



STATE OF IDAHO – BOARD OF DENTISTRY
OFFICE INSPECTION FORM

Inspector's Name: _____ Date of Inspection: _____

Address of Dental Office: _____

Name(s) of Dentist(s) in Practice: _____

Name(s) of Hygienist(s) in Practice: _____

DISPLAY OF PROFESSIONAL LICENSE

- Yes/No Dentist(s) Displayed or Produced Valid License Upon Request
Yes/No Dental Hygienist(s) Displayed or Produced Valid License Upon Request

MEDICAL EMERGENCY DRUGS

- Yes/No Anti-anaphylactic Agent Expiration Date: _____
Yes/No Antihistaminic Expiration Date: _____
Yes/No Aspirin Expiration Date: _____
Yes/No Bronchodilator Expiration Date: _____
Yes/No Coronary Artery Vasodilator Expiration Date: _____
Yes/No Glucose Expiration Date: _____

INFECTION CONTROL

- Yes/No Barrier Equipment Used (gloves, masks, protective eyewear, etc.)
Yes/No Sharps and Bio-Hazard Disposal Containers Available
Yes/No Water Systems: Following CDC Guidelines for Flushing and Monitoring

STERILIZATION AND DISINFECTION

Check All Sterilization Techniques Used:

- Steam Sterilization Chemical Vapor Cold Sterilization Dry Heat Sterilization
Yes/No Chemical Indicators Used (tape, strips, tabs, etc.)
Yes/No Clean Supplies and Instruments Stored in Closed or Covered Cabinet
Yes/No Equipment Barriers Used (light handles, keyboards, etc.)
Yes/No Surfaces Disinfected

BIOLOGIC MONITORING

- Independent Testing Agency In-House Testing
Yes/No Spore Testing Done Weekly
Yes/No Spore Test Results Documented/Logged

ADDITIONAL REVIEWER COMMENTS:

I understand that my dental office was randomly selected by the Idaho State Board of Dentistry in furtherance of the Board of Dentistry's obligation to conduct inspections of dental offices in the state. I acknowledge that my dental office was inspected on the above-mentioned date and that I was provided with a copy of the results of the review.

Dentist

Date

Inspector

Date

REQUIRED FOR OFFICES USING LOCAL ANESTHESIA

- Yes/No Suction Equipment
Yes/No Portable Oxygen
Yes/No Full Face Mask Suitable for the Patient Being Treated
Yes/No Bag Valve Mask
Yes/No Blood Pressure Cuff
Yes/No Stethoscope

REQUIRED FOR OFFICES USING NITROUS OXIDE

- Yes/No System Prohibits the Delivery of Less Than Thirty Percent (30%) Oxygen or Calibrated and Functioning Oxygen Analyzer with Audible Alarm
Yes/No Scavenging System
Yes/No Positive-Pressure Oxygen Delivery System Suitable for the Patient Being Treated
Yes/No Current Certification in BLS for Healthcare Providers for All Auxiliary Personnel