. For our purposes, "registration" encompasses any issuance of a state credential to a dental assistant who has met competence requirements set forth by the state.

The Workgroup notes that there are many practical benefits to requiring registration for dental assistants at all levels, including these:

- Accurate and up-to-date rosters of employed dental assistants in every state will greatly assist the dental community in monitoring trends in dental assisting employment and measuring the success of steps taken to mitigate the shortage.
- Information collected through registration will allow for additional research into factors influencing successful recruitment and retention that could provide valuable insights to those seeking solutions to the workforce shortage.

For these reasons alone, we encourage state policymakers to require registration for all dental assistants.

Registering dental assistants will also bring these public protection benefits:

- Regulators report that in states where dental assistants are not registered, a dental hygienist whose license is revoked for disciplinary reasons may legally work in a dental setting as a dental assistant, which may pose a risk to patient health and safety; giving the state board of dentistry regulatory authority over dental assistants will eliminate this problem.

- Registration allows the state to revoke an authorization to work in cases where dental assistants have demonstrated that they are a danger to patients.

- Registration removes the burden from employers to verify that dental assistants have met requirements.

- Registration enables the state to require and verify that dental assistants complete continuing education requirements, which fosters a more competent workforce and supports delivery of high-quality patient care.

- Registered or licensed dental assistants may be required to complete education required of other health professionals, such as child abuse recognition and reporting, identifying victims of human trafficking, cultural competency, and similar topics that benefit the public; these requirements support public safety and the provision of a higher level of care to patients.

- Registration facilitates the process of verifying credentials when a dental assistant moves to a new state.

Despite these considerable benefits, the Workgroup recognizes that it may be unfeasible in some states, for administrative or political reasons, to adopt a model calling for registration of all dental assistants. With this in mind, we have sought to propose a model founded on objective criteria that are straightforward for an employer to verify so that, if registration cannot be implemented in a state, the state can nonetheless participate in the benefits brought about by adopting uniform descriptions, scopes of practice, and requirements for each level of dental assistant.

We also make note of the strong trend among states to require registration for the restorative EFDA level (Level 3 in the model). Of the 25 states that expressly allow some level of dental assistant to perform expanded restorative functions, 21 require registration or licensure for that level. Functions performed at this level hold the highest risk of injury or harm to the patient, and registration of this level aligns with each state's public protection interests. We therefore recommend registration for the restorative EFDA level.

Continuing Education

We encourage states to require continuing education (CE) for dental assistants. For Level 1, at a minimum, CE in infection prevention and control should be required. For Level 2 and Level 3, we encourage states to adopt similar CE requirements to include, at a minimum, infection control and patient safety CE.

While CE requirements in the 24 states that require CE for dental assistants vary from one hour/unit per year to 15 hours/units per year, we encourage states to adopt requirements for Level 2 and Level 3 that are no less than the average number of units across all the states that have a CE requirement for dental assistants — approximately 8 hours/units per year. We also note that 12 hours/units per year is the most common quantity of CE units required, and this higher number may be a more appropriate requirement for Level 3.

As long as CE requirements are within reasonable ranges, we don't believe a state that has adopted the model should view moderate differences in approaches to CE as a reason for not recognizing the status of a dental assistant from another state that has also adopted the model.

Jurisprudence Education or Exam

The Workgroup supports verification of dental assistants' knowledge of state laws, rules, and regulation through a required course or examination. However, for the foreseeable future, we expect the content of such courses or exams to continue to be state-specific, and for any jurisprudence requirements to be determined and administered at the state level.

Guidance for Implementation

Flexibility and Adaptability

The Workgroup emphasizes and is committed to enhancing uniformity for the dental assisting profession. The Workgroup also recognizes that all healthcare professions are regulated at the state level, allowing states to make policies that address the unique conditions and circumstances

affecting their residents. The Dental Assisting Professional Model is a set of recommendations for the dental community to use as a resource and guide in planning and making decisions about the structure of the dental assisting profession. It is intended to be specific enough to create a shared national understanding about the scope of practice of dental assistants and the knowledge and skills required for them to support high-quality, consistent and safe patient care, but also to be flexible enough to allow for adaptations that address the unique realities in particular states.

As stakeholders consider how to use the Dental Assisting Professional Model as a resource in their own state or setting, the Workgroup encourages inclusion of a wide range of perspectives, including those of dentists, dental assistants, other dental team members, educators, regulators and the public.

Maintaining the Model

The recommendations described in this document were developed in collaboration and with representation and input from key dental and dental assisting organizations. The Workgroup believes there may be value in forming a more permanent coalition to continue considering questions that affect the uniformity of the dental assisting profession, including providing guidance on incorporating emerging functions into practice and regulations and how the model can be adjusted to accommodate different states' needs without undermining the goal of enhancing uniformity. Additional information about the formation of such a coalition will be shared with stakeholders as those plans develop.

Approaches to Transition

As states consider adopting the recommended model, we expect stakeholders to express concerns about how the new framework will affect dental assistants who have already been employed and working before the introduction of the new model.

To facilitate the transition to a new model, we recommend establishing an alternative pathway for dental assistants who are already working to qualify for the appropriate equivalent level in the new model.

Each state may handle the transition differently, because the current variations in state regulation of dental assistant do not allow for a uniform solution to transition these dental assistants.

Broadly speaking, a state's options for transitioning existing participants in the workforce to equivalent levels in the new model consist of:

- Allow dental assistants who were working prior to adoption of the model to continue performing those duties they have already been performing; provide a grace period for them to meet requirements outlined in the model for qualifying to perform new functions.

- Require dental assistants who were working prior to adoption of the model to meet all requirements under the new model within a reasonably generous timeframe.

- Require dental assistants who were working prior to adoption of the model to meet modified requirements that take into account their existing level of knowledge gained

through prior training, education and experience; an example of a modified requirement is allowing work experience and a dentist's attestation of competence to substitute for all or part of an education or exam requirement.

In some states, it might be appropriate to deploy some combination of the above approaches, if prior requirements create different considerations for different levels.

Resources and Support

Certain aspects of the Workgroup's recommendations will require resources and support materials that may not be currently available. In some cases, existing materials, such as training manuals, course curricula, and exams, may need to be adapted to bring them into alignment with the recommended model. In other cases, new materials may need to be developed to support successful implementation. Identifying and evaluating existing resources and developing plans for the creation of new resources has been outside the scope of the Workgroup's current 12-month endeavor. It has been the Workgroup's intention to provide enough detail to allow relevant organizations and providers of services to begin to identify what work will be needed to help advance and support the model.

We call upon all stakeholders in dentistry to support and participate in the development of the tools that states, employers, and dental assistants will need to ensure that adoption of the model by a state will bring about real changes that support a high quality of care and provide the foundation for attractive career prospects for potential dental assistants, enhanced recruitment and retention, and improvements in dental offices' capacity to serve patients.

Model Statutory and Regulatory Language

A future version of this document will include model legal language for statutes (laws) and rules/regulations for state policymakers and regulators who wish to implement the model in their states to use as a template.

Phase 2: Orthodontic and Anesthesia Functions

The foregoing model is the product of 12 months' intensive analysis and deliberation by the Workgroup. Most of our discussion centered around tasks that dental assistants perform in a general dentistry setting. As we deliberated, we understood that there are several subsets of dental assisting tasks that require deeper analysis and engagement with the dentist specialists in whose practices those dental assisting functions are performed, and that the close consideration required would be outside the scope of what the Workgroup would be able to address in its proposed 12-month timeframe. Specifically, orthodontic functions and anesthesia functions are two critical areas that warrant detailed attention.

Orthodontic Functions

In some states, orthodontic duties are included in a dental assistant's scope of practice along with general dental assisting functions and specialty functions. In four states, the state has carved out a separate specialty designation for orthodontic assistants, with accompanying specialized scope and requirements. While there is much overlap among the orthodontic functions addressed across

states, as with general duties, no two states have the same scope of practice with respect to orthodontic dental assisting and no two states have the same requirements for assistants who perform orthodontic expanded functions. However, identifying a common orthodontic assisting scope of practice and set of requirements will bring these benefits:

- Protect the public in orthodontic settings, where there is a significant trend toward delegating intraoral functions to dental assistants
- Establish a clear way for dental assistants to train and qualify to perform orthodontic expanded functions
- Identify and define an attractive option for dental assistants to pursue career advancement

Anesthesia Functions

Administration of anesthesia is the dental office procedure that carries the greatest risk for immediate adverse outcomes. Many states have adopted or amended rules addressing requirements for dentists to administer anesthesia in their offices to conform with the 2016 *ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists* in the last eight years, and these requirements frequently also address the role of auxiliaries in assisting in anesthesia procedures. There are currently seven states that have defined requirements for a "dental anesthesia assistant," an "oral maxillofacial surgery assistant" or similarly titled role. Unsurprisingly, there are variations in the scope of practice and requirements for these anesthesia assistants across states.

Establishing recommendations for a uniform scope of practice and requirements for anesthesia assistants will help states regulate this critical area with more certainty that they are following best practices and providing the safest patient care.

In a second phase to this project, DANB intends to convene two smaller sets of stakeholders and subject matter experts to collaborate on developing recommendations for uniform regulation of orthodontic assistants and anesthesia assistants, following the same guiding principles centered on protecting the public, building on existing commonalities among states, providing and clearly defining a career road map for dental assistants, and supporting feasible implementation.

Stakeholder Feedback

The Workgroup completed a draft of this document at the end of January 2025. In February and March 2025, the staff supporting the Workgroup circulated the draft document to organizations representing key stakeholder groups, including national dental associations and organizations, state dental associations, state dental boards, and dental support organizations (DSOs), and made a survey form available for those that wished to provide feedback. Support staff also conducted a survey of dental assistants and dental assisting educators. The stakeholder comment period remained open through May 2025.

In soliciting comments from stakeholders, the Workgroup received significant supportive feedback for the project as whole, with many stakeholders expressing that an effort to improve uniformity for the dental assisting profession was long overdue. There was also broad support for the proposed three-tier structure and scope of practice for each level. When it came to proposed education, training, and exam requirements for each level, there were some differences of opinion among important stakeholder groups, with some dentists tending to favor fewer requirements and

reductions in onboarding costs, and dental assistants and educators tending to favor formal requirements at each level.

During the yearlong development of the model, the views of dentists, dental assistants, educators, and regulators were well represented on the Workgroup, and all participants strove to work through differences to develop a balanced set of recommendations that would protect the public, provide career growth opportunities for dental assistants, promote recruitment and retention of personnel, increase practice efficiency and improve access to and consistency in the quality of patient care. The Workgroup is grateful to the stakeholders who provided feedback and hopes to continue the conversation as we educate the dental community about the Dental Assisting Professional Model and work with stakeholders on additional resources to support dentistry in its efforts to develop the dental assisting workforce.

Appendix A: Dental Assisting Professional Model Workgroup Members

Workgroup Member (State)	Affiliation	Nominating Organization
Dolores A. Cottrell, DDS, MSHA (NY) — Workgroup Co-Chair	Executive Secretary, New York State Board for Dentistry	Invited participant
Helen Sublette, BS, CDA, COA, CDIPC, FADAA (NC) — Workgroup Co-Chair	Owner, Coastal Dental Professionals Consulting	American Dental Assistants Association
Bridgett Anderson, LDA, MBA (MN)	Executive Director, Minnesota Board of Dentistry	American Association of Dental Administrators
Christian Avelar, CDA, RDA (NJ)	Dental Assistant, Mountain Lakes Premier Dental	Hispanic Dental Association
Bobby Carmen, DDS, MAGD (OK)	Owner, Bobby J Carmen DDS; President, Oklahoma Board of Dentistry	American Association of Dental Boards
Tracy Cramer (OR)	State Representative (District-22), Oregon House of Representatives	Invited participant
Megen Elliott, MS, CDA, RDH (WI)	Dental Assistant Program Director, Northwood Technical College	American Dental Hygienists' Association
Rebecca Erwin, CDA, RDH (WV)	Dental Assisting Instructor, Putnam Career & Technical Center	Invited participant
Nabil Fehmi, DDS (AZ)	Founder and Chief Clinical Officer, Westwind Integrated Health	Association of Dental Support Organizations
David Fried, DMD (CT)	Co-Chair, Council on Government Affairs and Past President, Connecticut State Dental Association; Faculty, General Dentistry, University of Connecticut	ADA Council on Dental Practice
Sandra Garcia-Young, CDA, CDIPC, RDA, FADAA, FAADOM (TX)	Practice Administrator, CentroMed; Trustee, The DALE Foundation	DALE Foundation
Margaret Gingrich, DDS (MI)	Owner and General Dentist, Gingrich Dental PC	ADA Council on Dental Practice
Sarah Holland, MS (VA) — Public Representative	Founding CEO, Virginia Health Catalyst; Co-Founder, American Network of Oral Health Coalitions	Invited participant
Kay Jukes, BS, CDA, RDA (TX)	Dental Assisting Program Director, Houston Community College	American Dental Education Association

Workgroup Member (State)	Affiliation	Nominating Organization
Lenny Mayorga, DDS (CA)	Pediatric Dentist, AltaMed Health Services	Hispanic Dental Association
Julie Muhle, M.Ed., BOE, CDA, CRFDA (NV)	Academic Program Director for Dental Assisting, Truckee Meadows Community College	Invited participant
Jamie Sacksteder, Ph.D. (VA)	Executive Director, Virginia Board of Dentistry	American Association of Dental Administrators
Enrique Sanchez-Castillo, CDA, EFDA (IN)	Expanded Function Dental Assistant, Meridian Health Services	Invited participant
Leah Schulz, DDS (CO)	Director of Dental Projects, Salud Family Health; President, Colorado Dental Association	National Network for Oral Health Access
Janée Tamayo, CDA, CPFDA (NC)	Dental Flight Chief, U.S. Air Force; Chair, Dental Assisting National Board	Dental Assisting National Board

Kerri Friel, CDA, COA, RDH, MA (RI), a professor in the Dental Health Department at the Community College of Rhode Island, participated in select Workgroup meetings as part of her role on a dental assistant workforce coalition.

Appendix B: Supplemental List of Functions

Dental assistants perform an extraordinary number of functions and tasks, and it would not be possible to consider and address all of them in these recommendations. The functions presented above in each level are representative of that level and are also the most commonly addressed in state dental practice acts and regulations. To supplement these selected functions and provide additional guidance, the Workgroup makes the following recommendations for levels of delegation of functions that are not addressed above:

Level 1:

1. Transfer dental instruments
2. Record dental screenings
3. Record charting of the oral cavity and surrounding structures
4. Chart existing restorations or conditions
5. Recognize basic dental emergencies
6. Instructing in the use and care of dental appliances
7. Remove debris created in the course of treatment
8. Application of disclosing solutions
9. Recording patient treatment
10. Perform mouth mirror inspection of the oral cavity
11. Assist with basic restorative procedures, including prosthodontics and restorative dentistry
12. Recognize basic medical emergencies
13. Perform intra/extraoral photography
14. Apply hot/cold packs
15. Provide pre- and post-operative instructions
16. Monitor vital signs
17. Clean and polish removable appliances and prostheses
18. Assist with basic intraoral surgical procedures, including extractions, periodontics, endodontics, and implants
19. Respond to basic medical emergencies
20. Instruct patients on bleaching procedures
21. Review medical/dental history
22. Complete laboratory authorization forms for provider review/approval
23. Respond to basic dental emergencies
24. Prepare a patient for nitrous oxide analgesia administration
25. Use light curing device
26. Pour and trim diagnostic casts for evaluation by the provider

Level 2:

1. Monitor and respond to post-surgical bleeding
2. Polish assigned teeth with a slow-speed rotary handpiece immediately before an acid etch procedure
3. Remove excess temporary cement from supragingival surfaces of a tooth with hand instruments only
4. Cleanse/polish teeth in preparation for a procedure
5. Place periodontal dressings

Level 3:

1. Place temporary fillings
2. Remove temporary fillings
3. Before cementation by the dentist, adjusting and polishing contacts and occlusion of indirect restorations
4. Etch, wash and dry dentin
5. Extraorally adjust dentures

US-Based AI Company Completes World's First Fully Automated Dental Procedure on a Human

07/30/2024 by Oral Health



Perceptive dental robotic system. (Photo credit: Perceptive)

Is it possible for a robotic arm to finish crown placements in 15 minutes using AI? The answer is 'Yes,' according to Boston-headquartered company Perceptive.

Perceptive announced the completion of the world's first fully automated dental procedure on a human using its advanced robotic dentistry system, in a press release on Tuesday, July 30.

"This medical breakthrough enhances the precision and efficiency of dental procedures, and democratizes access to better dental care, for improved patient experience and clinical outcomes," says Dr. Chris Ciriello, CEO and Founder of Perceptive.

So, how does it work?

Starting with restorative dentistry, the company's dental robotics system integrates AI-driven 3D imaging software with a robotic arm designed to perform dental procedures. The proprietary system aims to complete tasks such as crown placements in just 15 minutes, a major reduction from the current method that requires two office visits of at least one hour each.

Perceptive's AI robotics system also uses 3D volumetric data for diagnostics and treatment planning, enabling early and highly accurate diagnoses.

And how does the procedure begin?

The procedure begins with an optical coherence tomography (OCT) scan of the patient's tooth and mouth using Perceptive's handheld intraoral scanner. This advanced scanner captures 3D images beneath the gum line, through fluids, and under the tooth surface, offering unparalleled imaging capabilities. Patients can clearly visualize their dental conditions through these detailed images, helping them better understand their need for care.

Idea Born in Rural Canada

Dr. Ciriello, born and raised in Canada, expressed his interest in advancing the scalability of this breakthrough. After completing dental school, Ciriello noticed that there weren't enough dentists in the area to treat all available patients. In response, he built his own Dental Support Organization (DSO). However, early into scaling his DSO, he was again confronted with more patients than he could treat. He realized that if he wanted to reach more patients, he would need to find a solution with technology.

"I've been closely tracking Perceptive's progress since seeing Dr. Ciriello present his concept at the ADA Forsyth dentech conference years ago," said Stephen E. Thorne IV, Founder and CEO of PDS Health, a leading integrated dental and medical support organization with more than 1,000 offices across the U.S. "I have seen the promise of Perceptive's incredible technology firsthand."

"We are excited to help them operationalize their vision of fully completed dental restorations in minutes," he added.

Perceptive has raised $30 million in funding to date, with leading investors including PDS Health, Dr. Ed Zuckerberg, Innospark Ventures, KdT Ventures, Primavera Capital, Plaisance Capital, Y Combinator, and others. The company is also partnered with the Harvard School of Dental Medicine and the American Dental Association's Forsyth Institute.

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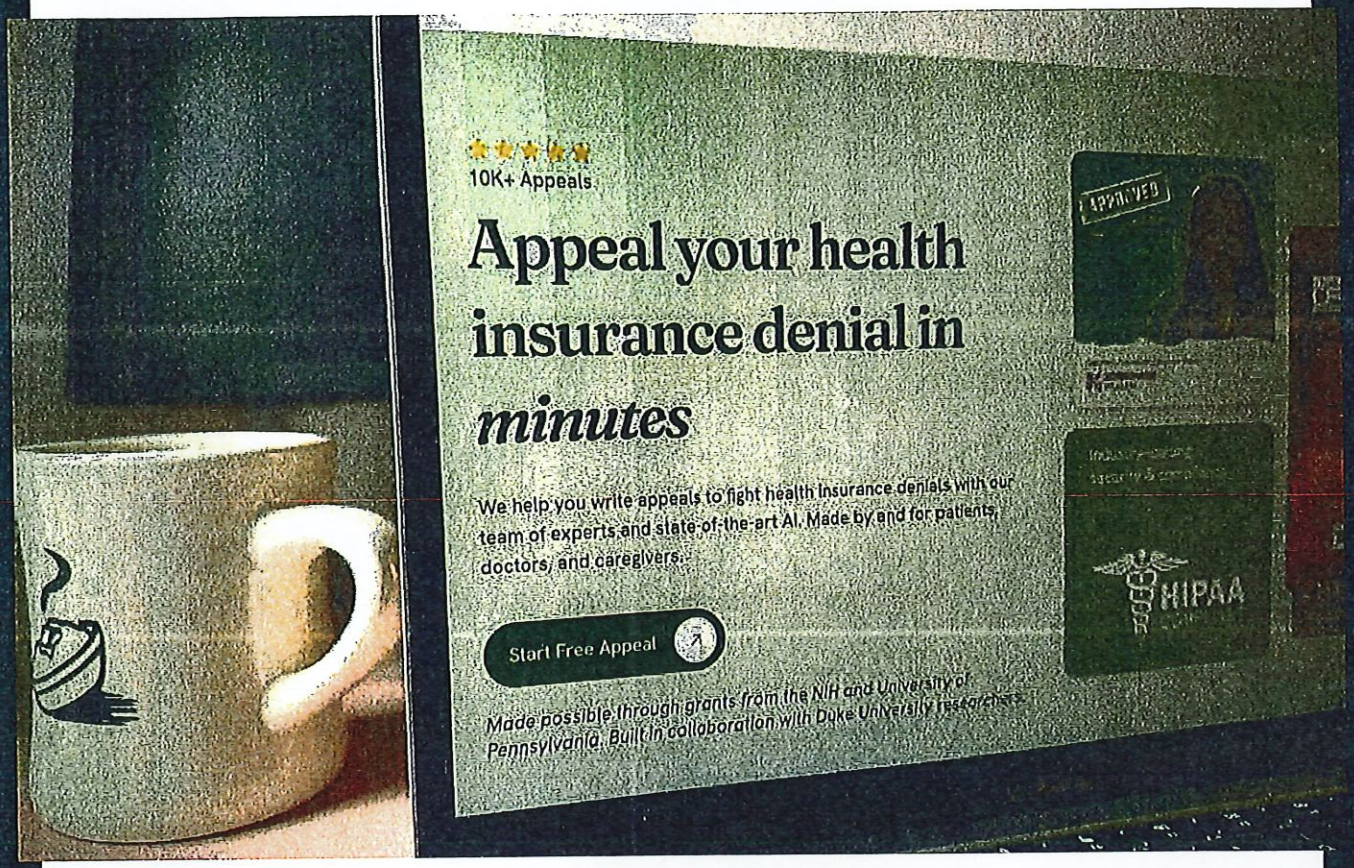


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Oklahoma Voice

AI vs. AI: Patients deploy bots to battle health insurers that deny care

BY: ANNA CLAIRE VOLLERS - NOVEMBER 21, 2025 9:09 AM



As states continue to curb health insurers' use of artificial intelligence, patients and doctors are arming themselves th AI tools to fight claims denials, prior authorizations and soaring medical bills. (Photo by Anna Claire llers/Stateline)

s states strive to curb health insurers' use of artificial intelligence, patients and doctors are rming themselves with AI tools to fight claims denials, prior authorizations and soaring edical bills.

everal businesses and nonprofits have launched AI-powered tools to help patients get their surance claims paid and navigate byzantine medical bills, creating a robotic tug-of-war over ho gets care and who foots the bill for it.

neer Health, a three-year-old company that helps patients and providers navigate health surance and billing, now has an app that allows consumers to connect their health insurance ccount, upload medical bills and claims, and ask questions about deductibles, copays and overed benefits.

You would think there would be some sort of technology that could explain in real English hy I'm getting a bill for $1,500," said cofounder Jeff Witten. The program uses both AI and

umans to provide the answers for free, he said. Patients who want extra support in challenging denied claim or dealing with out-of-network reimbursements can pay Sheer Health to handle ose for them.

North Carolina, the nonprofit Counterforce Health designed an AI assistant to help patients peal their denied health insurance claims and fight large medical bills. The free service uses I models to analyze a patient's denial letter, then look through the patient's policy and outside edical research to draft a customized appeal letter.

ther consumer-focused services use AI to catch billing errors or parse medical jargon. Some atients are even turning to AI chatbots like Grok for help.

quarter of adults under age 30 said they used an AI chatbot at least once a month for health formation or advice, according to a poll the health care research nonprofit KFF published in ugust 2024. But most adults said they were not confident that the health information is curate.

ate legislators on both sides of the aisle, meanwhile, are scrambling to keep pace, passing new gulations that govern how insurers, physicians and others use AI in health care. Already this ear, more than a dozen states have passed laws regulating AI in health care, according to anatt, a consulting firm.

t doesn't feel like a satisfying outcome to just have two robots argue back and forth over hether a patient should access a particular type of care," said Carmel Shachar, assistant clinical rofessor of law and the faculty director of the Health Law and Policy Clinic at Harvard Law chool.

We don't want to get on an AI-enabled treadmill that just speeds up."

black box

ealth care can feel like a black box. If your doctor says you need surgery, for example, the cost epends on a dizzying number of factors, including your health insurance provider, your ecific health plan, its copayment requirements, your deductible, where you live, the facility here the surgery will be performed, whether that facility and your doctor are in-network and our specific diagnosis.

me insurers may require prior authorization before a surgery is approved. That can entail tensive medical documentation. After a surgery, the resulting bill can be difficult to parse.

itten, of Sheer Health, said his company has seen thousands of instances of patients whose octors recommend a certain procedure, like surgery, and then a few days before the surgery the atient learns insurance didn't approve it.

> You would think there would be some sort of technology that could explain in real English why I'm getting a bill for $1,500.
>
> *– Sheer Health co-founder Jeff Witten*

recent years, as more health insurance companies have turned to AI to automate claims rocessing and prior authorizations, the share of denied claims has risen. This year, 41% of hysicians and other providers said their claims are denied more than 10% of the time, up from 0% of providers who said that three years ago, according to a September report from credit porting company Experian.

surers on Affordable Care Act marketplaces denied nearly 1 in 5 in-network claims in 2023, up from 17% in 2021, and more than a third of out-of-network claims, according to the most cently available data from KFF.

surance giant UnitedHealth Group has come under fire in the media and from federal wmakers for using algorithms to systematically deny care to seniors, while Humana and other surers face lawsuits and regulatory investigations that allege they've used sophisticated gorithms to block or deny coverage for medical procedures.

surers say AI tools can improve efficiency and reduce costs by automating tasks that can volve analyzing vast amounts of data. And companies say they're monitoring their AI to entify potential problems. A UnitedHealth representative pointed Stateline to the company's I Review Board, a team of clinicians, scientists and other experts that reviews its AI models for curacy and fairness.

Health plans are committed to responsibly using artificial intelligence to create a more amless, real-time customer experience and to make claims management faster and more ffective for patients and providers," a spokesperson for America's Health Insurance Plans, the ational trade group representing health insurers, told Stateline.

ut states are stepping up oversight.

Arizona, Maryland, Nebraska and Texas, for example, have banned insurance companies from sing AI as the sole decisionmaker in prior authorization or medical necessity denials.

r. Arvind Venkat is an emergency room physician in the Pittsburgh area. He's also a emocratic Pennsylvania state representative and the lead sponsor of a bipartisan bill to gulate the use of AI in health care.

e's seen new technologies reshape health care during his 25 years in medicine, but AI feels holly different, he said. It's an "active player" in people's care in a way that other technologies aven't been.

f we're able to harness this technology to improve the delivery and efficiency of clinical care, at is a huge win," said Venkat. But he's worried about AI use without guardrails.

is legislation would force insurers and health care providers in Pennsylvania to be more ansparent about how they use AI; require a human to make the final decision any time AI is sed; and mandate that they show evidence of minimizing bias in their use of AI.

n health care, where it's so personal and the stakes are so high, we need to make sure we're andating in every patient's case that we're applying artificial intelligence in a way that looks at e individual patient," Venkat said.

atient supervision

istorically, consumers rarely challenge denied claims: A KFF analysis found fewer than 1% of ealth coverage denials are appealed. And even when they are, patients lose more than half of hose appeals.

ew consumer-focused AI tools could shift that dynamic by making appeals easier to file and e process easier to understand. But there are limits; without human oversight, experts say, the I is vulnerable to mistakes.

t can be difficult for a layperson to understand when AI is doing good work and when it is allucinating or giving something that isn't quite accurate," said Shachar, of Harvard Law chool.

or example, an AI tool might draft an appeals letter that a patient thinks looks impressive. But ecause most patients aren't medical experts, they may not recognize if the AI misstates medical formation, derailing an appeal, she said.

The challenge is, if the patient is the one driving the process, are they going to be able to roperly supervise the AI?" she said.

arlier this year, Mathew Evins learned just 48 hours before his scheduled back surgery that his surer wouldn't cover it. Evins, a 68-year-old public relations executive who lives in Florida, orked with his physician to appeal, but got nowhere. He used an AI chatbot to draft a letter to s insurer, but that failed, too.

n his son's recommendation, Evins turned to Sheer Health. He said Sheer identified a coding ror in his medical records and handled communications with his insurer. The surgery was pproved about three weeks later.

t's unfortunate that the public health system is so broken that it needs a third party to tervene on the patient's behalf," Evins told Stateline. But he's grateful the technology made it ossible to get life-changing surgery.

AI in and of itself isn't an answer," he said. "AI, when used by a professional that understands e issues and ramifications of a particular problem, that's a different story. Then you've got an ffective tool."

Most experts and lawmakers agree a human is needed to keep the robots in check.

AI has made it possible for insurance companies to rapidly assess cases and make decisions bout whether to authorize surgeries or cover certain medical care. But that ability to make ghtning-fast determinations should be tempered with a human, Venkat said.

t's why we need government regulation and why we need to make sure we mandate an dividualized assessment with a human decisionmaker."

Witten said there are situations in which AI works well, such as when it sifts through an surance policy – which is essentially a contract between the company and the consumer – nd connects the dots between the policy's coverage and a corresponding insurance claim.

ut, he said, "there are complicated cases out there AI just can't resolve." That's when a human is eeded to review.

think there's a huge opportunity for AI to improve the patient experience and overall rovider experience," Witten said. "Where I worry is when you have insurance companies or ther players using AI to completely replace customer support and human interaction."

urthermore, a growing body of research has found AI can reinforce bias that's found elsewhere medicine, discriminating against women, ethnic and racial minorities, and those with public surance.

The conclusions from artificial intelligence can reinforce discriminatory patterns and violate rivacy in ways that we have already legislated against," Venkat said.

tateline reporter Anna Claire Vollers can be reached at avollers@stateline.org.

his story was originally produced by Stateline, which is part of States Newsroom, a nonprofit news etwork which includes Oklahoma Voice, and is supported by grants and a coalition of donors as a 01c(3) public charity.

FEATURE STORY | 29-SEP-2025

Inventing a next-generation cavity fighter

NYU scientists are developing a zinc-based treatment for tooth decay that combats bacteria, blocks pain, and avoids staining teeth—all without drilling

NEW YORK UNIVERSITY



image:

NYU professors Deepak Saxena (left) and Marc Walters (right) with junior research scientist Samantha Hwang (center) in Saxena's lab

view more ›

Credit: Jonathan King/NYU

Tooth decay is the most common health condition worldwide. While it is preventable and treatable, billions of people are living with cavities and the pain that accompanies them.

Given the massive scale of the problem, there's a growing movement in dentistry to treat cavities without drilling and filling them. One such approach is applying a clear liquid called silver diamine fluoride to the surface of teeth. Silver diamine fluoride is already FDA approved to treat tooth sensitivity, and recent NYU research shows that the compound's antimicrobial properties also make it effective at preventing cavities and stopping small cavities from progressing into larger ones. Because it's inexpensive and easy to administer, it can be given in schools, in rural areas lacking dentists, or to patients who may have difficulty with dental care, including those with disabilities.

But treatment with silver diamine fluoride comes with one notable drawback: when the silver in it interacts with tooth decay, it turns the treated surface black. While this is not a significant issue for molars at the back of the mouth or baby teeth that fall out, it's not a great option for teeth seen in a smile.

"Once your teeth are treated with silver diamine fluoride, that stain is permanent, which is a barrier for many people wanting to use the product," explains Marc Walters, professor of chemistry at NYU.

Walters has long studied silver and other elements used in medicine to carry drugs and imaging contrast agents. Several years ago, he was approached by researchers at NYU College of Dentistry seeking to better understand how silver stains teeth in order to avoid that outcome.

From silver to zinc

Walters had an idea. What if another mineral could be used that was also colorless and antimicrobial but didn't turn teeth black? This question led him to zinc, an important nutrient found in foods like oysters and beef, as well as in over-the-counter products intended to shorten the duration of colds. Zinc is also used in dentistry, including in toothpaste and mouthwash to fight bacteria and bad breath, as well as in some denture adhesives and cementing agents to affix crowns or temporary fillings.

Walters began studying a zinc phosphate compound to see how it interacts with cavities, and crucially, to determine whether it can permeate deep into teeth. In order to address pain and hypersensitivity, the compound would need to reach the tooth's dentin, the porous material sandwiched between the hard enamel outer layer and the nerves within. Dentin contains an abundance of microscopic, hollow channels—in fact, 40,000 of these tubules are packed into each square millimeter of dentin.

"We had to develop a solution to give dentists that will be taken up in these very small openings and go deep enough in the tubules so that the material will be retained," Walters explains.

Walters applied phosphate followed by zinc to slices of a human tooth. Under the microscope, he saw deposits of the compound deep inside the dentin tubules. But while the zinc phosphate successfully permeated the teeth, he knew that a simpler approach that didn't require applying two treatments would be easier for dentists. "Two steps is one too many," says Walters.

Drawing inspiration from silver diamine fluoride, Walters developed another zinc-based molecule called zinc tetramine difluoride, which forms a colorless zinc oxide deep inside dentin tubules. The agent starts out as a liquid that is sensitive to concentration and pH. When painted onto a tooth and absorbed, the conditions within dentin tubules prompt a chemical change that quickly turns it into a solid, blocking the tubules and slowly releasing the antimicrobial zinc into the tooth.

His team is continuing to develop several related compounds for the treatment of cavities and has applied for patents of these zinc-based materials in several countries.

Fast and slow

Having both fact-acting and long-lasting properties would offer an ideal combination for fighting cavities and tooth sensitivity, given that many current treatments for sensitive teeth require multiple applications and can take days or weeks to work.

"In one of our studies, two minutes after treatment with our agent, we can see using the electron microscope that the zinc forms long cylinders of mineral that occupy the tubules," says Walters. "Blocking the dentin tubules cuts off access to the nerves that are much deeper in dentin. It's like putting a cork in place that shuts off the lower portion of the tubule from the outside environment—and this happens within a minute or two."

In additional tests, Walters found that zinc oxide persisted in tooth samples for at least one to two months. The goal is to develop a product that lasts for months or even years inside of teeth, stopping hypersensitivity and fighting bacteria on an ongoing basis.

"Not only do you have the analgesic result of having tubules blocked, but you also have a very low solubility agent that can slowly release the zinc into the tubule to prevent the growth of Streptococcus mutans and other bacteria," Walters adds.

The journey from lab to shelves

With a promising zinc nanocrystal agent in hand, Walters sought out other experts at NYU and beyond. His work caught the attention of Southern Dental Industries (SDI), an Australian company that makes restorative dental materials, including silver diamine fluoride. The company purchased the license for the zinc technology and NYU is working with them to develop it.

Closer to home, Walters began collaborating with Deepak Saxena, professor of molecular pathobiology and director of research innovation and entrepreneurship at NYU College of Dentistry, who has a strong track record of developing oral health products through Periomics Care, the startup company he co-founded with Xin Li at NYU Dentistry.

"As soon as I met Marc and I saw his enthusiasm, I decided that we should work together and try to make this as a commercial product," Saxena recalls.

As a result of bringing together this diverse expertise—dentistry, chemistry, microbiology, and entrepreneurship—Saxena and Walters received a Technology Acceleration and Commercialization award from NYU, and last month, secured a nearly $300,000 grant from the National Institutes of Health under its Small Business Technology Transfer program.

The NIH grant will fund feasibility studies for Walters's team to further develop the formulation and confirm its ability to block tubules in a range of dentin samples. It will also fund research through Periomics Care in which Saxena's team will study the agent's antimicrobial properties. Specifically, they will look to see if the zinc creates a "zone of inhibition"—preventing the growth of decay-causing bacteria in the vicinity of it or even killing bacteria that comes in contact with it.

"The mouth is full of bacteria. A compound needs to have good antimicrobial activity, which can occur from ionic imbalance, the properties of the zinc, or by the fluoride," Saxena says. "If a compound does not stain, has good antimicrobial activity, plus it blocks the tubules, then it should be successful in stopping tooth decay and be aesthetically accepted."

Saxena and Walters are already planning for the next phase of their research, which will include additional studies on the compound's formulation, effectiveness, toxicity, and shelf life. Ultimately, if these studies go well, the researchers and SDI will approach the FDA for permission to do a clinic trial.

One factor working in their favor: because zinc phosphate has long been used as a dental adhesive, it's known to be safe and the FDA has already approved it in other forms. These existing products may pave the way for faster research and development of a cavity treatment compared to untested elements, which can take many years to develop.

The future of dentistry

A new non-invasive treatment for cavities could help be a gamechanger in oral health. "We know that there's a need—and a market—for a product that stops tooth decay that is effective, cheap, easy to use, and non-staining, given the rise in global numbers of untreated cavities," Saxena says.

Dentists could use it to treat cavities without needing to scrape or drill out the cavity in preparation. Squirmy kids would need less time in the dentist's chair. Older adults who get cavities near the roots of their teeth as their gums recede could have a new option for stopping sensitivity and decay in difficult-to-treat areas. If safe and effective, perhaps small quantities could even be available on drugstore shelves and sold directly to consumers.

For Walters and Saxena, their goal is a future with less tooth decay and pain—and if their studies of zinc confirm its potential, silver-stained teeth may be a thing of the past.

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UC San Diego Health and Navy Perform Reconstructive Jaw Surgery using 3D Printed Teeth

With part of his leg bone serving as his new jaw, UC San Diego student walks across commencement stage two weeks after surgery and accomplishes his professional dream



Surgeons at UC San Diego Health and Navy Medical Center San Diego used 3-D technology to reconstruct the jaw of a UC San Diego graduate. The surgery was a first of its kind at UC San Diego Health.

By:

Tiffany Fox - tfox@ucsd.edu

Media Contact:

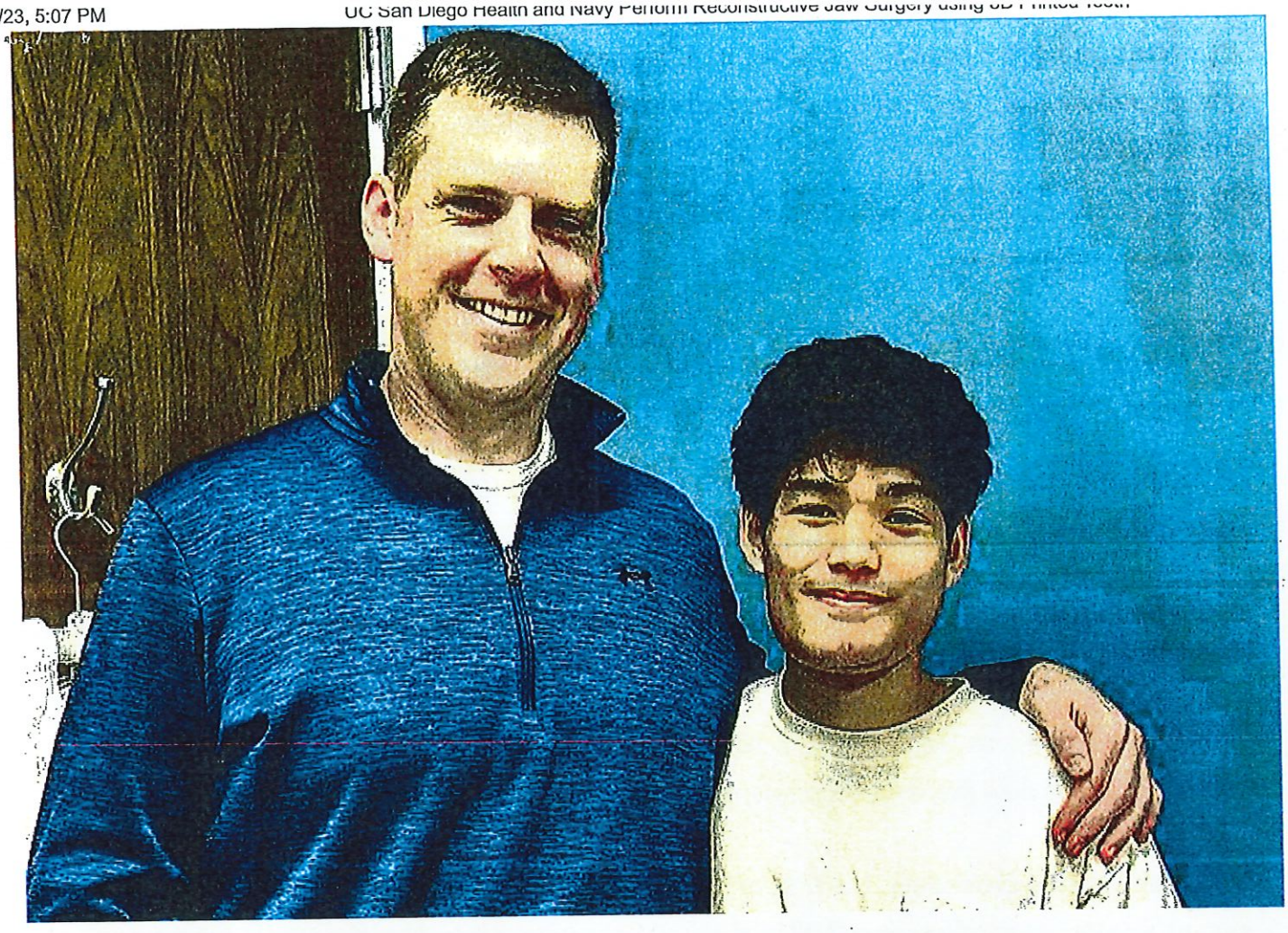
Michelle Brubaker - mmbrubaker@ucsd.edu

December 12, 2023

Felix Ung entered UC San Diego as an undergrad four years ago with a dream of attending law school after completing his degree in Cognitive Science. Through hard work and determination, Ung was accepted to New York University School of Law during his senior year.

Around this time, however, Ung got disturbing news that would have him questioning his future as an attorney. He had been diagnosed with a cyst that had already destroyed a large portion of his lower jaw. After numerous referrals and appointments, it was determined Ung needed to have two-thirds of his lower jaw removed, including nearly all of his lower teeth — a procedure that would require rare expertise and a ground-breaking dental implant restoration using 3D-printed teeth.

With his professional dream uncertain, Ung searched for and found a collaborative team of specialized plastic and dental surgeons at UC San Diego Health and Naval Medical Center San Diego. The team was led by U.S. Navy Commander Dan Hammer, DDS, Navy maxillofacial surgeon and Captain Eamon O'Reilly, MD, Navy plastic surgeon and Christopher Reid, MD, associate professor of surgery at UC San Diego School of Medicine and plastic surgeon at UC San Diego Health.



U.S. Navy Commander Dan Hammer, DDS, and patient Felix Ung, who graduated from UC San Diego two weeks after surgery and is now able to accomplish his professional dream of becoming an attorney.

In a series of complex procedures, the team partnered with the Department of Otolaryngology at UC San Diego School of Medicine to both remove a large portion of Ung's jaw and transplant — during the same surgery — a portion of Ung's leg bone to serve as his new jaw, complete with dental implants and 3D printed teeth.

"This procedure is an example of UC San Diego Health's commitment to providing leading-edge, comprehensive care that encompasses both functional and aesthetic aspects," said Reid. "This innovative approach ensures the patient's swift recovery and an improved quality of life."

Hammer notes that, with no need for additional surgeries, the procedure reduces the surgical time a patient is under anesthesia while also immediately restoring the patient's form and function.

"In a moment of despair for Felix, there was a new sense of hope that his diagnosis would not forever derail his dream of a career as an attorney," said Hammer.

By utilizing advanced digital dental technologies, including intra-oral scanning, computer aided design software and 3-D printing, Ung had restored function and was discharged home in less than a week.

"This procedure is an example of UC San Diego Health's commitment to providing leading-edge, comprehensive care that encompasses both functional and aesthetic aspects. This innovative approach ensures the patient's swift recovery and an improved quality of life."

Christopher Reid, MD, associate professor of surgery at UC San Diego School of Medicine and plastic surgeon at UC San Diego Health

"Most impressive was Ung walking across the stage at commencement two weeks after surgery with his new jaw and accompanying smile," said Reid.

This multifaceted procedure, the first of its kind at UC San Diego Health, has enabled Ung to accept a deferred enrollment to NYU School of Law, where he will matriculate this winter.

Hammer added that patients who lack access to these technologies typically require a years-long recovery to experience the same outcomes, with many additional surgeries.

"This procedure is done very rarely in the United States or across the world," he added. "There are very few locations in California that have extensive experience with this technique and a handful in the entire nation. Prior to this case, Naval Medical Center San Diego was the only site in San Diego County that had this capability."

To learn more about plastic and reconstructive surgery at UC San Diego Health, visit health.ucsd.edu/plastic-reconstructive-surgery.

Topics:

Plastic and Reconstructive Surgery, Otolaryngology, Surgery Services, Jaw Surgery

Share This:

An Act

ENROLLED SENATE
BILL NO. 1642

By: Frix of the Senate

and

Marti of the House

An Act relating to controlled dangerous substances; amending 63 O.S. 2021, Section 2-309I, as amended by Section 1, Chapter 257, O.S.L. 2022 (63 O.S. Supp. 2025, Section 2-309I), which relates to prescription limits and rules for opioid drugs; authorizing divided quantities for certain acute pain prescriptions; updating statutory language; modifying statutory references; and providing an effective date.

SUBJECT: Opioid prescription guidelines

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 63 O.S. 2021, Section 2-309I, as amended by Section 1, Chapter 257, O.S.L. 2022 (63 O.S. Supp. 2025, Section 2-309I), is amended to read as follows:

Section 2-309I. A. ~~A practitioner shall not issue an initial prescription for an opioid drug in a quantity exceeding a seven-day supply for treatment of acute pain. Any opioid prescription for acute pain shall be for the lowest effective dose of an immediate-release drug.~~

~~B.~~ Prior to issuing an initial prescription for an opioid drug in a course of treatment for acute or chronic pain, a practitioner shall:

1. Take and document the results of a thorough medical history, including the experience of the patient with nonopioid medication and nonpharmacological pain-management approaches and substance abuse history;

2. Conduct, as appropriate, and document the results of a physical examination;

3. Develop a treatment plan with particular attention focused on determining the cause of pain of the patient;

4. Access relevant prescription monitoring information from the central repository pursuant to Section 2-309D of this title;

5. ~~Limit the supply of any opioid drug prescribed for acute pain to a duration of no more than seven (7) days as determined by the directed dosage and frequency of dosage; provided, however, upon issuing an initial prescription for acute pain pursuant to this section, the practitioner may issue one (1) subsequent prescription for an opioid drug in a quantity not to exceed seven (7) days if:~~

~~a. the subsequent prescription is due to a major surgical procedure or "confined to home" status as defined in 42 U.S.C., Section 1395n(a),~~

~~b. the practitioner provides the subsequent prescription on the same day as the initial prescription,~~

~~c. the practitioner provides written instructions on the subsequent prescription indicating the earliest date on which the prescription may be filled, otherwise known as a "do not fill until" date, and~~

~~d. the subsequent prescription is dispensed no more than five (5) days after the "do not fill until" date indicated on the prescription;~~

~~6.~~ In the case of a patient under the age of eighteen (18) years, enter into a patient-provider agreement with a parent or guardian of the patient; and

~~7.~~ 6. In the case of a patient who is a pregnant woman, enter into a patient-provider agreement with the patient.

B. 1. A practitioner shall not issue an initial prescription for an opioid drug for treatment of acute pain in a quantity exceeding a seven-day supply, as determined by the directed dosage and frequency of dosage.

2. Any initial or subsequent opioid prescription for acute pain shall be for the lowest effective dose of an immediate-release drug.

3. The practitioner may issue the initial seven-day prescription in divided quantities, which shall only count as a single prescription for purposes of the requirements of this section.

C. ~~No~~ Except as provided in subsection D of this section, no less than seven (7) days after issuing the initial acute pain prescription pursuant to subsection ~~A~~ B of this section, the practitioner, after consultation with the patient, may issue a subsequent acute pain prescription for the opioid drug to the patient in a quantity not to exceed seven (7) days, provided that:

1. The subsequent prescription would not be deemed an initial prescription under this section;

2. The practitioner determines the prescription is necessary and appropriate to the treatment needs of the patient and documents the rationale for the issuance of the subsequent prescription; and

3. The practitioner determines that issuance of the subsequent prescription does not present an undue risk of abuse, addiction or diversion and documents that determination.

D. 1. The practitioner may issue the subsequent seven-day acute pain prescription under subsection C of this section in divided quantities, which shall only count as a single prescription for purposes of the requirements of this section.

2. Notwithstanding the timing and quantity restrictions specified in subsection C of this section, upon issuing an initial prescription of an opioid drug for acute pain under subsection B of

this section, the practitioner may simultaneously issue one subsequent prescription for an opioid drug in a quantity not to exceed seven (7) days if:

a. the subsequent prescription is due to a major surgical procedure or confined to home status as described in 42 U.S.C., Section 1395n(a),

b. the practitioner provides the subsequent prescription on the same day as the initial prescription,

c. the practitioner provides written instructions on the subsequent prescription indicating the earliest date on which the prescription may be filled, otherwise known as a "do not fill until" date, and

d. the subsequent prescription is dispensed no more than five (5) days after the "do not fill until" date indicated on the prescription.

E. Prior to issuing the initial prescription of an opioid drug in a course of treatment for acute or chronic pain and again prior to issuing the third prescription of the course of treatment, a practitioner shall discuss with the patient or the parent or guardian of the patient if the patient is under eighteen (18) years of age and is not an emancipated minor, the risks associated with the drugs being prescribed, including, but not limited to:

1. The risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants;

2. The reasons why the prescription is necessary;

3. Alternative treatments that may be available; and

4. Risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed or mixing

sedatives, benzodiazepines or alcohol with opioids can result in fatal respiratory depression.

The practitioner shall include a note in the medical record of the patient that the patient or the parent or guardian of the patient, as applicable, has discussed with the practitioner the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available. The applicable state licensing board of the practitioner shall develop and make available to practitioners guidelines for the discussion required pursuant to this subsection.

~~E.~~ F. At the time of the issuance of the third prescription for an opioid drug, the practitioner shall enter into a patient-provider agreement with the patient.

~~F.~~ G. When an opioid drug is continuously prescribed for three (3) months or more for chronic pain, the practitioner shall:

1. Review, at a minimum of every three (3) months, the course of treatment, any new information about the etiology of the pain, and the progress of the patient toward treatment objectives and document the results of that review;

2. In the first year of the patient-provider agreement, assess the patient prior to every renewal to determine whether the patient is experiencing problems associated with an opioid use disorder as defined by the American Psychiatric Association and document the results of that assessment. Following one (1) year of compliance with the patient-provider agreement, the practitioner shall assess the patient at a minimum of every six (6) months;

3. Periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, or try other drugs or treatment modalities in an effort to reduce the potential for abuse or the development of an opioid use disorder as defined by the American Psychiatric Association and document with specificity the efforts undertaken;

4. Review the central repository information in accordance with Section 2-309D of this title; and

5. Monitor compliance with the patient-provider agreement and any recommendations that the patient seek a referral.

~~G.~~ H. 1. Any prescription for acute pain pursuant to this section shall have the words "acute pain" notated on the face of the prescription by the practitioner.

2. Any prescription for chronic pain pursuant to this section shall have the words "chronic pain" notated on the face of the prescription by the practitioner.

~~H.~~ I. This section shall not apply to a prescription for a patient:

1. Who has sickle cell disease;

2. Who is in treatment for cancer or receiving aftercare cancer treatment;

3. Who is receiving hospice care from a licensed hospice;

4. Who is receiving palliative care in conjunction with a serious illness;

5. Who is a resident of a long-term care facility; or

6. For any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

~~I.~~ J. Every policy, contract, or plan delivered, issued, executed, or renewed in this state, or approved for issuance or renewal in this state by the Insurance Commissioner, and every contract purchased by the Employees Group Insurance Division of the Office of Management and Enterprise Services, on or after November 1, 2018, that provides coverage for prescription drugs subject to a copayment, coinsurance or deductible shall charge a copayment, coinsurance, or deductible for an initial prescription of an opioid drug prescribed pursuant to this section that is either:

1. Proportional between the cost sharing for a thirty-day supply and the amount of drugs the patient was prescribed; or

2. Equivalent to the cost sharing for a full thirty-day supply of the drug, provided that no additional cost sharing may be charged for any additional prescriptions for the remainder of the thirty-day supply.

~~J.~~ K. Any practitioner authorized to prescribe an opioid drug shall adopt and maintain a written policy or policies that include execution of a written agreement to engage in an informed consent process between the prescribing practitioner and qualifying opioid therapy patient. For the purposes of this section, "qualifying opioid therapy patient" means:

1. A patient requiring opioid treatment for more than three (3) months;

2. A patient who is prescribed benzodiazepines and opioids together for more than one twenty-four-hour period; or

3. A patient who is prescribed a dose of opioids that exceeds one hundred (100) morphine equivalent doses.

~~K.~~ L. Nothing in ~~the Anti-Drug Diversion Act~~ this section shall be construed to require a practitioner to limit or forcibly taper a patient on opioid therapy. The standard of care requires effective and individualized treatment for each patient as deemed appropriate by the prescribing practitioner without an administrative or codified limit on dose or quantity that is more restrictive than approved by the Food and Drug Administration (FDA).

SECTION 2. This act shall become effective November 1, 2026.

Passed the Senate the 2nd day of March, 2026.

_____
Presiding Officer of the Senate

Passed the House of Representatives the 29th day of April, 2026.

_____
Presiding Officer of the House
of Representatives

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____

Approved by the Governor of the State of Oklahoma this _____

day of _____, 20_____, at _____ o'clock _____ M.

_____
Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____

day of _____, 20 _____, at _____ o'clock _____ M.

By: _____

OKLAHOMA STATE COURTS NETWORK

Title 63. Public Health and Safety

Oklahoma Statutes Citationized

Title 63. Public Health and Safety

Chapter 2 - Uniform Controlled Dangerous Substances Act

Article Article 3 - Regulation of Manufacture, Distribution, Dispensing, Prescribing, Administering, and Using for Scientific Purposes of Controlled Dangerous Substances

Section 2-309I - Prescription Requirements for Opioids and Benzodiazepines - Copayment, Co-Insurance, or Deductible - Provider Policy - Standard of Care

This Statute Will Be Superceded

Effective On: 11/01/2026

Cite as: 63 O.S. § 2-309I (OSCN 2026)

A. A practitioner shall not issue an initial prescription for an opioid drug in a quantity exceeding a seven-day supply for treatment of acute pain. Any opioid prescription for acute pain shall be for the lowest effective dose of an immediate-release drug.

B. Prior to issuing an initial prescription for an opioid drug in a course of treatment for acute or chronic pain, a practitioner shall:

1. Take and document the results of a thorough medical history, including the experience of the patient with nonopioid medication and nonpharmacological pain-management approaches and substance abuse history;

2. Conduct, as appropriate, and document the results of a physical examination;

3. Develop a treatment plan with particular attention focused on determining the cause of pain of the patient;

4. Access relevant prescription monitoring information from the central repository pursuant to Section 2-309D of this title;

5. Limit the supply of any opioid drug prescribed for acute pain to a duration of no more than seven (7) days as determined by the directed dosage and frequency of dosage; provided, however, upon issuing an initial prescription for acute pain pursuant to this section, the practitioner may issue one (1) subsequent prescription for an opioid drug in a quantity not to exceed seven (7) days if:

a. the subsequent prescription is due to a major surgical procedure or "confined to home" status as defined in 42 U.S.C., Section 1395n(a),

b. the practitioner provides the subsequent prescription on the same day as the initial prescription,

c. the practitioner provides written instructions on the subsequent prescription indicating the earliest date on which the prescription may be filled, otherwise known as a "do not fill until" date, and

d. the subsequent prescription is dispensed no more than five (5) days after the "do not fill until" date indicated on the prescription;

6. In the case of a patient under the age of eighteen (18) years, enter into a patient-provider agreement with a parent or guardian of the patient; and

7. In the case of a patient who is a pregnant woman, enter into a patient-provider agreement with the patient.

C. No less than seven (7) days after issuing the initial prescription pursuant to subsection A of this section, the practitioner, after consultation with the patient, may issue a subsequent prescription for the drug to the patient in a quantity not to exceed seven (7) days, provided that:

1. The subsequent prescription would not be deemed an initial prescription under this section;

2. The practitioner determines the prescription is necessary and appropriate to the treatment needs of the patient and documents the rationale for the issuance of the subsequent prescription; and

3. The practitioner determines that issuance of the subsequent prescription does not present an undue risk of abuse, addiction or diversion and documents that determination.

D. Prior to issuing the initial prescription of an opioid drug in a course of treatment for acute or chronic pain and again prior to issuing the third prescription of the course of treatment, a practitioner shall discuss with the patient or the parent or guardian of the patient if the patient is under eighteen (18) years of age and is not an emancipated minor, the risks associated with the drugs being prescribed, including but not limited to:

1. The risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants;

2. The reasons why the prescription is necessary;

3. Alternative treatments that may be available; and

4. Risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed or mixing sedatives, benzodiazepines or alcohol with opioids can result in fatal respiratory depression.

The practitioner shall include a note in the medical record of the patient that the patient or the parent or guardian of the patient, as applicable, has discussed with the practitioner the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available. The applicable state licensing board of the practitioner shall develop and make available to practitioners guidelines for the discussion required pursuant to this subsection.

E. At the time of the issuance of the third prescription for an opioid drug, the practitioner shall enter into a patient-provider agreement with the patient.

F. When an opioid drug is continuously prescribed for three (3) months or more for chronic pain, the practitioner shall:

1. Review, at a minimum of every three (3) months, the course of treatment, any new information about the etiology of the pain, and the progress of the patient toward treatment objectives and document the results of that review;

2. In the first year of the patient-provider agreement, assess the patient prior to every renewal to determine whether the patient is experiencing problems associated with an opioid use disorder as defined by the American Psychiatric Association and document the results of that assessment. Following one (1) year of compliance with the patient-provider agreement, the practitioner shall assess the patient at a minimum of every six (6) months;

3. Periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities in an effort to reduce the potential for abuse or the development of an opioid use disorder as defined by the American Psychiatric Association and document with specificity the efforts undertaken;

4. Review the central repository information in accordance with Section 2-309D of this title; and

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5. Monitor compliance with the patient-provider agreement and any recommendations that the patient seek a referral.

G. 1. Any prescription for acute pain pursuant to this section shall have the words "acute pain" notated on the face of the prescription by the practitioner.

2. Any prescription for chronic pain pursuant to this section shall have the words "chronic pain" notated on the face of the prescription by the practitioner.

H. This section shall not apply to a prescription for a patient:

1. Who has sickle cell disease;

2. Who is in treatment for cancer or receiving aftercare cancer treatment;

3. Who is receiving hospice care from a licensed hospice;

4. Who is receiving palliative care in conjunction with a serious illness;

5. Who is a resident of a long-term care facility; or

6. For any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

I. Every policy, contract or plan delivered, issued, executed or renewed in this state, or approved for issuance or renewal in this state by the Insurance Commissioner, and every contract purchased by the Employees Group Insurance Division of the Office of Management and Enterprise Services, on or after November 1, 2018, that provides coverage for prescription drugs subject to a copayment, coinsurance or deductible shall charge a copayment, coinsurance or deductible for an initial prescription of an opioid drug prescribed pursuant to this section that is either:

1. Proportional between the cost sharing for a thirty-day supply and the amount of drugs the patient was prescribed; or

2. Equivalent to the cost sharing for a full thirty-day supply of the drug, provided that no additional cost sharing may be charged for any additional prescriptions for the remainder of the thirty-day supply.

J. Any practitioner authorized to prescribe an opioid drug shall adopt and maintain a written policy or policies that include execution of a written agreement to engage in an informed consent process between the prescribing practitioner and qualifying opioid therapy patient. For the purposes of this section, "qualifying opioid therapy patient" means:

1. A patient requiring opioid treatment for more than three (3) months;

2. A patient who is prescribed benzodiazepines and opioids together for more than one twenty-four-hour period; or

3. A patient who is prescribed a dose of opioids that exceeds one hundred (100) morphine equivalent doses.

K. Nothing in the Anti-Drug Diversion Act shall be construed to require a practitioner to limit or forcibly taper a patient on opioid therapy. The standard of care requires effective and individualized treatment for each patient as deemed appropriate by the prescribing practitioner without an administrative or codified limit on dose or quantity that is more restrictive than approved by the Food and Drug Administration (FDA).

Historical Data

Laws 2018, SB 1446, c. 175, § 5, eff. November 1, 2018; Amended by Laws 2019, HB 1155, c. 139, § 1, eff. November 1, 2019, amended by Laws 2019, SB 848, c. 428, § 19, emerg. eff. May 21, 2019 (superseded document available); Amended by Laws 2021, SB 57, c. 395, § 2, emerg. eff. May 3, 2021 (superseded document available); Amended by Laws 2022, HB 3073, c. 257, § 1 (superseded document available).

Citationizer® Summary of Documents Citing This Document

Cite Name	*Level*	
Title 63. Public Health and Safety		
Cite	*Name*	*Level*
63 O.S. 2-309I,	*Prescription Requirements for Opioids and Benzodiazepines - Copayment, Co-Insurance, or Deductible - Provider Policy - Standard of Care*	*Cited*

Citationizer: Table of Authority

Cite	*Name*	*Level*
None Found.		

OKLAHOMA STATE COURTS NETWORK

Title 63. Public Health and Safety

Oklahoma Statutes Citationized

Title 63. Public Health and Safety

Chapter 2 - Uniform Controlled Dangerous Substances Act

Article Article 5 - Enforcement and Administration

Section 2-551 - Controlled Dangerous Drugs - Treatment of Pain Relief

Cite as: O.S. §, ___

A. Schedule II, III, IV and V controlled dangerous drugs have useful and legitimate medical and scientific purposes and are necessary to maintain the health and general welfare of the people of this state.

B. The State of Oklahoma recognizes that principles of quality medical practice dictate that the people of the State of Oklahoma have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as to reduce the morbidity, and costs associated with untreated or inappropriately treated pain. The State of Oklahoma encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic. It is especially important for patients who experience pain as a result of terminal illness.

C. If, in the judgment of the medical doctor or the doctor of osteopathic medicine, appropriate pain management warrants a high dosage of controlled dangerous drugs and the benefit of the relief expected outweighs the risk of the high dosage, the medical doctor or doctor of osteopathic medicine may administer such a dosage, even if its use may increase the risk of death, so long as it is not also furnished for the purpose of causing, or the purpose of assisting in causing, death for any reason and so long as it falls within policies, guidelines and rules of the Oklahoma State Board of Medical Licensure and Supervision or the Oklahoma State Board of Osteopathic Examiners.

D. The Oklahoma State Board of Medical Licensure and Supervision and the Oklahoma State Board of Osteopathic Examiners shall issue policies, guidelines or rules that ensure that physicians who are engaged in the appropriate treatment of pain are not subject to disciplinary action, and the Boards shall consider policies and guidelines developed by national organizations with expertise in pain medicine or in a medical discipline for this purpose.

Historical Data

Laws 1998, HB 2624, c. 387, § 1, eff. November 1, 1998.

Citationizer® Summary of Documents Citing This Document

Cite Name	*Level*	
Oklahoma Attorney General's Opinions		
Cite	*Name*	*Level*
2001 OK AG 28,	*Question Submitted by: Lyle R. Kelsey, CAE, Executive Director, Board of Medical Licensure and Supervision*	*Cited*

Citationizer: Table of Authority

Cite	*Name*	*Level*
None Found.		

OKLAHOMA STATE COURTS NETWORK

Title 63. Public Health and Safety

Oklahoma Statutes Citationized

Title 63. Public Health and Safety

Chapter 2 - Uniform Controlled Dangerous Substances Act

Anti-Drug Diversion Act

Article Article 3 - Regulation of Manufacture, Distribution, Dispensing, Prescribing, Administering, and Using for Scientific Purposes of Controlled Dangerous Substances

Section 2-309I - Prescription Requirements for Opioids and Benzodiazepines - Copayment, Co-Insurance, or Deductible - Provider Policy - Standard of Care

This Statute Will Go Into Effect

Effective On: 11/01/2026

See Historical Data for Current Version

Cite as: 63 O.S. § 2-309I (OSCN 2026), Anti-Drug Diversion Act

A. Prior to issuing an initial prescription for an opioid drug in a course of treatment for acute or chronic pain, a practitioner shall:

1. Take and document the results of a thorough medical history, including the experience of the patient with nonopioid medication and nonpharmacological pain-management approaches and substance abuse history;

2. Conduct, as appropriate, and document the results of a physical examination;

3. Develop a treatment plan with particular attention focused on determining the cause of pain of the patient;

4. Access relevant prescription monitoring information from the central repository pursuant to Section 2-309D of this title;

5. In the case of a patient under the age of eighteen (18) years, enter into a patient-provider agreement with a parent or guardian of the patient; and

6. In the case of a patient who is a pregnant woman, enter into a patient-provider agreement with the patient.

B. 1. A practitioner shall not issue an initial prescription for an opioid drug for treatment of acute pain in a quantity exceeding a seven-day supply, as determined by the directed dosage and frequency of dosage.

2. Any initial or subsequent opioid prescription for acute pain shall be for the lowest effective dose of an immediate-release drug.

3. The practitioner may issue the initial seven-day prescription in divided quantities, which shall only count as a single prescription for purposes of the requirements of this section.

C. Except as provided in subsection D of this section, no less than seven (7) days after issuing the initial acute pain prescription pursuant to subsection B of this section, the practitioner, after consultation with the patient, may issue a subsequent acute pain prescription for the opioid drug to the patient in a quantity not to exceed seven (7) days, provided that:

1. The subsequent prescription would not be deemed an initial prescription under this section;

2. The practitioner determines the prescription is necessary and appropriate to the treatment needs of the patient and documents the rationale for the issuance of the subsequent prescription; and

3. The practitioner determines that issuance of the subsequent prescription does not present an undue risk of abuse, addiction or diversion and documents that determination.

D. 1. The practitioner may issue the subsequent seven-day acute pain prescription under subsection C of this section in divided quantities, which shall only count as a single prescription for purposes of the requirements of this section.

2. Notwithstanding the timing and quantity restrictions specified in subsection C of this section, upon issuing an initial prescription of an opioid drug for acute pain under subsection B of this section, the practitioner may simultaneously issue one subsequent prescription for an opioid drug in a quantity not to exceed seven (7) days if:

a. the subsequent prescription is due to a major surgical procedure or confined to home status as described in 42 U.S.C., Section 1395n(a),

b. the practitioner provides the subsequent prescription on the same day as the initial prescription,

c. the practitioner provides written instructions on the subsequent prescription indicating the earliest date on which the prescription may be filled, otherwise known as a "do not fill until" date, and

d. the subsequent prescription is dispensed no more than five (5) days after the "do not fill until" date indicated on the prescription.

E. Prior to issuing the initial prescription of an opioid drug in a course of treatment for acute or chronic pain and again prior to issuing the third prescription of the course of treatment, a practitioner shall discuss with the patient or the parent or guardian of the patient if the patient is under eighteen (18) years of age and is not an emancipated minor, the risks associated with the drugs being prescribed, including, but not limited to:

1. The risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants;

2. The reasons why the prescription is necessary;

3. Alternative treatments that may be available; and

4. Risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed or mixing sedatives, benzodiazepines or alcohol with opioids can result in fatal respiratory depression.

The practitioner shall include a note in the medical record of the patient that the patient or the parent or guardian of the patient, as applicable, has discussed with the practitioner the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available. The applicable state licensing board of the practitioner shall develop and make available to practitioners guidelines for the discussion required pursuant to this subsection.

F. At the time of the issuance of the third prescription for an opioid drug, the practitioner shall enter into a patient-provider agreement with the patient.

G. When an opioid drug is continuously prescribed for three (3) months or more for chronic pain, the practitioner shall:

1. Review, at a minimum of every three (3) months, the course of treatment, any new information about the etiology of the pain, and the progress of the patient toward treatment objectives and document the results of that review;

2. In the first year of the patient-provider agreement, assess the patient prior to every renewal to determine whether the patient is experiencing problems associated with an opioid use disorder as defined by the American Psychiatric Association and document the results of that assessment. Following one (1) year of compliance with the patient-provider agreement, the practitioner shall assess the patient at a minimum of every six (6) months;

3. Periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, or try other drugs or treatment modalities in an effort to reduce the potential for abuse or the development of an opioid use disorder as defined by the American Psychiatric Association and document with specificity the efforts undertaken;

4. Review the central repository information in accordance with Section 2-309D of this title; and

5. Monitor compliance with the patient-provider agreement and any recommendations that the patient seek a referral.

H. 1. Any prescription for acute pain pursuant to this section shall have the words "acute pain" notated on the face of the prescription by the practitioner.

2. Any prescription for chronic pain pursuant to this section shall have the words "chronic pain" notated on the face of the prescription by the practitioner.

I. This section shall not apply to a prescription for a patient:

1. Who has sickle cell disease;

2. Who is in treatment for cancer or receiving aftercare cancer treatment;

3. Who is receiving hospice care from a licensed hospice;

4. Who is receiving palliative care in conjunction with a serious illness;

5. Who is a resident of a long-term care facility; or

6. For any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

J. Every policy, contract, or plan delivered, issued, executed, or renewed in this state, or approved for issuance or renewal in this state by the Insurance Commissioner, and every contract purchased by the Employees Group Insurance Division of the Office of Management and Enterprise Services, on or after November 1, 2018, that provides coverage for prescription drugs subject to a copayment, coinsurance or deductible shall charge a copayment, coinsurance, or deductible for an initial prescription of an opioid drug prescribed pursuant to this section that is either:

1. Proportional between the cost sharing for a thirty-day supply and the amount of drugs the patient was prescribed; or

2. Equivalent to the cost sharing for a full thirty-day supply of the drug, provided that no additional cost sharing may be charged for any additional prescriptions for the remainder of the thirty-day supply.

K. Any practitioner authorized to prescribe an opioid drug shall adopt and maintain a written policy or policies that include execution of a written agreement to engage in an informed consent process between the prescribing practitioner and qualifying opioid therapy patient. For the purposes of this section, "qualifying opioid therapy patient" means:

1. A patient requiring opioid treatment for more than three (3) months;

2. A patient who is prescribed benzodiazepines and opioids together for more than one twenty-four-hour period; or

3. A patient who is prescribed a dose of opioids that exceeds one hundred (100) morphine equivalent doses.

L. Nothing in this section shall be construed to require a practitioner to limit or forcibly taper a patient on opioid therapy. The standard of care requires effective and individualized treatment for each patient as deemed appropriate by the prescribing practitioner without an administrative or codified limit on dose or quantity that is more restrictive than approved by the Food and Drug Administration (FDA).

Historical Data

Laws 2018, SB 1446, c. 175, § 5, eff. November 1, 2018; Amended by Laws 2019, HB 1155, c. 139, § 1, eff. November 1, 2019, amended by Laws 2019, SB 848, c. 428, § 19, emerg. eff. May 21, 2019 (superseded document available); Amended by Laws 2021, SB 57, c. 395, § 2, emerg. eff. May 3, 2021 (superseded document available); Amended by Laws 2022, HB 3073, c. 257, § 1 (superseded document available); Amended by Laws 2026, SB 1642, c. 228, § 1, eff. November 1, 2026 (superseded document available).

Citationizer® Summary of Documents Citing This Document

Cite Name	*Level*	
Title 59. Professions and Occupations		
Cite	*Name*	*Level*
59 O.S. 567.8,	*Denial, Revocation or Suspension of Licensure - Grounds - Charges, Investigations and Hearings - Reinstatement - Appeal*	*Cited*
59 O.S. 509,	*Unprofessional Conduct - Definition*	*Cited*
59 O.S. 328.32,	*Dentist - Grounds for Penalties*	*Cited*
59 O.S. 637,	*Disciplinary Actions - Violations - Burden - Emergency Suspension - Judicial Review - Rules*	*Cited*

Citationizer: Table of Authority

Cite Name	*Level*	
Oklahoma Session Laws - 2026		
Cite	*Name*	*Level*
2026 O.S.L. 228, 2026 O.S.L. 228,	*[SB 1642] - Opioid prescription guidelines*	*Cited*
Title 63. Public Health and Safety		
Cite	*Name*	*Level*
63 O.S. 2-309D,	*Confidential Nature of Information - Disclosure - Investigative Reports*	*Discussed*
63 O.S. 2-309I,	*Prescription Requirements for Opioids and Benzodiazepines - Copayment, Co-Insurance, and Deductible - Provider Policy*	*Cited*
63 O.S. 2-309I,	*Prescription Requirements for Opioids and Benzodiazepines - Copayment, Co-Insurance, or Deductible - Provider Policy*	*Cited*
63 O.S. 2-309I,	*Prescription Requirements for Opioids and Benzodiazepines - Copayment, Co-Insurance, or Deductible - Provider Policy - Standard of Care*	*Cited*
63 O.S. 2-309I,	*Prescription Requirements for Opioids and Benzodiazepines - Copayment, Co-Insurance, or Deductible - Provider Policy - Standard of Care*	*Cited*

An Act

ENROLLED SENATE
BILL NO. 1642

By: Frix of the Senate

and

Marti of the House

An Act relating to controlled dangerous substances; amending 63 O.S. 2021, Section 2-309I, as amended by Section 1, Chapter 257, O.S.L. 2022 (63 O.S. Supp. 2025, Section 2-309I), which relates to prescription limits and rules for opioid drugs; authorizing divided quantities for certain acute pain prescriptions; updating statutory language; modifying statutory references; and providing an effective date.

SUBJECT: Opioid prescription guidelines

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 63 O.S. 2021, Section 2-309I, as amended by Section 1, Chapter 257, O.S.L. 2022 (63 O.S. Supp. 2025, Section 2-309I), is amended to read as follows:

Section 2-309I. A. ~~A practitioner shall not issue an initial prescription for an opioid drug in a quantity exceeding a seven-day supply for treatment of acute pain. Any opioid prescription for acute pain shall be for the lowest effective dose of an immediate-release drug.~~

~~B.~~ Prior to issuing an initial prescription for an opioid drug in a course of treatment for acute or chronic pain, a practitioner shall:

1. Take and document the results of a thorough medical history, including the experience of the patient with nonopioid medication and nonpharmacological pain-management approaches and substance abuse history;

2. Conduct, as appropriate, and document the results of a physical examination;

3. Develop a treatment plan with particular attention focused on determining the cause of pain of the patient;

4. Access relevant prescription monitoring information from the central repository pursuant to Section 2-309D of this title;

5. ~~Limit the supply of any opioid drug prescribed for acute pain to a duration of no more than seven (7) days as determined by the directed dosage and frequency of dosage; provided, however, upon issuing an initial prescription for acute pain pursuant to this section, the practitioner may issue one (1) subsequent prescription for an opioid drug in a quantity not to exceed seven (7) days if:~~

~~a. the subsequent prescription is due to a major surgical procedure or "confined to home" status as defined in 42 U.S.C., Section 1395n(a),~~

~~b. the practitioner provides the subsequent prescription on the same day as the initial prescription,~~

~~c. the practitioner provides written instructions on the subsequent prescription indicating the earliest date on which the prescription may be filled, otherwise known as a "do not fill until" date, and~~

~~d. the subsequent prescription is dispensed no more than five (5) days after the "do not fill until" date indicated on the prescription;~~

~~6.~~ In the case of a patient under the age of eighteen (18) years, enter into a patient-provider agreement with a parent or guardian of the patient; and

~~7.~~ 6. In the case of a patient who is a pregnant woman, enter into a patient-provider agreement with the patient.

B. 1. A practitioner shall not issue an initial prescription for an opioid drug for treatment of acute pain in a quantity exceeding a seven-day supply, as determined by the directed dosage and frequency of dosage.

2. Any initial or subsequent opioid prescription for acute pain shall be for the lowest effective dose of an immediate-release drug.

3. The practitioner may issue the initial seven-day prescription in divided quantities, which shall only count as a single prescription for purposes of the requirements of this section.

C. ~~No~~ Except as provided in subsection D of this section, no less than seven (7) days after issuing the initial acute pain prescription pursuant to subsection ~~A~~ B of this section, the practitioner, after consultation with the patient, may issue a subsequent acute pain prescription for the opioid drug to the patient in a quantity not to exceed seven (7) days, provided that:

1. The subsequent prescription would not be deemed an initial prescription under this section;

2. The practitioner determines the prescription is necessary and appropriate to the treatment needs of the patient and documents the rationale for the issuance of the subsequent prescription; and

3. The practitioner determines that issuance of the subsequent prescription does not present an undue risk of abuse, addiction or diversion and documents that determination.

D. 1. The practitioner may issue the subsequent seven-day acute pain prescription under subsection C of this section in divided quantities, which shall only count as a single prescription for purposes of the requirements of this section.

2. Notwithstanding the timing and quantity restrictions specified in subsection C of this section, upon issuing an initial prescription of an opioid drug for acute pain under subsection B of

this section, the practitioner may simultaneously issue one subsequent prescription for an opioid drug in a quantity not to exceed seven (7) days if:

a. the subsequent prescription is due to a major surgical procedure or confined to home status as described in 42 U.S.C., Section 1395n(a),

b. the practitioner provides the subsequent prescription on the same day as the initial prescription,

c. the practitioner provides written instructions on the subsequent prescription indicating the earliest date on which the prescription may be filled, otherwise known as a "do not fill until" date, and

d. the subsequent prescription is dispensed no more than five (5) days after the "do not fill until" date indicated on the prescription.

E. Prior to issuing the initial prescription of an opioid drug in a course of treatment for acute or chronic pain and again prior to issuing the third prescription of the course of treatment, a practitioner shall discuss with the patient or the parent or guardian of the patient if the patient is under eighteen (18) years of age and is not an emancipated minor, the risks associated with the drugs being prescribed, including, but not limited to:

1. The risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants;

2. The reasons why the prescription is necessary;

3. Alternative treatments that may be available; and

4. Risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed or mixing

sedatives, benzodiazepines or alcohol with opioids can result in fatal respiratory depression.

The practitioner shall include a note in the medical record of the patient that the patient or the parent or guardian of the patient, as applicable, has discussed with the practitioner the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available. The applicable state licensing board of the practitioner shall develop and make available to practitioners guidelines for the discussion required pursuant to this subsection.

~~E.~~ F. At the time of the issuance of the third prescription for an opioid drug, the practitioner shall enter into a patient-provider agreement with the patient.

~~F.~~ G. When an opioid drug is continuously prescribed for three (3) months or more for chronic pain, the practitioner shall:

1. Review, at a minimum of every three (3) months, the course of treatment, any new information about the etiology of the pain, and the progress of the patient toward treatment objectives and document the results of that review;

2. In the first year of the patient-provider agreement, assess the patient prior to every renewal to determine whether the patient is experiencing problems associated with an opioid use disorder as defined by the American Psychiatric Association and document the results of that assessment. Following one (1) year of compliance with the patient-provider agreement, the practitioner shall assess the patient at a minimum of every six (6) months;

3. Periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, or try other drugs or treatment modalities in an effort to reduce the potential for abuse or the development of an opioid use disorder as defined by the American Psychiatric Association and document with specificity the efforts undertaken;

4. Review the central repository information in accordance with Section 2-309D of this title; and

5. Monitor compliance with the patient-provider agreement and any recommendations that the patient seek a referral.

~~G.~~ H. 1. Any prescription for acute pain pursuant to this section shall have the words "acute pain" notated on the face of the prescription by the practitioner.

2. Any prescription for chronic pain pursuant to this section shall have the words "chronic pain" notated on the face of the prescription by the practitioner.

~~H.~~ I. This section shall not apply to a prescription for a patient:

1. Who has sickle cell disease;

2. Who is in treatment for cancer or receiving aftercare cancer treatment;

3. Who is receiving hospice care from a licensed hospice;

4. Who is receiving palliative care in conjunction with a serious illness;

5. Who is a resident of a long-term care facility; or

6. For any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

~~I.~~ J. Every policy, contract, or plan delivered, issued, executed, or renewed in this state, or approved for issuance or renewal in this state by the Insurance Commissioner, and every contract purchased by the Employees Group Insurance Division of the Office of Management and Enterprise Services, on or after November 1, 2018, that provides coverage for prescription drugs subject to a copayment, coinsurance or deductible shall charge a copayment, coinsurance, or deductible for an initial prescription of an opioid drug prescribed pursuant to this section that is either:

1. Proportional between the cost sharing for a thirty-day supply and the amount of drugs the patient was prescribed; or

2. Equivalent to the cost sharing for a full thirty-day supply of the drug, provided that no additional cost sharing may be charged for any additional prescriptions for the remainder of the thirty-day supply.

~~J.~~ K. Any practitioner authorized to prescribe an opioid drug shall adopt and maintain a written policy or policies that include execution of a written agreement to engage in an informed consent process between the prescribing practitioner and qualifying opioid therapy patient. For the purposes of this section, "qualifying opioid therapy patient" means:

1. A patient requiring opioid treatment for more than three (3) months;

2. A patient who is prescribed benzodiazepines and opioids together for more than one twenty-four-hour period; or

3. A patient who is prescribed a dose of opioids that exceeds one hundred (100) morphine equivalent doses.

~~K.~~ L. Nothing in ~~the Anti-Drug Diversion Act~~ this section shall be construed to require a practitioner to limit or forcibly taper a patient on opioid therapy. The standard of care requires effective and individualized treatment for each patient as deemed appropriate by the prescribing practitioner without an administrative or codified limit on dose or quantity that is more restrictive than approved by the Food and Drug Administration (FDA).

SECTION 2. This act shall become effective November 1, 2026.

Passed the Senate the 2nd day of March, 2026.

_____
Presiding Officer of the Senate

Passed the House of Representatives the 29th day of April, 2026.

_____
Presiding Officer of the House
of Representatives

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____

Approved by the Governor of the State of Oklahoma this _____

day of _____, 20_____, at _____ o'clock _____ M.

_____
Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____

day of _____, 20 _____, at _____ o'clock _____ M.

By: _____

adha™ | Oklahoma DENTAL HYGIENISTS' ASSOCIATION

September 28, 2026

Dear OK Board of Dentistry Members,

On behalf of the Oklahoma Dental Hygienists' Association, I respectfully ask the Board to support adding two elected registered dental hygienist seats, bringing the total to three RDH members elected by Oklahoma dental hygienists.

The Board regulates dental hygiene as part of its responsibility to protect the public. We believe additional RDH members would strengthen that work for the following reasons:

- RDHs should help shape decisions that affect dental hygiene. The Board currently has eight dentist seats, one dental hygienist seat, and two public seats. Adding two RDH seats would bring more direct experience to discussions about dental hygiene while preserving strong dentist representation.
- Three RDHs would bring a broader view of patient care. Hygienists work in private and group practices, public health, education, and communities across Oklahoma. One member cannot be expected to speak from every perspective.
- RDHs are essential to dental practices. We provide preventive and periodontal care, educate patients, and build ongoing relationships that help them stay engaged in their oral health. Our experience can help the Board understand how proposed rules work in daily practice.
- We are showing up and ready to serve. Dental hygienists want to participate in decisions that affect our patients, colleagues, and profession. Additional elected seats would give that commitment a meaningful place at the table.
- More RDH voices would support collaboration and public protection. We want to work with dentists, dental assistants, public members, and Board staff toward safe care and successful practices for every profession the Board regulates. Protecting the public is one of our highest priorities.
- Additional members would provide continuity. When one RDH member's term ends, the others could retain knowledge of the Board's ongoing work and help a new member contribute sooner.

Oklahoma dental hygienists are showing up because we care about our patients and the success of the entire dental team. We ask for two additional elected RDH seats so the Board can hear a wider range of dental hygiene perspectives when making decisions that affect our practice. We are ready to collaborate with dentists and the Board, bring practical experience to the table, and help every profession succeed in serving Oklahomans.

Because the number of Board seats is established in state law, we ask the Board to support the legislative change needed to add these two elected RDH seats. Thank you for considering our request. We welcome the opportunity to discuss it with you.

Respectfully,

Carly Mindemann, RDH, BSDH
President, Oklahoma Dental Hygienists' Association

Oklahoma
DENTAL HYGIENISTS' ASSOCIATION

September 28, 2026

Dear Members of the Oklahoma Board of Dentistry:

On behalf of the Oklahoma Dental Hygienists' Association (OKDHA), I respectfully request that the Board select a licensed dental hygienist to serve as Oklahoma's commissioner on the Dentist and Dental Hygienist Compact Commission.

Oklahoma's enactment of the compact through Senate Bill 540 was an important step for both dentists and dental hygienists. OKDHA worked to advance this legislation in alignment with the American Dental Hygienists' Association, the Council of State Governments, and other stakeholders. We share the Board's interest in implementing the compact successfully and supporting safe, effective care across both professions.

The commission will make decisions about the compact's administration that affect dental hygienists as well as dentists. An RDH commissioner would bring direct knowledge of dental hygiene education, licensure, clinical practice, and workforce needs to those discussions. That perspective would strengthen Oklahoma's contribution to the commission while supporting collaborative work with dentists and the Board.

We ask the Board to consider a qualified dental hygienist member when selecting Oklahoma's commissioner. If a commissioner has already been selected, we ask the Board to establish a meaningful role for an RDH in Oklahoma's ongoing compact work and to consider RDH representation as well.

OKDHA welcomes the opportunity to discuss this request with the Board and to help identify qualified dental hygienists willing to serve. We appreciate the Board's consideration and look forward to working together on a successful implementation of the compact.

Respectfully,

Carly Mindemann, RDH, BSDH
President, Oklahoma Dental Hygienists' Association