



<b>PERSONNEL (Please provide a copy of each to the evaluator)</b>		
ACLS/PALS Certification of Sedation Provider?	YES	NO
Assistant and/or Auxiliary personnel Basic Life Support for Healthcare Providers Certification?	YES	NO

OVERALL PERSONNEL? \_\_\_\_\_ Adequate \_\_\_\_\_ Inadequate

<b>RECORDS (Please provide a copy of each to the evaluator)</b>		
Medical History Form (which should include ASA Patient Physical Status Classifications)	YES	NO
Preoperative Instructions	YES	NO
Sedation Consent Form	YES	NO
Postoperative Instructions	YES	NO

OVERALL RECORDS? \_\_\_\_\_ Adequate \_\_\_\_\_ Inadequate

<b>SIMULATED EMERGENCIES – The DDS/DMD and his/her clinical team must indicate competency (by demonstration or discussion) in treating the following emergencies.</b>		
Laryngospasm	_____ Satisfactory	_____ Unsatisfactory
Bronchospasm and Airway Obstruction	_____ Satisfactory	_____ Unsatisfactory
Emesis and Aspiration	_____ Satisfactory	_____ Unsatisfactory
Angina Pectoris	_____ Satisfactory	_____ Unsatisfactory
Myocardial Infarction	_____ Satisfactory	_____ Unsatisfactory
Cardiac Arrest	_____ Satisfactory	_____ Unsatisfactory
Hypotension	_____ Satisfactory	_____ Unsatisfactory
Hypertension	_____ Satisfactory	_____ Unsatisfactory
Acute Allergic Reaction	_____ Satisfactory	_____ Unsatisfactory
Syncope, Loss of Consciousness	_____ Satisfactory	_____ Unsatisfactory
Hyperventilation	_____ Satisfactory	_____ Unsatisfactory
Convulsions	_____ Satisfactory	_____ Unsatisfactory



PATIENT CONSENT FORM

I, the undersigned, am a patient of \_\_\_\_\_ (hereinafter “dentist/dental specialist”). My dentist/dental specialist has explained to me that a periodic evaluation is required in connection with the anesthesia permit issued to him/her by the Idaho State Board of Dentistry (“Board of Dentistry”). The Board of Dentistry is required to routinely conduct evaluations of all the anesthesia permit holders in Idaho. My dentist/dental specialist has further explained to me that it is necessary for one (1) or more Idaho State Board of Dentistry evaluators to personally observe the treatment provided to a patient. The evaluators are also dentists/dental specialists who are anesthesia permits holders in Idaho. My dentist/dental specialist has requested my consent to allow the Board of Dentistry’s evaluators to observe the treatment provided to me. Although my dentist/dental specialist may discuss my treatment with the evaluators and that the evaluators may discuss my treatment between themselves, I understand that the evaluators will treat any of the information they receive during their evaluation as confidential. Therefore, I hereby freely, knowingly and voluntarily consent to and authorize the Board of Dentistry’s evaluators to observe the treatment provided to me by my dentist/dental specialist. This consent shall be in full force and effect for a period of fourteen (14) days from the date of its execution, at which time it will expire.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date