Chapter 246-817 WAC
DENTAL QUALITY ASSURANCE COMMISSION
(Formerly chapters 246-816 and 246-818 WAC)

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

246-817-170 Applications—Permits—Renewals for the administration of conscious sedation with multiple oral or parenteral agents or general anesthesia (including deep sedation). [Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-170, filed 10/10/95, effective 11/10/95.] Repealed by 09-04-042, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.640 and 18.32.0365.

246-817-175 Conscious sedation with parenteral or multiple oral agents—Education and training requirements—Application. [Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-175, filed 10/10/95, effective 11/10/95.] Repealed by 09-04-042, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.640 and 18.32.0365.

246-817-180 General anesthesia (including deep sedation)—Education and training requirements. [Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-180, filed 10/10/95, effective 11/10/95.] Repealed by 09-04-042, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.640 and 18.32.0365.

246-817-201 Application for licensure—AIDS education requirements. [Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-201, filed 10/10/95, effective 11/10/95.] Repealed by 98-05-060, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.280.

246-817-750 Conscious sedation with an oral agent. [Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-750, filed 10/10/95, effective 11/10/95.] Repealed by 09-04-042, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.640 and 18.32.0365.

DENTISTS

WAC 246-817-001 Purpose. The purpose of these rules is to further clarify and define chapter 18.32 RCW, Dentistry.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-001, filed 10/10/95, effective 11/10/95.]

WAC 246-817-010 Definitions. The following general terms are defined within the context used in this chapter.

"Acquired immunodeficiency syndrome" or **"AIDS"** means the clinical syndrome of HIV-related illness as defined by the board of health by rule.

"Clinics" are locations situated away from the School of Dentistry on the University of Washington campus, as recommended by the dean in writing and approved by the DQAC.

"CITA" means Council of Interstate Testing Agencies, a regional dental testing agency that provides clinical dental testing services.

"CRDTS" means Central Regional Dental Testing Services, a regional testing agency that provides clinical dental testing services.

"Department" means the department of health.

"DQAC" means the dental quality assurance commission as established by RCW 18.32.0351.

"Facility" is defined as the building housing the School of Dentistry on the University of Washington campus, and other buildings, designated by the dean of the dental school and approved by the DQAC.

"NERB" means the Northeast Regional Board, a regional testing agency that provides clinical dental testing services.

"Office on AIDS" means that section within the department of health or any successor department with jurisdiction over public health matters as defined in chapter 70.24 RCW.

"Secretary" means the secretary of the department of health or the secretary's designee.

"SRTA" means the Southern Regional Testing Agency, a regional testing agency that provides clinical dental testing services.

"WREB" means the Western Regional Examining Board, a national testing agency that provides clinical dental testing services.

[Statutory Authority: RCW 18.32.0365 and 18.32.040. 08-23-019, § 246-817-010, filed 11/6/08, effective 12/7/08. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-010, filed 10/10/95, effective 11/10/95.]

WAC 246-817-015 Adjudicative proceedings—Procedural rules for the dental quality assurance commission. The DQAC adopts the model procedural rules for adjudicative proceedings as adopted by the department of health and contained in chapter 246-11 WAC, including subsequent amendments.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-015, filed 10/10/95, effective 11/10/95.]

LICENSURE—APPLICATION AND ELIGIBILITY REQUIREMENTS

WAC 246-817-101 Dental licenses—Types authorized. The DQAC is granted the authority to issue the following types of dental licenses or permits:

(1) Licensure by examination standard. (RCW 18.32.040)

(2) Licensure without examination—Licensed in another state. (RCW 18.32.215)

(3) Faculty licensure. (RCW 18.32.195)

(4) Dental resident licensure. (RCW 18.32.195)

(5) Conscious sedation permits. (RCW 18.32.640)

(6) Anesthesia permits. (RCW 18.32.640)

(7) Temporary practice permits. (RCW 18.130.075)

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-101, filed 10/10/95, effective 11/10/95.]

WAC 246-817-110 Dental licensure—Initial eligibility and application requirements. To be eligible for Washington state dental licensure, the applicant must provide:

(1) A completed application and fee. The applicant must submit a signed, notarized application and required fee as defined in WAC 246-817-990;

(2) Proof of graduation from a dental school approved by the DQAC:

(a) DQAC recognizes only those applicants who are students or graduates of dental schools in the United States or Canada, approved, conditionally or provisionally, by the Commission on Dental Accreditation of the American Dental Association. The applicant must have received, or will receive, a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) degree from that school;

(b) Other dental schools which apply for DQAC approval and which meet these adopted standards to the DQAC's satisfaction may be approved, but it is the responsibility of a school to apply for approval and of a student to ascertain whether or not a school has been approved;

(3) Proof of successful completion of the National Board Dental Examination Parts I and II, or the Canadian National

Dental Examining Board Examination. An original scorecard or a certified copy of the scorecard shall be accepted. Exception: Dentists who obtained initial licensure in a state prior to that state's requirement for successful completion of the national boards, may be licensed in Washington, provided that the applicant provide proof that their original state of licensure did not require passage of the national boards at the time they were initially licensed. Applicants need to meet all other requirements for licensure;

(4) Proof of graduation from an approved dental school. The only acceptable proof is an official, posted transcript sent directly from such school, or in the case of recent graduates, a verified list of graduating students submitted directly from the dean of the dental school. Graduates of nonaccredited dental schools must also meet the requirements outlined in WAC 246-817-160;

(5) A complete listing of professional education and experience including college or university (predental), and a complete chronology of practice history from the date of dental school graduation to present, whether or not engaged in activities related to dentistry;

(6) Proof of completion of seven clock hours of AIDS education as required in chapter 246-12 WAC, Part 8;

(7) Proof of malpractice insurance if available, including dates of coverage and any claims history;

(8) Written certification of any licenses held, submitted directly from another licensing entity, and including license number, issue date, expiration date and whether applicant has been the subject of final or pending disciplinary action;

(9) Proof of successful completion of an approved:

(a) Practical/clinical examination; or

(b) A qualifying postgraduate residency program, approved by or administered under the direction of the DQAC;

(10) Proof of successful completion of an approved written jurisprudence examination;

(11) A recent 2" x 2" photograph, signed, dated, and attached to the application;

(12) Authorization for background inquiries to other sources may be conducted as determined by the DQAC, including but not limited to the national practitioner data bank and drug enforcement agency. Applicants are responsible for any fees incurred in obtaining verification of requirements;

(13) Any other information for each license type as determined by the DQAC.

[Statutory Authority: RCW 18.32.0365 and 18.32.040. 08-23-019, § 246-817-110, filed 11/6/08, effective 12/7/08. Statutory Authority: RCW 43.70.280. 98-05-060, § 246-817-110, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-110, filed 10/10/95, effective 11/10/95.]

WAC 246-817-120 Examination content. An applicant seeking licensure in Washington by examination, must successfully complete a written and practical examination approved by the DQAC.

(1) The examination will consist of:

(a) A written examination. Only the national board exam will be accepted, except as provided in (c) of this subsection.

(b) A practical/practice examination.

(i) The DQAC will accept the Western Regional Examining Board's (WREB) clinical examination as meeting its examination standard after January 1, 1995. The results of the WREB examination will be accepted for five years immediately preceding application for state licensure; or

(ii) The DQAC accepts the Central Regional Dental Testing Services (CRDTS) clinical examination as meeting its examination standard as of November 2001. The results of the CRDTS examination will be accepted for five years immediately preceding application for state licensure; or

(iii) The DQAC accepts the results of the Northeast Regional Board (NERB) and the Southern Regional Testing Agency (SRTA) clinical examinations as meeting its examination standard as of January 2006. The results of the NERB and SRTA examinations will be accepted for five years immediately preceding application for state licensure; or

(iv) The DQAC will consider acceptance of the examination results from candidates who pass the final portions of the Council of Interstate Testing Agency's (CITA) clinical examination after January 1, 2006; or

(v) The DQAC will consider acceptance of the examination results of those states with individual state board examinations after September 30, 2006.

(c) The DQAC may, at its discretion, give or require an examination in any other subject under (a) and (b) of this subsection, whether in written or practical form or both written and practical.

(2) An applicant for the practical/practice examination may obtain an application directly from the relevant regional testing agency, or individual state board.

[Statutory Authority: RCW 18.32.0365 and 18.32.040. 08-23-019, § 246-817-120, filed 11/6/08, effective 12/7/08. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-120, filed 10/10/95, effective 11/10/95.]

WAC 246-817-130 Licensure without examination for dentists—Eligibility. The DQAC may grant licensure without an examination to dentists licensed in other states if they meet the requirements of RCW 18.32.215 and WAC 246-817-110 and:

(1) Hold a valid license in another state;

(2) Are currently engaged in the practice of dentistry in another state;

(3) Are a graduate of a dental college, school, or dental department of an institution approved by the DQAC under RCW 18.32.040(1);

(4) Pay the applicable fees as defined in WAC 246-817-990;

(5) Agree to participate in a personal interview with the DQAC, if requested.

[Statutory Authority: RCW 18.32.0365 and 18.32.215. 08-23-017, § 246-817-130, filed 11/6/08, effective 12/7/08. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-130, filed 10/10/95, effective 11/10/95.]

WAC 246-817-135 Licensure without examination for dentists—Application procedure. The applicant is responsible for obtaining and furnishing to the DQAC all materials required to establish eligibility for a license without examination. In addition to the requirements defined in WAC 246-817-110 the following documentation must be provided:

(1) A statement by the applicant as to whether the applicant has been the subject of any disciplinary action in the

state(s) of licensure and whether the applicant has engaged in unprofessional conduct as defined in RCW 18.130.180.

(2) A statement by the applicant that they are not an impaired practitioner as defined in RCW 18.130.170.

(3) A certification by the state board(s) of dentistry (or equivalent authority) that the applicant was issued a license, registration, certificate or privilege to practice dentistry, without restrictions, and whether the applicant has been the subject of final or pending disciplinary action.

(4) Documentation to substantiate that standards defined in WAC 246-817-140 have been met.

(5) Proof that the applicant is currently engaged in the practice of dentistry, in another state as demonstrated by the following information:

(a) Address of practice location(s);

(b) Length of time at the location(s);

(c) A letter from all malpractice insurance carrier(s) defining years when insured and any claims history;

(d) Federal or state tax numbers;

(e) DEA numbers if any;

Dentists serving in the United States federal services as described in RCW 18.32.030(2), for the period of such service, need not provide (a) through (e) of this subsection, but must provide documentation from their commanding officer regarding length of service, duties and responsibilities including any adverse actions or restrictions. Such dental service, including service within the state of Washington, shall be credited toward the dental practice requirement.

Dentists employed by a dental school approved by the DQAC for the period of such dental practice, need not provide (a) through (e) of this subsection, but must provide documentation from the dean or appropriate administrator of the institution regarding the length and terms of employment and their duties and responsibilities, and any adverse actions or restrictions. Such dental practice, including practice within the state of Washington, shall be credited toward the dental practice requirement. Dental practice within a residency program shall be credited toward the dental practice requirement. A license may be revoked upon evidence of misinformation or substantial omission.

All information must be completed and received within one hundred eighty days of receipt of the initial application. Only completed applications will be reviewed by the DQAC, or its designee(s) at the next scheduled DQAC meeting or at other intervals as determined by the DQAC.

[Statutory Authority: RCW 18.32.0365 and 18.32.215. 08-23-017, § 246-817-135, filed 11/6/08, effective 12/7/08. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-135, filed 10/10/95, effective 11/10/95.]

WAC 246-817-140 Licensure without examination for dentists—Licensing examination standards. The DQAC has determined that the licensing and examination standards of all regional testing agencies, as defined in WAC 246-817-010, and all states with independent licensing examinations are adequate to meet the standards for licensure without examination in the state of Washington. The DQAC shall periodically review these standards.

[Statutory Authority: RCW 18.32.0365 and 18.32.215. 08-23-017, § 246-817-140, filed 11/6/08, effective 12/7/08. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-140, filed 10/10/95, effective 11/10/95.]

WAC 246-817-150 Licenses—Persons licensed or qualified out-of-state who are faculty at school of dentistry—Conditions. (1) The department shall provide an application for faculty licensure upon receipt of a written request from the dean of the University of Washington, School of Dentistry.

(2) Applicants for faculty licensure shall submit a signed, notarized application, including applicable fees, and other documentation as required by the DQAC.

(3) The dean of the University of Washington, School of Dentistry, or his designee, shall notify the department of health of any changes in employment status of any person holding a faculty license.

[Statutory Authority: RCW 18.32.0365 and 18.32.195. 11-11-073, § 246-817-150, filed 5/17/11, effective 6/17/11. Statutory Authority: RCW 43.70.280. 98-05-060, § 246-817-150, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-150, filed 10/10/95, effective 11/10/95.]

WAC 246-817-155 Dental resident license to full dental license—Conditions. To be eligible for full Washington state dental licensure, a postdoctoral dental resident must:

(1) Meet the initial application and eligibility requirements in WAC 246-817-110;

(2) Provide a completed application on forms provided by the secretary;

(3) Provide evidence of successful completion of a full-time postdoctoral dental residency program. The residency program must:

(a) Be one to three years in duration;

(b) Be located in Washington state;

(c) Be located in a community health clinic that serves predominantly low-income patients or located in a dental care health professional shortage area in this state;

(d) Include an outcome assessment evaluation, other than the clinical examinations assessing the resident's competence to practice dentistry listed in WAC 246-817-120;

(e) Provide a certificate of completion, signed and submitted directly to the department of health by the director of the dental residency program;

(f) Use standards of the American Dental Association's Commission on Dental Accreditation (ADA/CODA), for community clinics to use when sponsoring students in a residency program under RCW 18.32.040 (3)(c), including the ADA/CODA guidelines for proper supervision of residents and measurement of the resident's competency to practice dentistry;

(g) Be accredited by the ADA/CODA in the following programs:

(i) For advanced education programs general dentistry (AEGD); or

(ii) For advanced education programs general practice residency (GPR); or

(iii) For advanced specialty education programs.

(4) Provide evidence of successful completion of the jurisprudence examination;

(5) Provide any other information determined by the DQAC.

[Statutory Authority: RCW 18.32.0365 and 18.32.040. 08-23-018, § 246-817-155, filed 11/6/08, effective 12/7/08.]

WAC 246-817-160 Graduates of nonaccredited schools. The following requirements apply to persons who are graduates of dental schools or colleges not accredited by the American Dental Association Commission on Accreditation.

(1) A person who has been issued a degree of doctor of dental medicine or doctor of dental surgery by a nonaccredited dental school listed by the World Health Organization, or by a nonaccredited dental school approved by the DQAC, shall be eligible to take the examination in the theory and practice of the science of dentistry upon furnishing all of the following:

(a) Certified copies of dental school diplomas.

(b) Official dental school transcripts.

(c) Proof of identification by an appropriate governmental agency. Alternate arrangements may be made for political refugees.

(d) Effective February 1, 1985, satisfactory evidence of the successful completion of at least two additional predoctoral or postdoctoral academic years of dental school education at a dental school approved pursuant to WAC 246-817-110(2) and a certification by the dean of that school that the candidate has achieved the same level of didactic and clinical competence as expected of a graduate of that school.

(2) Upon completion of the requirements in subsection (1) of this section, an applicant under this section shall be allowed to take the examination pursuant to WAC 246-817-120 and shall be subject to the applicable provisions of WAC 246-817-110. This rule supersedes WAC 246-818-090 which provided applicants one opportunity to take and pass the clinical (practical) examination, in 1985, without meeting the postgraduate training requirement.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-160, filed 10/10/95, effective 11/10/95.]

WAC 246-817-185 Temporary practice permits—Eligibility. Fingerprint-based national background checks may cause a delay in credentialing. Individuals who satisfy all other licensing requirements and qualifications may receive a temporary practice permit while the national background check is completed.

(1) A temporary practice permit, as defined in RCW 18.130.075, shall be issued at the written request of an applicant for dentists, expanded function dental auxiliaries, and dental assistants. The applicant must be credentialed in another state, with credentialing standards substantially equivalent to Washington.

(2) The conditions of WAC 246-817-160 must be met for applicants who are graduates of dental schools or colleges not accredited by the American Dental Association Commission on Dental Accreditation.

[Statutory Authority: RCW 18.130.064, 18.130.075, and 18.32.0365. 10-07-026, § 246-817-185, filed 3/8/10, effective 4/8/10. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-185, filed 10/10/95, effective 11/10/95.]

WAC 246-817-186 Temporary practice permits—Issuance and duration. (1) Unless there is a basis for denial of the credential or for issuance of a conditional credential, the applicant shall be issued a temporary practice permit when DQAC receives:

(a) A completed application form, all other documentation required to complete the credential application, completed fingerprint card, and fees for the credential;

(b) A written request for a temporary practice permit;

(c) Written verification of all credentials, whether active or not, attesting that the applicant has a credential in good standing and is not the subject of any disciplinary action for unprofessional conduct or impairment; and

(d) Results of disciplinary national practitioner data bank reports.

(2) The temporary practice permit shall expire when one of the following occurs:

(a) A full, unrestricted credential is granted;

(b) A notice of decision is mailed;

(c) One hundred eighty days after the temporary practice permit is issued.

(3) A temporary practice permit shall not be renewed, reissued or extended.

(4) A temporary practice permit grants the individual the full scope of practice for the profession.

[Statutory Authority: RCW 18.130.064, 18.130.075, and 18.32.0365. 10-07-026, § 246-817-186, filed 3/8/10, effective 4/8/10. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-186, filed 10/10/95, effective 11/10/95.]

WAC 246-817-190 Dental assistant registration. To be eligible for registration as a dental assistant you must:

(1) Provide a completed application on forms provided by the secretary;

(2) Pay applicable fees as defined in WAC 246-817-99005;

(3) Provide evidence of completion of seven clock hours of AIDS education and training as required by chapter 246-12 WAC Part 8; and

(4) Provide any other information determined by the secretary.

[Statutory Authority: RCW 18.260.120 and 18.32.0365. 08-14-010, § 246-817-190, filed 6/19/08, effective 7/1/08.]

WAC 246-817-195 Licensure requirements for expanded function dental auxiliaries (EFDAs). To be eligible for licensure as an EFDA in Washington an applicant must:

(1) Provide a completed application on forms provided by the secretary;

(2) Pay applicable fees as defined in WAC 246-817-99005;

(3) Provide evidence of:

(a) Completion of a dental assisting education program accredited by the Commission on Dental Accreditation (CODA); or

(b) Obtain the Dental Assisting National Board (DANB) certified dental assistant credential, earned through pathway II, which includes:

(i) A minimum of three thousand five hundred hours of experience as a dental assistant within a continuous twenty-four through forty-eight month period;

(ii) Employer-verified knowledge in areas as specified by DANB;

(iii) Passage of DANB certified dental assistant examination; and

(iv) An additional dental assisting review course, which may be provided online, in person or through self-study; or

(c) A Washington limited license to practice dental hygiene; or

(d) A Washington full dental hygiene license and completion of a course in taking final impressions affiliated with or provided by a CODA accredited dental assisting program, dental hygiene school or dental school.

(4) Except for applicants qualified under subsection (3)(d) of this section, provide evidence of completing an EFDA education program approved by the commission where training includes:

(a) In a didactic, clinical and laboratory model to the clinically competent level required for close supervision:

(i) In placing and finishing composite restorations on a typodont and on clinical patients; and

(ii) In placing and finishing amalgam restorations on a typodont and on clinical patients; and

(iii) In taking final impressions on a typodont; and

(b) In a didactic, clinical and laboratory model to the clinically competent level required for general supervision:

(i) In performing coronal polish, fluoride treatment, and sealants on a typodont and on clinical patients; and

(ii) In providing patient oral health instructions; and

(iii) In placing, exposing, processing, and mounting dental radiographs; and

(c) The basic curriculum shall require didactic, laboratory, and clinical competency for the following:

(i) Tooth morphology and anatomy;

(ii) Health and safety (current knowledge in dental materials, infection control, ergonomics, mercury safety, handling);

(iii) Placement and completion of an acceptable quality reproduction of restored tooth surfaces—Laboratory and clinic only;

(iv) Radiographs (covered in path II)—Laboratory and clinic only;

(v) Ethics and professional knowledge of law as it pertains to dentistry, dental hygiene, dental assisting, and EFDA;

(vi) Current practices in infection control;

(vii) Health history alerts;

(viii) Final impression;

(ix) Matrix and wedge;

(x) Rubber dam;

(xi) Acid etch and bonding;

(xii) Occlusion and bite registration;

(xiii) Temporary restorations;

(xiv) Dental emergencies;

(xv) Risk management and charting;

(xvi) Intra-oral anatomy;

(xvii) Pharmacology; and

(xviii) Bases, cements, liners and sealers.

(5) Except for applicants qualified under subsection (3)(d) of this section, attain a passing score on:

(a) A written restorations examination approved by the commission; and

(b) A clinical restorations examination approved by the commission.

(6) Provide evidence of completion of seven clock hours of AIDS education and training as required by chapter 246-12 WAC Part 8.

(7) Provide any other information determined by the secretary.

[Statutory Authority: RCW 18.260.120 and 18.32.0365. 08-14-010, § 246-817-195, filed 6/19/08, effective 7/1/08.]

WAC 246-817-200 Licensure without examination for expanded function dental auxiliary (EFDA). To be eligible for a license as an EFDA without examination you must:

(1) Provide a completed application on forms provided by the secretary;

(2) Pay applicable fees as defined in WAC 246-817-990;

(3) Provide evidence of:

(a) A current license in another state with substantially equivalent licensing standards as determined by the commission; or

(b) A Washington full dental hygiene license and completion of a course in taking final impressions affiliated with or provided by a CODA accredited dental assisting program, dental hygiene school or dental school.

(4) Provide evidence of completion of seven clock hours of AIDS education and training as required by chapter 246-12 WAC Part 8; and

(5) Provide any other information determined by the secretary.

[Statutory Authority: RCW 18.260.120 and 18.32.0365. 08-14-010, § 246-817-200, filed 6/19/08, effective 7/1/08.]

WAC 246-817-210 Expired credential. (1) If the credential has expired for three years or less, the practitioner must meet the requirements of chapter 246-12 WAC, Part 2.

(2) If the credential has expired for over three years, the practitioner must:

(a) Comply with the current statutory conditions;

(b) Meet the requirements of chapter 246-12 WAC, Part 2.

[Statutory Authority: RCW 18.260.120 and 18.32.0365. 08-14-010, § 246-817-210, filed 6/19/08, effective 7/1/08. Statutory Authority: RCW 43.70.280. 98-05-060, § 246-817-210, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-210, filed 10/10/95, effective 11/10/95.]

WAC 246-817-220 Inactive license. (1) A dentist may obtain an inactive license by meeting the requirements of WAC 246-12-090 and RCW 18.32.185.

(2) An inactive license must be renewed every year on or before the practitioner's birthday according to WAC 246-12-100 and 246-817-990.

(3) If a license is inactive for three years or less, to return to active status a dentist must meet the requirements of WAC 246-12-110, 246-817-440, and 246-817-990.

(4) If a license is inactive for more than three years, and the dentist has been actively practicing in another United States jurisdiction, to return to active status the dentist must:

(a) Provide certification of an active dentist license, submitted directly from another licensing entity. The certification shall include the license number, issue date, expiration date and whether the applicant has been the subject of final or pending disciplinary action;

(b) Provide verification of active practice in another United States jurisdiction within the last three years; and

(c) Meet the requirements of WAC 246-12-110, 246-817-440, and 246-817-990.

(5) If a license is inactive for more than three years, and the dentist has not been actively practicing in another United States jurisdiction, to return to active status the dentist must provide:

(a) A written request to change licensure status;

(b) The applicable fees according to WAC 246-817-990;

(c) Proof of successful completion of an approved:

(i) Practical/practice examination according to WAC 246-817-120; or

(ii) A qualifying postgraduate residency program, approved by or administered under the direction of the DQAC;

(d) Written certification of all dental or health care licenses held, submitted directly from the licensing entity. The certification shall include the license number, issue date, expiration date and whether the applicant has been the subject of final or pending disciplinary action;

(e) Written declaration that continuing education and competency requirements for the two most recent years have been met according to WAC 246-817-440;

(f) Proof of successful completion of an approved written jurisprudence examination within the past year;

(g) Proof of malpractice insurance if available, including dates of coverage and any claims history; and

(h) Proof of AIDS education according to WAC 246-817-110, if not previously provided.

[Statutory Authority: RCW 18.32.185 and 18.32.0365. 11-07-052, § 246-817-220, filed 3/17/11, effective 4/17/11.]

GENERAL PRACTICE REQUIREMENTS AND PROHIBITIONS

WAC 246-817-301 Display of licenses. The license of any dentist, dental hygienist or other individual licensed pursuant to the laws of Washington to engage in any activity being performed in the premises under the supervision or control of a licensed dentist shall be displayed in a place visible to individuals receiving services in the premises, and readily available for inspection by any designee of the DQAC.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-301, filed 10/10/95, effective 11/10/95.]

WAC 246-817-310 Maintenance and retention of records. Any dentist who treats patients in the state of Washington shall maintain complete treatment records regarding patients treated. These records shall include, but shall not be limited to X rays, treatment plans, patient charts, patient histories, correspondence, financial data and billing. These records shall be retained by the dentist for five years in an orderly, accessible file and shall be readily available for inspection by the DQAC or its authorized representative: X rays or copies of records may be forwarded to a second party upon the patient's or authorized agent's written request. Also, office records shall state the date on which the records were released, method forwarded and to whom, and the reason for the release. A reasonable fee may be charged the patient to cover mailing and clerical costs.

Every dentist who operates a dental office in the state of Washington must maintain a comprehensive written and dated record of all services rendered to his/her patients. In offices where more than one dentist is performing the services the records must specify the dentist who performed the services. Whenever requested to do so, by the secretary or his/her authorized representative, the dentist shall supply documentary proof:

(1) That he/she is the owner or purchaser of the dental equipment and/or the office he occupies.

(2) That he/she is the lessee of the office and/or dental equipment.

(3) That he/she is, or is not, associated with other persons in the practice of dentistry, including prosthetic dentistry, and who, if any, the associates are.

(4) That he/she operates his office during specific hours per day and days per week, stipulating such hours and days.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-310, filed 10/10/95, effective 11/10/95.]

WAC 246-817-320 Report of patient injury or mortality. All licensees engaged in the practice of dentistry shall submit a complete report of any patient mortality or other incident which results in temporary or permanent physical or mental injury requiring hospitalization of said patient during, or as a direct result of dental procedures or anesthesia related thereto. This report shall be submitted to the DQAC within thirty days of the occurrence.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-320, filed 10/10/95, effective 11/10/95.]

WAC 246-817-330 Prescriptions. Every dentist who operates a dental office in the state of Washington must write a valid prescription to the dental laboratory or dental technician with whom he/she intends to place an order for the making, repairing, altering or supplying of artificial restorations, substitutes or appliances to be worn in the human mouth. A separate prescription must be submitted to the dental laboratory or dental technician for each patient's requirements. To be valid, such prescriptions must be written in duplicate and contain the date, the name and address of the dental laboratory or the dental technician, the name and address of the patient, description of the basic work to be done, the signature of the dentist serving the patient for whom the work is being done and the dentist's license certificate number. The original prescription shall be referred to the dental laboratory or the dental technician and the carbon copy shall be retained for three years, by the dentist, in an orderly, accessible file and shall be readily available for inspection by the secretary or his/her authorized representative.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-330, filed 10/10/95, effective 11/10/95.]

WAC 246-817-340 Recording requirements for all prescription drugs. An accurate record of any medication(s) prescribed or dispensed shall be clearly indicated on the patient history. This record shall include the date prescribed or the date dispensed, the name of the patient prescribed or dispensed to, the name of the medication, and the dosage and amount of the medication prescribed or dispensed.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-340, filed 10/10/95, effective 11/10/95.]

WAC 246-817-350 Recording requirement for scheduled drugs. When Schedule II, III, IV or V drugs as described in chapter 69.50 RCW are stocked by the dental office for dispensing to patients, an inventory control record must be kept in such a manner to identify disposition of such medicines. Such records shall be available for inspection by the secretary or his/her authorized representative.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-350, filed 10/10/95, effective 11/10/95.]

WAC 246-817-360 Prescribing, dispensing or distributing drugs. No dentist shall prescribe, dispense or distribute any controlled substance or legend drug for other than dental-related conditions.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-360, filed 10/10/95, effective 11/10/95.]

WAC 246-817-370 Nondiscrimination. It shall be unprofessional conduct for any dentist to discriminate or to permit any employee or any person under the supervision and control of the dentist to discriminate against any person, in the practice of dentistry, on the basis of race, color, creed or national origin, or to violate any of the provisions of any state or federal antidiscrimination law.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-370, filed 10/10/95, effective 11/10/95.]

WAC 246-817-380 Patient abandonment. The attending dentist, without reasonable cause, shall not neglect, ignore, abandon, or refuse to complete the current procedure for a patient. If the dentist chooses to withdraw responsibility for a patient of record, the dentist shall:

(1) Advise the patient that termination of treatment is contemplated and that another dentist should be sought to complete the current procedure and for future care; and

(2) Advise the patient that the dentist shall remain reasonably available under the circumstances for up to fifteen days from the date of such notice to render emergency care related to that current procedure.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-380, filed 10/10/95, effective 11/10/95.]

WAC 246-817-390 Representation of care, fees, and records. Dentists shall not represent the care being rendered to their patients or the fees being charged for providing such care in a false or misleading manner, nor alter patient records, such as but not limited to, misrepresenting dates of service or treatment codes.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-390, filed 10/10/95, effective 11/10/95.]

WAC 246-817-400 Disclosure of provider services. A dentist who is personally present, operating as a dentist or personally overseeing the operations being performed in a dental office, over fifty percent of the time that such office is being operated, shall identify himself/herself in any representation to the public associated with such office or practice and shall provide readily visible signs designating his/her name at such respective office entrances or office buildings. Any representation that omits such a listing of dentists is misleading, deceptive, or improper conduct. Dentists who are present or overseeing operations under this rule less than fifty percent of the time shall identify themselves to patients prior to services being initiated or rendered in any fashion. Every office shall have readily available a list of the names of dentists who are involved in such office less than fifty percent of the time.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-400, filed 10/10/95, effective 11/10/95.]

WAC 246-817-410 Disclosure of membership affiliation. It shall be misleading, deceptive or improper conduct for any dentist to represent that he/she is a member of any dental association, society, organization, or any component thereof where such membership in fact does not exist.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-410, filed 10/10/95, effective 11/10/95.]

WAC 246-817-420 Specialty representation. (1) It shall be misleading, deceptive or improper conduct for a dentist to represent or imply that he/she is a specialist or use any of the terms to designate a dental specialty such as:

(a) Endodontist
(b) Oral or maxillofacial surgeon
(c) Oral pathologist
(d) Orthodontist
(e) Pediatric dentist
(f) Periodontist
(g) Prosthodontist
(h) Public health

or any derivation of these specialties unless he/she is entitled to such specialty designation under the guidelines or requirements for specialties approved by the Commission on Dental Accreditation and the Council on Dental Education of the American Dental Association, or such guidelines or requirements as subsequently amended and approved by the DQAC, or other such organization recognized by the DQAC.

(2) A dentist not currently entitled to such specialty designation shall not represent that his/her practice is limited to providing services in a specialty area without clearly disclosing in the representation that he/she is a general dentist. A specialist who represents services in areas other than his/her specialty is considered a general dentist.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-420, filed 10/10/95, effective 11/10/95.]

WAC 246-817-430 A rule applicable to dental technicians. To be exempt from the law prohibiting the practice of dentistry, dental technicians must comply with the provisions of RCW 18.32.030(6). The form of the required prescription is defined in WAC 246-817-330.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-430, filed 10/10/95, effective 11/10/95.]

WAC 246-817-440 Continuing education requirements. (1) **Purpose.** The dental quality assurance commission (DQAC) has determined that the public health, safety and welfare of the citizens of the state will be served by requiring all dentists, licensed under chapter 18.32 RCW, to

continue their professional development via continuing education after receiving such licenses.

(2) **Effective date.** The effective date for the continuing education requirement for dentists is July 1, 2001. The first reporting cycle for verifying completion of continuing education hours will begin with renewals due July 1, 2002, and each renewal date thereafter. Every licensed dentist must sign an affidavit attesting to the completion of the required number of hours as a part of their annual renewal requirement.

(3) **Requirements.** Licensed dentists must complete twenty-one clock hours of continuing education, each year, in conjunction with their annual renewal date. DQAC may randomly audit up to twenty-five percent of practitioners for compliance after the credential is renewed as allowed by chapter 246-12 WAC, Part 7.

(4) **Acceptable continuing education - Qualification of courses for continuing education credit.** DQAC will not authorize or approve specific continuing education courses. Continuing education course work must contribute to the professional knowledge and development of the practitioner, or enhance services provided to patients.

For the purposes of this chapter, acceptable continuing education means courses offered or authorized by industry recognized state, private, national and international organizations, agencies or institutions of higher learning. Examples of sponsors, or types of continuing education courses may include, but are not limited to:

(a) The American Dental Association, Academy of General Dentistry, National Dental Association, American Dental Hygienists' Association, National Dental Hygienists' Association, American Dental Association specialty organizations, including the constituent and component/branch societies.

(b) Basic first aid, CPR, BLS, ACLS, OSHA/WISHA, or emergency related training; such as courses offered or authorized by the American Heart Association or the American Cancer Society; or any other organizations or agencies.

(c) Educational audio or videotapes, films, slides, internet, or independent reading, where an assessment tool is required upon completion are acceptable but may not exceed seven hours per year.

(d) Teaching a seminar or clinical course for the first time is acceptable but may not exceed ten hours per year.

(e) Nonclinical courses relating to dental practice organization and management, patient management, or methods of health delivery may not exceed seven hours per year. Estate planning, financial planning, investments, and personal health courses are not acceptable.

(f) Dental examination standardization and calibration workshops.

(g) Provision of clinical dental services in a formal volunteer capacity may be considered for continuing education credits when preceded by an educational/instructional training prior to provision of services. Continuing education credits in this area shall not exceed seven hours per renewal cycle.

(5) Refer to chapter 246-12 WAC, Part 7, administrative procedures and requirements for credentialed health care providers for further information regarding compliance with the continuing education requirements for health care providers.

[Statutory Authority: RCW 18.32.002 and 18.32.0365. 06-07-036, § 246-817-440, filed 3/8/06, effective 4/8/06. Statutory Authority: RCW 18.32.0365. 01-16-007, § 246-817-440, filed 7/19/01, effective 8/19/01.]

SEXUAL MISCONDUCT RULES FOR DENTISTS

WAC 246-817-450 Definitions. (1) "Dentist" means an individual applying for a credential or credentialed specifically as defined in chapter 18.32 RCW.

(2) "Health care information" means any information, whether oral or recorded in any form or medium that identifies or can readily be associated with the identity of, and relates to the health care of, a patient.

(3) "Key party" means a person legally authorized to make health care decisions for the patient.

(4) "Legitimate health care purpose" means activities for examination, diagnosis, treatment, and personal care of patients, including palliative care, as consistent with community standards of practice for the dental profession. The activity must be within the scope of practice of the dentist.

(5) "Patient" means an individual who receives health care services from a dentist. The determination of when a person is a patient is made on a case-by-case basis with consideration given to a number of factors, including the nature, extent and context of the professional relationship between the dentist and the person. The fact that a person is not receiving treatment or professional services is not the sole determining factor.

[Statutory Authority: RCW 18.32.0365 and 18.130.050 (1) and (12). 08-01-137, § 246-817-450, filed 12/19/07, effective 1/19/08.]

WAC 246-817-460 Sexual misconduct. (1) A dentist shall not engage, or attempt to engage, in sexual misconduct with a current patient, or key party, inside or outside the health care setting. Sexual misconduct shall constitute grounds for disciplinary action. Sexual misconduct includes but is not limited to:

(a) Sexual intercourse;

(b) Touching the breasts, genitals, anus or any sexualized body part except as consistent with accepted community standards of practice for examination, diagnosis and treatment and within the dentist's scope of practice;

(c) Rubbing against a patient or key party for sexual gratification;

(d) Kissing;

(e) Hugging, touching, fondling or caressing of a romantic or sexual nature;

(f) Examination of or touching genitals without using gloves;

(g) Not allowing a patient privacy to dress or undress except as may be necessary in emergencies or custodial situations;

(h) Not providing the patient a gown or draping except as may be necessary in emergencies;

(i) Dressing or undressing in the presence of the patient or key party;

(j) Removing patient's clothing or gown or draping without consent, emergent medical necessity or being in a custodial setting;

(k) Encouraging masturbation or other sex act in the presence of the dentist;

(l) Masturbation or other sex act by the dentist in the presence of the patient or key party;

(m) Soliciting a date with a patient or key party;

(n) Discussing the sexual history, preferences or fantasies of the dentist;

(o) Any behavior, gestures, or expressions that can reasonably be interpreted as seductive or sexual;

(p) Sexually demeaning behavior including any verbal or physical contact which can reasonably be interpreted as demeaning, humiliating, embarrassing, threatening or harming a patient or key party;

(q) Photographing or filming the body or any body part or pose of a patient or key party, other than for legitimate health care purposes; or for the educational or marketing purposes with the consent of the patient; and

(r) Showing a patient or key party sexually explicit photographs, other than for legitimate health care purposes.

(2) A dentist shall not:

(a) Offer to provide health care services in exchange for sexual favors;

(b) Use health care information to contact the patient or key party for the purpose of engaging in sexual misconduct;

(c) Use health care information or access to health care information to meet or attempt to meet the dentist's sexual needs.

(3) A dentist shall not engage in the activities listed in subsection (1) of this section with a former patient or key party if the dentist:

(a) Uses or exploits the trust, knowledge, influence or emotions derived from the professional relationship; or

(b) Uses or exploits privileged information or access to privileged information to meet the dentist's personal or sexual needs.

(4) When evaluating whether a dentist has engaged or has attempted to engage in sexual misconduct, the commission will consider factors, including but not limited to:

(a) Documentation of a formal termination;

(b) Transfer of care to another health care provider;

(c) Duration of the dentist-patient relationship;

(d) Amount of time that has passed since the last dental health care services to the patient;

(e) Communication between the dentist and the patient between the last dental health care services rendered and commencement of the personal relationship;

(f) Extent to which the patient's personal or private information was shared with the dentist;

(g) Nature of the patient's health condition during and since the professional relationship; and

(h) The patient's emotional dependence and vulnerability.

(5) Patient or key party initiation or consent does not excuse or negate the dentist's responsibility.

(6) These rules do not prohibit:

(a) Providing health care services in case of emergency where the services cannot or will not be provided by another health care provider;

(b) Contact that is necessary for a legitimate health care purpose and that meets the standard of care appropriate to the dental profession; or

(c) Providing dental services for a legitimate health care purpose to a person who is in a preexisting, established personal relationship with the dentist where there is no evidence of, or potential for, exploiting the patient.

[Statutory Authority: RCW 18.32.0365 and 18.130.050 (1) and (12). 08-01-137, § 246-817-460, filed 12/19/07, effective 1/19/08.]

DELEGATIONS OF DUTIES TO PERSONS NOT LICENSED AS DENTISTS

WAC 246-817-501 Purpose. The purpose of WAC 246-817-501 through 246-817-570 is to establish guidelines on delegation of duties to persons who are not licensed to practice dentistry. The dental laws of Washington state authorized the delegation of certain duties to nondentist personnel and prohibit the delegation of certain other duties. By statute, the duties that may be delegated to a person not licensed to practice dentistry may be performed only under the supervision of a licensed dentist. The degree of supervision required to assure that treatment is appropriate and does not jeopardize the systemic or oral health of the patient varies with, among other considerations, the nature of the procedure and the qualifications of the person to whom the duty is delegated. The dentist is ultimately responsible for the services performed in his/her office and this responsibility cannot be delegated. In order to protect the health and well-being of the people of this state, the DQAC finds it necessary to adopt the following definitions and regulations.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-501, filed 10/10/95, effective 11/10/95.]

WAC 246-817-510 Definitions for WAC 246-817-501 through 246-817-570. (1) **"Close supervision"** means that a licensed dentist whose patient is being treated has personally diagnosed the condition to be treated and has personally authorized the procedures to be performed. A dentist shall be physically present in the treatment facility while the procedures are performed. Close supervision does not require a dentist to be physically present in the operatory; however, an attending dentist must be in the treatment facility and be capable of responding immediately in the event of an emergency.

(2) **"Coronal polishing"** means a procedure limited to the removal of plaque and stain from exposed tooth surfaces, utilizing an appropriate instrument and polishing agent.

This procedure shall not be intended or interpreted as an oral prophylaxis as defined in WAC 246-817-510 a procedure specifically reserved to performance by a licensed dentist or dental hygienist. Coronal polishing may, however, be performed by dental assistants under close supervision as a portion of the oral prophylaxis. In all instances, however, a licensed dentist shall determine that the teeth need to be polished and are free of calculus or other extraneous material prior to performance of coronal polishing by a dental assistant.

(3) **"Debridement at the periodontal surgical site"** means curettage or root planing after reflection of a flap by the supervising dentist. This does not include cutting of osseous tissues.

(4) **"Elevating soft tissues"** is defined as part of a surgical procedure involving the use of the periosteal elevator to raise flaps of soft tissues. Elevating soft tissue is not a separate and distinct procedure in and of itself.

(5) **"General supervision"** means supervision of dental procedures based on examination and diagnosis of the patient and subsequent instructions given by a licensed dentist but not requiring the physical presence of the supervising dentist in the treatment facility during the performance of those procedures.

(6) **"Incising"** is defined as part of the surgical procedure of which the end result is removal of oral tissue. Incising, or the making of an incision, is not a separate and distinct procedure in and of itself.

(7) **"Luxation"** is defined as an integral part of the surgical procedure of which the end result is extraction of a tooth. Luxation is not a distinct procedure in and of itself. It is the dislocation or displacement of a tooth or of the temporomandibular articulation.

(8) **"Oral prophylaxis"** means the preventive dental procedure of scaling and polishing which includes complete removal of calculus, soft deposits, plaque, stains and the smoothing of unattached tooth surfaces. The objective of this treatment shall be creation of an environment in which hard and soft tissues can be maintained in good health by the patient.

(9) **"Periodontal soft tissue curettage"** means the closed removal of tissue lining the periodontal pocket, not involving the reflection of a flap.

(10) **"Root planing"** means the process of instrumentation by which the unattached surfaces of the root are made smooth by the removal of calculus or deposits.

(11) **"Supportive services"** means services that are related to clinical functions in direct relationship to treating a patient.

(12) **"Suturing"** is defined as the readaption of soft tissue by use of stitches as a phase of an oral surgery procedure. Suturing is not a separate and distinct procedure in and of itself.

(13) **"Treatment facility"** means a dental office or connecting suite of offices, dental clinic, room or area with equipment to provide dental treatment, or the immediately adjacent rooms or areas. A treatment facility does not extend to any other area of a building in which the treatment facility is located.

(14) **"Noncredentialed person"** means a person who is not a dentist licensed under chapter 18.32 RCW; dental hygienist licensed under chapter 18.29 RCW; expanded function dental auxiliary licensed under chapter 18.260 RCW; or a dental assistant registered under chapter 18.260 RCW.

(15) **"Volunteer dental assistant"** means an individual who, without compensation, provides the supportive services set forth in WAC 246-817-520 in a charitable dental clinic.

[Statutory Authority: RCW 18.32.0365, 18.260.110, and 18.260.120. 09-15-075, § 246-817-510, filed 7/13/09, effective 8/13/09. Statutory Authority: RCW 18.260.120 and 18.32.0365. 08-14-010, § 246-817-510, filed 6/19/08, effective 7/1/08. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-510, filed 10/10/95, effective 11/10/95.]

WAC 246-817-520 Supportive services that may be performed by registered dental assistants. A dentist may allow registered dental assistants to perform the following supportive services under the dentist's close supervision:

(1) Oral inspection, with no diagnosis.

(2) Patient education in oral hygiene.

(3) Place and remove the rubber dam.

(4) Hold in place and remove impression materials after the dentist has placed them.

(5) Take impressions solely for diagnostic and opposing models.

(6) Take impressions and wax bites solely for study casts.

(7) Take impressions, fabricate, and deliver bleaching and fluoride trays.

(8) Remove the excess cement after the dentist has placed a permanent or temporary inlay, crown, bridge or appliance, or around orthodontic bands.

(9) Perform coronal polish.

(10) Give fluoride treatments.

(11) Place periodontal packs.

(12) Remove periodontal packs or sutures.

(13) Place a matrix and wedge for a metallic and nonmetallic direct restorative material after the dentist has prepared the cavity.

(14) Place a temporary filling (as zinc oxide-eugenol (ZOE)) after diagnosis and examination by the dentist.

(15) Apply tooth separators as for placement for Class III gold foil.

(16) Fabricate, place, and remove temporary crowns or temporary bridges.

(17) Pack and medicate extraction areas.

(18) Deliver an oral sedative drug to patient.

(19) Place topical anesthetics.

(20) Place retraction cord.

(21) Polish restorations at a subsequent appointment.

(22) Select denture shade and mold.

(23) Acid etch.

(24) Apply sealants.

(25) Place dental X-ray film and expose and develop the films.

(26) Take intra-oral and extra-oral photographs.

(27) Take health histories.

(28) Take and record blood pressure and vital signs.

(29) Give preoperative and postoperative instructions.

(30) Assist in the administration of inhalation minimal sedation (nitrous oxide) analgesia or sedation.

(31) Select orthodontic bands for size.

(32) Place and remove orthodontic separators.

(33) Prepare teeth for the bonding or orthodontic appliances.

(34) Fit and adjust headgear.

(35) Remove fixed orthodontic appliances.

(36) Remove and replace archwires and orthodontic wires.

(37) Take a facebow transfer for mounting study casts.

(38) Take impressions for temporary oral devices, such as but not limited to space maintainers, orthodontic retainers, and occlusal guards.

[Statutory Authority: RCW 18.260.120 and 18.32.0365. 08-14-010, § 246-817-520, filed 6/19/08, effective 7/1/08. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-520, filed 10/10/95, effective 11/10/95.]

WAC 246-817-525 Supportive services that may be performed by expanded function dental auxiliaries (EFDAs). (1) A dentist may allow EFDAs to perform the fol-

lowing supportive services under the dentist's close supervision:

(a) Oral inspection, with no diagnosis.

(b) Place and remove the rubber dam.

(c) Take preliminary and final impressions and bite registrations, to include computer assisted design and computer assisted manufacture applications.

(d) Take impressions, fabricate, and deliver bleaching and fluoride trays.

(e) Remove the excess cement after the dentist has placed a permanent or temporary inlay, crown, bridge or appliance, or around orthodontic bands.

(f) Place periodontal packs.

(g) Remove periodontal packs or sutures.

(h) Place a matrix and wedge for a metallic and nonmetallic direct restorative material after the dentist has prepared the cavity.

(i) Place a temporary filling (as zinc oxide-eugenol (ZOE)) after diagnosis and examination by the dentist.

(j) Apply tooth separators as for placement for Class III gold foil.

(k) Fabricate, place, and remove temporary crowns or temporary bridges.

(l) Pack and medicate extraction areas.

(m) Deliver an oral sedative drug to patient.

(n) Place topical anesthetics.

(o) Place retraction cord.

(p) Polish restorations.

(q) Select denture shade and mold.

(r) Acid etch.

(s) Take intra-oral and extra-oral photographs.

(t) Take health histories.

(u) Take and record blood pressure and vital signs.

(v) Give preoperative and postoperative instructions.

(w) Assist in the administration of inhalation minimal sedation (nitrous oxide) analgesia or sedation.

(x) Select orthodontic bands for size.

(y) Place and remove orthodontic separators.

(z) Prepare teeth for the bonding or orthodontic appliances.

(aa) Fit and adjust headgear.

(bb) Remove fixed orthodontic appliances.

(cc) Remove and replace archwires and orthodontic wires.

(dd) Take a facebow transfer for mounting study casts.

(ee) Place and carve direct restorations.

(ff) Take impressions for temporary oral devices, such as but not limited to space maintainers, orthodontic retainers, and occlusal guards.

(2) A dentist may allow EFDAs to perform the following supportive services under the dentist's general supervision:

(a) Perform coronal polishing.

(b) Give fluoride treatments.

(c) Apply sealants.

(d) Place dental X-ray film and exposing and developing the films.

(e) Give patient oral health instructions.

[Statutory Authority: RCW 18.260.120 and 18.32.0365. 08-14-010, § 246-817-525, filed 6/19/08, effective 7/1/08.]

WAC 246-817-530 An act that may be performed by unlicensed persons outside the treatment facility. Unlicensed persons may select shade for crowns or fixed prostheses with the use of a technique which does not contact the oral cavity to avoid contamination with blood or saliva. The procedure shall be performed pursuant to the written instructions and order of a licensed dentist.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-530, filed 10/10/95, effective 11/10/95.]

WAC 246-817-540 Acts that may not be performed by registered dental assistants or noncredentialed persons. No dentist shall allow registered dental assistants or noncredentialed persons who are in his or her employ or are acting under his or her supervision or direction to perform any of the following procedures:

(1) Any removal of or addition to the hard or soft natural tissue of the oral cavity.

(2) Any placing of permanent or semi-permanent restorations in natural teeth.

(3) Any diagnosis of or prescription for treatment of disease, pain, deformity, deficiency, injury, or physical condition of the human teeth or jaws, or adjacent structure.

(4) Any administration of general or local anesthetic, including intravenous sedation.

(5) Any oral prophylaxis, except coronal polishing as a part of oral prophylaxis as defined in WAC 246-817-510 and 246-817-520(8).

(6) Any scaling procedure.

(7) The taking of any impressions of the teeth or jaws, or the relationships of the teeth or jaws, for the purpose of fabricating any intra-oral restoration, appliances, or prosthesis. Not prohibited are the taking of impressions solely for diagnostic and opposing models or taking wax bites solely for study casts.

(8) Intra-orally adjust occlusal of inlays, crowns, and bridges.

(9) Intra-orally finish margins of inlays, crowns, and bridges.

(10) Cement or recement, permanently, any cast restoration or stainless steel crown.

(11) Incise gingiva or other soft tissue.

(12) Elevate soft tissue flap.

(13) Luxate teeth.

(14) Curette to sever epithelial attachment.

(15) Suture.

(16) Establish occlusal vertical dimension for dentures.

(17) Try-in of dentures set in wax.

(18) Insertion and post-insertion adjustments of dentures.

(19) Endodontic treatment—open, extirpate pulp, ream and file canals, establish length of tooth, and fill root canal.

(20) Use of any light or electronic device for invasive procedures.

(21) Intra-oral air abrasion or mechanical etching devices.

(22) Place direct pulp caps.

(23) Fit and adjust occlusal guards.

[Statutory Authority: RCW 18.260.120 and 18.32.0365. 08-14-010, § 246-817-540, filed 6/19/08, effective 7/1/08. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-540, filed 10/10/95, effective 11/10/95.]

WAC 246-817-545 Acts that may not be performed by expanded function dental auxiliaries (EFDAs) or non-credentialed persons. No dentist shall allow EFDAs or non-credentialed persons who are in his or her employ or are acting under his or her supervision or direction to perform any of the following procedures:

(1) Any removal of or addition to the hard or soft natural tissue of the oral cavity except for placing and carving direct restorations by an EFDA.

(2) Any diagnosis of or prescription for treatment of disease, pain, deformity, deficiency, injury, or physical condition of the human teeth or jaws, or adjacent structure.

(3) Any administration of general or local anesthetic, including intravenous sedation.

(4) Any oral prophylaxis, except coronal polishing as a part of oral prophylaxis as defined in WAC 246-817-510 and 246-817-520(8).

(5) Any scaling procedure.

(6) Intra-orally adjust occlusal of inlays, crowns, and bridges.

(7) Intra-orally finish margins of inlays, crowns, and bridges.

(8) Cement or recement, permanently, any cast restoration or stainless steel crown.

(9) Incise gingiva or other soft tissue.

(10) Elevate soft tissue flap.

(11) Luxate teeth.

(12) Curette to sever epithelial attachment.

(13) Suture.

(14) Establish occlusal vertical dimension for dentures.

(15) Try-in of dentures set in wax.

(16) Insertion and postinsertion adjustments of dentures.

(17) Endodontic treatment—Open, extirpate pulp, ream and file canals, establish length of tooth, and fill root canal.

(18) Use of any light or electronic device for invasive procedures.

(19) Intra-oral air abrasion or mechanical etching devices.

(20) Place direct pulp caps.

(21) Fit and adjust occlusal guards.

[Statutory Authority: RCW 18.260.120 and 18.32.0365. 08-14-010, § 246-817-545, filed 6/19/08, effective 7/1/08.]

WAC 246-817-550 Acts that may be performed by licensed dental hygienists under general supervision. A dentist may allow a dental hygienist licensed under the provisions of chapter 18.29 RCW to perform the following acts under the dentist's general supervision:

(1) Oral inspection and measuring of periodontal pockets, with no diagnosis.

(2) Patient education in oral hygiene.

(3) Take intra-oral and extra-oral radiographs.

(4) Apply topical preventive or prophylactic agents.

(5) Polish and smooth restorations.

(6) Oral prophylaxis and removal of deposits and stains from the surfaces of the teeth.

(7) Record health histories.

(8) Take and record blood pressure and vital signs.

(9) Perform sub-gingival and supra-gingival scaling.

(10) Perform root planing.

(11) Apply sealants.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-550, filed 10/10/95, effective 11/10/95.]

WAC 246-817-560 Acts that may be performed by licensed dental hygienists under close supervision. In addition to the acts performed under WAC 246-817-520, a dentist may allow a dental hygienist licensed under the provisions of chapter 18.29 RCW to perform the following acts under the dentist's close supervision:

(1) Perform soft-tissue curettage.

(2) Give injections of a local anesthetic.

(3) Place restorations into the cavity prepared by the dentist, and thereafter could carve, contour, and adjust contacts and occlusion of the restoration.

(4) Administer nitrous oxide analgesia.

(5) Place antimicrobials.

[Statutory Authority: RCW 18.32.0365. 06-14-018, § 246-817-560, filed 6/23/06, effective 7/24/06. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-560, filed 10/10/95, effective 11/10/95.]

WAC 246-817-570 Acts that may not be performed by dental hygienists. No dentist shall allow a dental hygienist duly licensed under the provisions of chapter 18.29 RCW who is in his/her employ or is acting under his/her supervision or direction to perform any of the following procedures:

(1) Any surgical removal of tissue of the oral cavity, except for soft-tissue curettage, as defined in WAC 246-817-510.

(2) Any prescription of drugs or medications requiring the written order or prescription of a licensed dentist or physician.

(3) Any diagnosis for treatment or treatment planning.

(4) The taking of any impression of the teeth or jaw, or the relationship of the teeth or jaw, for the purpose of fabricating any intra-oral restoration, appliances, or prosthesis. Not prohibited are the taking of impressions solely for diagnostic and opposing models or taking wax bites solely for study casts.

(5) Intra-orally adjust occlusal of inlays, crowns, and bridges.

(6) Intra-orally finish margins of inlays, crowns, and bridges.

(7) Cement or recement, permanently, any cast restorations or stainless steel crowns.

(8) Incise gingiva or other soft tissue.

(9) Elevate soft tissue flap.

(10) Luxate teeth.

(11) Curette to sever epithelial attachment.

(12) Suture.

(13) Establish occlusal vertical dimension for dentures.

(14) Try-in of dentures set in wax.

(15) Insertion and post-insertion adjustments of dentures.

(16) Endodontic treatment—Open, extirpate pulp, ream and file canals, establish length of tooth, and fill root canal.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-570, filed 10/10/95, effective 11/10/95.]

INFECTION CONTROL

WAC 246-817-601 Purpose. The purpose of WAC 246-817-601 through 246-817-630 is to establish requirements for infection control in dental offices to protect the health and well-being of the people of the state of Washington. For purposes of infection control, all dental staff members and all patients shall be considered potential carriers of communicable diseases. Infection control procedures are required to prevent disease transmission from patient to doctor and staff, doctor and staff to patient, and from patient to patient. Every dentist is required to comply with the applicable standard of care in effect at the time of treatment. At a minimum, the dentist must comply with the requirements defined in WAC 246-817-620 and 246-817-630.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-601, filed 10/10/95, effective 11/10/95.]

WAC 246-817-610 Definitions. The following definitions pertain to WAC 246-817-601 through 246-817-660 which supersede WAC 246-816-701 through 246-816-740 which became effective May 15, 1992.

"Communicable diseases" means an illness caused by an infectious agent which can be transmitted from one person, animal, or object to another person by direct or indirect means including transmission via an intermediate host or vector, food, water or air.

"Decontamination" means the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

"Direct care staff" are the dental staff who directly provide dental care to patients.

"Sterilize" means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-610, filed 10/10/95, effective 11/10/95.]

WAC 246-817-620 Use of barriers and sterilization techniques. The use of barriers and sterilization techniques is the primary means of assuring that there is the least possible chance of the transmission of communicable diseases from doctor and staff to patients, from patient to patient and from patient to doctor and staff. To prevent patient to patient cross contamination, instruments and supplies contaminated or likely to be contaminated with blood or saliva and touched during treatment must be sterilized between patients or discarded except as otherwise set forth below. Surfaces and equipment which are likely to be contaminated with blood or saliva and touched during treatment must be decontaminated or covered with a barrier which is discarded and replaced between patients except as otherwise set forth below:

(1) Dentists shall comply with the following barrier techniques:

(a) Gloves shall be used by the dentist and direct care staff during treatment which involves intra-oral procedures or contact with items potentially contaminated with the patient's bodily fluids. Fresh gloves shall be used for every intraoral patient contact. Gloves shall not be washed or reused for any purpose. The same pair of gloves shall not be used, removed, and reused for the same patient at the same visit or for any other purpose. Gloves that have been used for dental treatment shall not be reused for any nondental purpose.

(b) Masks shall be worn by the dentist and direct care staff when splatter or aerosol is likely. Masks shall be worn during surgical procedures except in those specific instances in which the dentist determines that the use of a mask would prevent the delivery of health care services or would increase the hazard and risk to his/her patient. In those circumstances where a dentist determines not to wear a mask during a surgical procedure, such determination shall be documented in the patient record.

(c) Unless effective surface decontamination methods are used, protective barriers shall be placed over areas of the dental operatory which are likely to be touched during treatment, not removable to be sterilized, and likely to be contaminated by blood or saliva. These procedures must be followed between each patient. These include but are not limited to:

(i) Delivery unit.

(ii) Chair controls (not including foot controls).

(iii) Light handles.

(iv) High volume evacuator and air-water syringe controls.

(v) X-ray heads and controls.

(vi) Head rest.

(vii) Instrument trays.

(viii) Low speed handpiece motors.

(d) Protective eyewear shall be worn by the dentist and direct care staff and offered to all patients during times when splatter or aerosol is expected.

(2) Dentists shall comply with the following sterilization requirements:

(a) Every dental office shall have the capability to ultrasonically clean and sterilize contaminated items by autoclave, dry heat, unsaturated formaldehyde/alcohol vapor (such as MDT Chemiclave®) or ethylene oxide. Sterilizers shall be tested by biological spore test on at least a weekly basis. In the event of a positive biological spore test, the dentist shall take immediate remedial action to ensure the objectives of (a) of this subsection are accomplished. Documentation shall be maintained either in the form of a log reflecting dates and person(s) conducting the testing or copies of reports from an independent testing entity. The documentation shall be maintained for a period of at least five years.

(b) The following items shall be sterilized by an appropriate autoclave, dry heat, unsaturated formaldehyde/alcohol vapor (such as MDT Chemiclave®) or ethylene oxide sterilization method between patients:

(i) Low speed handpiece contra angles, prophy angles and nose cone sleeves.

(ii) High speed handpieces.

(iii) Hand instruments.

(iv) Burs.

(v) Endodontic instruments.

(vi) Air-water syringe tips.

(vii) High volume evacuator tips.

(viii) Surgical instruments.

(ix) Sonic or ultrasonic periodontal scalers and tips.

(x) Surgical handpieces.

(c) Gross debris shall be removed from items prior to sterilization. Ultrasonic cleaning shall be used whenever possible.

(d) Nondisposable items used in patient care which cannot be autoclaved, dry heat, unsaturated formaldehyde/alcohol vapor (such as MDT Chemiclave®) or ethylene oxide sterilized shall be immersed in a chemical sterilant. If such a technique is used, the solution shall be approved by the Environmental Protection Agency and used in accordance with the manufacturer's directions for sterilization.

(e) Items such as impressions contaminated with blood or saliva shall be thoroughly rinsed, placed in and transported to the dental laboratory in an appropriate case containment device that is properly sealed and labeled.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-620, filed 10/10/95, effective 11/10/95.]

WAC 246-817-630 Management of single use items. (1) Sterile disposable needles shall be used. The same needle may be recapped with a single-handed recapping technique or recapping device and subsequently reused for the same patient during the same visit.

(2) Single use items used in patient treatment which have been contaminated by saliva or blood shall be discarded and not reused. These include, but are not limited to, disposable needles, local anesthetic carpules, saliva ejectors, polishing discs, bonding agent brushes, prophy cups, prophy brushes, fluoride trays and interproximal wedges.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-630, filed 10/10/95, effective 11/10/95.]

ADMINISTRATION OF ANESTHETIC AGENTS FOR DENTAL PROCEDURES

WAC 246-817-701 Administration of anesthetic agents for dental procedures. The purpose of WAC 246-817-701 through 246-817-790 is to govern the administration of sedation and general anesthesia by dentists licensed in the state of Washington in settings other than hospitals as defined in WAC 246-320-010 and ambulatory surgical facilities as defined in WAC 246-310-010, pursuant to the DQAC authority in RCW 18.32.640.

(1) The DQAC has determined that anesthesia permitting should be based on the "level" of anesthesia because anesthesia/sedation is a continuum, and the route of administration and drug combinations are both capable of producing a deeper level of sedation/anesthesia than is initially intended. Practitioners intending to produce a given level of sedation should be able to rescue patients who enter a state deeper than initially intended.

(2) All anesthesia providers must provide twenty-four hour, on-call availability following an anesthesia procedure, excluding those procedures using only local anesthetic.

(3) The dental assistant and expanded function dental auxiliary may not administer any general or local anesthetic, including intravenous sedation.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 10-23-001, § 246-817-701, filed 11/3/10, effective 12/4/10; 09-04-042, § 246-817-701, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-701, filed 10/10/95, effective 11/10/95.]

WAC 246-817-710 Definitions—The definitions in this section apply throughout WAC 246-817-701 through 246-817-790 unless the context clearly requires otherwise. (1) **"Analgesia"** is the diminution of pain in the conscious patient.

(2) **"Anesthesia"** is the loss of feeling or sensation, especially loss of sensation of pain.

(3) **"Anesthesia assistant/anesthesia monitor"** means a credentialed health care provider specifically trained in monitoring patients under sedation and capable of assisting with procedures, problems and emergency incidents that may occur as a result of the sedation or secondary to an unexpected medical complication.

(4) **"Anesthesia provider"** means a dentist, physician anesthesiologist, dental hygienist or certified registered nurse anesthetist licensed and authorized to practice within the state of Washington.

(5) **"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.

(6) **"Direct supervision"** means that a licensed provider whose patient is being treated has personally diagnosed the condition to be treated and has personally authorized the procedure to be performed. A dentist must be physically present in the treatment facility while the procedures are performed.

(7) **"Direct visual supervision"** means direct supervision and direct line of sight to the activity being performed, chairside.

(8) **"General anesthesia"** is a drug induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or nonpharmacologic method, or combination thereof may be 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.

(9) **"Local anesthesia"** is the elimination of sensations, especially pain, in one part of the body by the topical application or regional injection of a drug.

(10) **"Minimal sedation"** is a drug induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

(11) **"Moderate 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. Moderate sedation can include both moderate sedation/analgesia (conscious sedation) and moderate sedation with parenteral agent.

(12) **"Parenteral"** means a technique of administration in which the drug bypasses the gastrointestinal (GI) tract (i.e., intramuscular, intravenous, intranasal, submuscosal, subcutaneous, intraosseous).

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 09-04-042, § 246-817-710, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-710, filed 10/10/95, effective 11/10/95.]

WAC 246-817-720 Basic life support requirements. Dental staff providing direct patient care in an in-office or out-patient setting must hold a current and valid health care provider basic life support (BLS) certification. Dental staff providing direct patient care include: Licensed dentists, licensed dental hygienists, licensed expanded function dental auxiliaries, and registered dental assistants.

Newly hired office staff providing direct patient care are required to obtain the required certification within forty-five days from the date hired.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 09-04-042, § 246-817-720, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-720, filed 10/10/95, effective 11/10/95.]

WAC 246-817-722 Defibrillator. (1) Every dental office in the state of Washington that administers minimal, moderate, or deep sedation, or general anesthesia, as defined in WAC 246-817-710, must have an automated external defibrillator (AED) or defibrillator.

(2) The dentist and staff must have access to the AED or defibrillator in an emergency, and it must be available and in reach within sixty seconds.

(3) A dental office may share a single AED or defibrillator with adjacent businesses if it meets the requirements in this section.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 10-23-001, § 246-817-722, filed 11/3/10, effective 12/4/10; 09-04-042, § 246-817-722, filed 1/30/09, effective 3/2/09.]

WAC 246-817-724 Recordkeeping, equipment and emergency medications or drugs required in all sites where anesthetic agents of any kind are administered. (1) Dental records must contain an appropriate medical history and patient evaluation. Any adverse reactions, and all medications and dosages, must be recorded.

(2) Office facilities and equipment must include:

(a) Suction equipment capable of aspirating gastric contents from the mouth and pharynx;

(b) Portable oxygen delivery system including full face masks and a bag-valve-mask combination with appropriate connectors capable of delivering positive pressure, oxygen enriched ventilation to the patient;

(c) Blood pressure cuff (sphygmomanometer) of appropriate size;

(d) Stethoscope or equivalent monitoring device.

(3) The following emergency drugs must be available and maintained:

(a) Bronchodilator;

(b) Sugar (glucose);

(c) Aspirin;

(d) Antihistaminic;

(e) Coronary artery vasodilator;

(f) Anti-anaphylactic agent.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 09-04-042, § 246-817-724, filed 1/30/09, effective 3/2/09.]

WAC 246-817-730 Local anesthesia. Local anesthesia shall be administered only by a person qualified under this chapter and dental hygienists as provided in chapter 18.29 RCW.

(1) All offices must comply with the requirements listed in WAC 246-817-724.

(2) A permit of authorization is not required.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 09-04-042, § 246-817-730, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-730, filed 10/10/95, effective 11/10/95.]

WAC 246-817-740 "Minimal sedation by inhalation" (to include but not limited to nitrous oxide). (1) Training requirements: To administer inhalation minimal sedation a dentist must have completed a course containing a minimum of fourteen hours of either predoctoral dental school or postgraduate instruction in inhalation minimal sedation.

(2) Procedures for administration: Inhalation minimal sedation must be administered under the close supervision of a person qualified under this chapter and dental hygienists as provided in chapter 18.29 RCW:

(a) When administering inhalation minimal sedation, a second individual must be on the office premises able to immediately respond to any request from the person administering the inhalation minimal sedation;

(b) The patient must be continuously observed while inhalation minimal sedation is administered.

(3) Equipment and emergency medications: All offices in which inhalation minimal sedation is administered must comply with the recordkeeping and equipment standards listed in WAC 246-817-724.

(4) Dental records must contain documentation in the chart of either nitrous oxide, oxygen or any other inhalation sedation agent dispensed. In the case of nitrous oxide sedation only "N_2O used" is required. Other inhalation agents require a dose record noting the time each concentration or agent was used.

(5) Continuing education: A dentist who administers inhalation sedation to patients must participate in seven hours of continuing education or equivalent every five years.

(a) The education must include instruction in one or more of the following areas: Sedation; physiology; pharmacology; inhalation analgesia; patient evaluation; patient monitoring and medical emergencies;

(b) Health care provider basic life support (BLS), or advanced cardiac life support (ACLS) training does not count towards this requirement; however, these continuing education credit hours may be used to meet renewal requirements for the dental license.

(6) A permit of authorization is not required.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 09-04-042, § 246-817-740, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-740, filed 10/10/95, effective 11/10/95.]

WAC 246-817-745 "Minimal sedation." (1) Training requirements: To administer "minimal sedation," including:

(a) A single oral agent, a dentist must have completed a course containing a minimum of fourteen hours of a predoc-

toral dental school, postgraduate instruction, or continuing education (as defined in WAC 246-817-440) in the use of oral agents;

(b) Any oral agent in combination with a different agent or multiple agents other than nitrous oxide or injectable agents, a dentist must have completed a course containing a minimum of twenty-one hours of either predoctoral dental school or postgraduate instruction.

(2) Procedures for administration:

(a) Oral sedative agents can be administered in the treatment setting or prescribed for patient dosage prior to the appointment;

(b) A second individual must be on the office premises and able to immediately respond to any request from the person administering the drug;

(c) The patient shall be continuously observed while in the office under the influence of the drug;

(d) Any adverse reactions must be documented in the records;

(e) If a patient unintentionally enters into a moderate level of sedation, the patient must be returned to a level of minimal sedation as quickly as possible. While returning the patient to the minimal sedation level, periodic monitoring of pulse, respiration, and blood pressure must be maintained. In such cases, these same parameters must be taken and recorded at appropriate intervals throughout the procedure and vital signs and level of consciousness must be recorded during the sedation and prior to dismissal of the patient.

(3) Dental records must contain documentation in the chart of all agents administered and dosage for minimal sedation. In the case of nitrous oxide sedation only "N_2O used" is required. Other inhalation agents require a dose record noting the time each concentration and agent was used.

(4) Continuing education: A dentist who administers minimal sedation to patients must participate in seven hours of continuing education or equivalent every five years.

(a) The education must include instruction in one or more of the following areas:

(i) Sedation;

(ii) Physiology;

(iii) Pharmacology;

(iv) Nitrous oxide analgesia;

(v) Patient evaluation;

(vi) Patient monitoring; and

(vii) Medical emergencies;

(b) Health care provider basic life support (BLS) or advanced cardiac life support (ACLS) must be taken in addition to the continuing education requirement; however, these continuing education credit hours may be used to meet the renewal requirements for the dental license.

(5) A permit of authorization is not required.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 09-04-042, § 246-817-745, filed 1/30/09, effective 3/2/09.]

WAC 246-817-755 Moderate sedation. (1) Training requirements: To administer moderate sedation the dentist must have completed a course containing a minimum of seven hours of a predoctoral dental school, postgraduate instruction, or continuing education (as defined in WAC 246-817-440) in moderate sedation in addition to twenty-one hours for minimal sedation.

(2) Procedures for administration:

(a) Oral sedative agents can be administered in the treatment setting or prescribed for patient dosage prior to the appointment.

(b) A second individual must be on the office premises who can immediately respond to any request from the person administering the drug.

(c) The patient must be continuously observed while in the office under the influence of the drug.

(d) Any adverse reactions must be documented in the records.

(e) If a patient unintentionally enters a deeper level of sedation, the patient must be returned to a level of moderate sedation as quickly as possible. While returning the patient to the moderate level of sedation, periodic monitoring of pulse, respiration, and blood pressure and pulse oximetry must be maintained. In such cases, these same parameters must be taken and recorded at appropriate intervals throughout the procedure and vital signs and level of consciousness must be recorded during the sedation and prior to dismissal of the patient.

(f) Patients receiving these forms of sedation must be accompanied by a responsible adult upon departure from the treatment facility.

(3) Equipment and emergency medications: All offices must comply with the requirements listed in WAC 246-817-724. When a sedative drug is used that has a reversal agent, the reversal agent must be in the office emergency kit and the equipment to administer the reversal agent must be stored with the delivery device. Pulse oximetry equipment or equivalent respiratory monitoring equipment must be available in the office.

(4) Continuing education: A dentist who administers moderate sedation to patients must participate in seven hours of continuing education or equivalent every five years.

(a) The education must include instruction in one or more of the following areas: Sedation; physiology; pharmacology; nitrous oxide analgesia; patient evaluation; patient monitoring or medical emergencies.

(b) Health care provider basic life support (BLS), advanced cardiac life support (ACLS) or pediatric advanced life support (PALS) must be taken in addition to the continuing education requirement; however, these continuing education credit hours may be used to meet the renewal requirements for the dental license.

(5) A permit of authorization is required. See WAC 246-817-774 for permitting requirements.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 09-04-042, § 246-817-755, filed 1/30/09, effective 3/2/09.]

WAC 246-817-760 Moderate sedation with parenteral agents. (1) Training requirements: To administer moderate sedation with parenteral agents, the dentist must have successfully completed a postdoctoral course(s) of sixty clock hours or more which includes training in basic moderate sedation, physical evaluation, venipuncture, technical administration, recognition and management of complications and emergencies, monitoring, and supervised experience in providing moderate sedation to fifteen or more patients.

(2) In addition to meeting the above criteria, the dentist must also have a current and documented proficiency in advanced cardiac life support (ACLS) or pediatric advanced life support (PALS). One way to demonstrate such proficiency is to hold a valid and current ACLS, PALS certificate or equivalent.

(3) Procedures for administration:

(a) In the treatment setting, a patient receiving moderate parenteral sedation must have that sedation administered by a person qualified under this chapter.

(b) A patient may not be left alone in a room and must be monitored by a dentist or trained anesthesia monitor.

(c) An intravenous infusion shall be maintained during the administration of a parenteral agent.

(d) When the operative dentist is also the person administering the moderate sedation, the operative dentist must be continuously assisted by at least one individual experienced in monitoring sedated patients.

(e) In the treatment setting, a patient experiencing moderate sedation with parenteral agents shall have visual and tactile observation as well as continual monitoring of pulse, respiration, blood pressure and blood oxygen saturation. Unless prevented by the patient's physical or emotional condition, these vital sign parameters must be noted and recorded whenever possible prior to the procedure. In all cases these vital sign parameters must be noted and recorded at the conclusion of the procedure.

(f) Blood oxygen saturation must be continuously monitored and recorded at appropriate intervals.

(g) The patient's level of consciousness shall be recorded prior to the dismissal of the patient.

(h) Patient's receiving these forms of sedation must be accompanied by a responsible adult upon departure from the treatment facility.

(i) If a patient unintentionally enters a deeper level of sedation, the patient must be returned to a level of moderate sedation as quickly as possible. While returning the patient to the moderate level of sedation, periodic monitoring of pulse, respiration, blood pressure and continuous monitoring of oxygen saturation must be maintained. In such cases, these same parameters must be taken and recorded at appropriate intervals throughout the procedure and vital signs and level of consciousness must be recorded during the sedation and prior to dismissal of the patient.

(4) Dental records must contain appropriate medical history and patient evaluation. Dosage and forms of medications dispensed shall be noted.

(5) Equipment and emergency medications: All offices in which moderate parenteral sedation is administered or prescribed must comply with the following equipment standards:

Office facilities and equipment shall include:

(a) Suction equipment capable of aspirating gastric contents from the mouth and pharynx;

(b) Portable oxygen delivery system including full face masks and a bag-valve-mask combination with appropriate connectors capable of delivering positive pressure, oxygen-enriched patient ventilation and oral and nasal pharyngeal airways of appropriate size;

(c) A blood pressure cuff (sphygmomanometer) of appropriate size and stethoscope; or equivalent monitoring devices;

(d) An emergency drug kit with minimum contents of:

(i) Sterile needles, syringes, and tourniquet;

(ii) Narcotic antagonist;

(iii) Alpha and beta adrenergic stimulant;

(iv) Vasopressor;

(v) Coronary vasodilator;

(vi) Antihistamine;

(vii) Parasympatholytic;

(viii) Intravenous fluids, tubing, and infusion set; and

(ix) Sedative antagonists for drugs used, if available.

(6) Continuing education: A dentist who administers moderate parenteral sedation must participate in eighteen hours of continuing education or equivalent every three years.

(a) The education must include instruction in one or more of the following areas: Venipuncture; intravenous sedation; physiology; pharmacology; nitrous oxide analgesia; patient evaluation; patient monitoring and medical emergencies.

(b) Health care provider basic life support (BLS), advanced cardiac life support (ACLS) or pediatric advanced life support (PALS) must be taken in addition to the continuing education requirement; however, these continuing education credit hours may be used to meet the renewal requirements for the dental license.

(7) A permit of authorization is required. See WAC 246-817-774 for permitting requirements.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 09-04-042, § 246-817-760, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-760, filed 10/10/95, effective 11/10/95.]

WAC 246-817-770 General anesthesia and deep sedation. Deep sedation and general anesthesia must be administered by an individual qualified to do so under this chapter.

(1) Training requirements: To administer deep sedation or general anesthesia, the dentist must meet one or more of the following criteria:

(a) Any provider currently permitted as of the effective date of this revision to provide deep sedation or general anesthesia by the state of Washington will be grandfathered regarding formal training requirements, provided they meet current continuing education and other ongoing applicable requirements.

(b) New applicants with anesthesia residency training will be required to have had two years of continuous full-time anesthesia training meeting the following requirements based on when they began their anesthesia training:

(i) For dentists who began their anesthesia training prior to 2008, training must include two full years of continuous full-time training in anesthesiology beyond the undergraduate dental school level, in a training program as outlined in part 2 of "*Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry*," published by the American Dental Association, Council on Dental Education (last revised October 2005).

(ii) For dentists who begin their anesthesia training in January 2008 or after, must have either received a certificate of completion.

(A) From a dental anesthesiology program accredited by CODA (ADA Commission on Dental Accreditation, "*Accreditation Standards for Advanced General Dentistry Education Programs in Dental Anesthesiology*," January 2007); or

(B) From a dental anesthesiology program approved by the Dental Quality Assurance Commission; or

(C) With a minimum of two years of full-time anesthesia residency training at a medical program accredited by the Accreditation Council for Graduate Medical Education (ACGME).

(c) New applicants who completed residency training in oral and maxillofacial surgery must meet at least one of the following requirements:

(i) Be a diplomate of the American Board of Oral and Maxillofacial Surgery;

(ii) Be a fellow of the American Association of Oral and Maxillofacial Surgeons; or

(iii) Be a graduate of an Oral and Maxillofacial Residency Program accredited by CODA.

(2) In addition to meeting one or more of the above criteria, the dentist must also have a current and documented proficiency in advanced cardiac life support (ACLS).

(3) Procedures for administration:

(a) Patients receiving deep sedation or general anesthesia must have continual monitoring of their heart rate, blood pressure, and respiration. In so doing, the licensee must utilize electrocardiographic monitoring and pulse oximetry;

(b) The patient's blood pressure and heart rate shall be recorded every five minutes and respiration rate shall be recorded at least every fifteen minutes;

(c) During deep sedation or general anesthesia, the person administering the anesthesia and the person monitoring the patient may not leave the immediate area;

(d) During the recovery phase, the patient must be continually observed by the anesthesia provider or credentialed personnel;

(e) A discharge entry shall be made in the patient's record indicating the patient's condition upon discharge and the responsible party to whom the patient was discharged.

(4) Dental records must contain appropriate medical history and patient evaluation. Anesthesia records shall be recorded during the procedure in a timely manner and must include: Blood pressure; heart rate; respiration; blood oxygen saturation; drugs administered including amounts and time administered; length of procedure; and any complications of anesthesia.

(5) Equipment and emergency medications: All offices in which general anesthesia (including deep sedation) is administered must comply with the following equipment standards:

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

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

(c) A lighting system which is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit conclusion of any operation underway at the time of general power failure;

(d) Suction equipment capable of aspirating gastric contents from the mouth and pharyngeal cavities. A backup suction device must be available;

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

(f) A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets. The recovery area can be the operating theater;

(g) Ancillary equipment which must include the following:

(i) Laryngoscope complete with adequate selection of blades, spare batteries, and bulb;

(ii) Endotracheal tubes and appropriate connectors, and laryngeal mask airway (LMA) and other appropriate equipment necessary to do an intubation;

(iii) Oral airways;

(iv) Tonsillar or pharyngeal suction tip adaptable to all office outlets;

(v) Endotracheal tube forceps;

(vi) Sphygmomanometer and stethoscope;

(vii) Adequate equipment to establish an intravenous infusion;

(viii) Pulse oximeter or equivalent;

(ix) Electrocardiographic monitor;

(x) Defibrillator or automatic external defibrillator (AED) available and in reach within sixty seconds from any area where general or deep anesthesia care is being delivered. Multiple AEDs or defibrillators may be necessary in large facilities. The AED or defibrillator must be on the same floor. (In dental office settings where sedation or general anesthesia are not administered, AEDs or defibrillators are required as defined in WAC 246-817-722);

(h) Emergency drugs of the following types shall be maintained:

(i) Vasopressor or equivalent;

(ii) Corticosteroid or equivalent;

(iii) Bronchodilator;

(iv) Muscle relaxant;

(v) Intravenous medications for treatment of cardiac arrest;

(vi) Narcotic antagonist;

(vii) Benzodiazepine antagonist;

(viii) Antihistaminic;

(ix) Anticholinergic;

(x) Antiarrhythmic;

(xi) Coronary artery vasodilator;

(xii) Antihypertensive;

(xiii) Anticonvulsant.

(6) Continuing education:

(a) A dentist granted a permit to administer general anesthesia (including deep sedation) under this chapter, must complete eighteen hours of continuing education every three years.

A dentist granted a permit must maintain records that can be audited and must submit course titles, instructors, dates attended, sponsors, and number of hours for each course every three years.

(b) The education must be provided by organizations approved by the DQAC and must be in one or more of the following areas: General anesthesia; conscious sedation; physical evaluation; medical emergencies; pediatric advanced life support (PALS); monitoring and use of monitoring equipment; pharmacology of drugs; and agents used in sedation and anesthesia.

(c) Hourly credits earned from certification in health care provider basic life support (BLS) and advanced cardiac life support (ACLS) courses may not be used to meet the continuing education hourly requirements for obtaining or renewing a general anesthesia and deep sedation permit, however these continuing education hours may be used to meet the renewal requirement for the dental license.

(7) A permit of authorization is required. See WAC 246-817-774 for permitting requirements.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 09-04-042, § 246-817-770, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-770, filed 10/10/95, effective 11/10/95.]

WAC 246-817-772 Training requirements for anesthesia monitor. (1) In addition to those individuals necessary to assist the practitioner in performing the procedure, a trained individual must be present to monitor the patient's cardiac and respiratory functions.

(2) When the dentist is also administering the deep sedation or general anesthesia, one additional appropriately trained team member must be designated for patient monitoring.

(3) When deep sedation or general anesthesia is administered by a dedicated anesthesia provider, the anesthesia provider may serve as the monitoring personnel.

(4) The dentist cannot employ an individual to monitor patients receiving deep sedation or general anesthesia unless that individual has received a minimum of fourteen hours of documented training (such as national certification American Association of Oral and Maxillofacial Surgeons "AAOMS") in a course specifically designed to include instruction and practical experience in use of equipment to include, but not be limited to, the following equipment:

(a) Sphygmomanometer; or a device able to measure blood pressure;

(b) Pulse oximeter; or other respiratory monitoring equipment;

(c) Electrocardiogram;

(d) Bag-valve-mask resuscitation equipment;

(e) Oral and nasopharyngeal airways;

(f) Defibrillator; automatic external defibrillator.

(5) The course referred to in subsection (4) of this section must also include instruction in:

(a) Basic sciences;

(b) Evaluation and preparation of patients with systemic diseases;

(c) Anesthetic drugs and techniques;

(d) Anesthesia equipment and monitoring; and

(e) Office anesthesia emergencies.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 09-04-042, § 246-817-772, filed 1/30/09, effective 3/2/09.]

WAC 246-817-774 Permitting/renewal requirements. (1) To administer moderate sedation (oral and/or parenteral), or general anesthesia (including deep sedation), a dentist must first meet the requirements of this chapter, possess and maintain a current dental license pursuant to chapter 18.32 RCW and obtain a permit of authorization from the DQAC through the department of health. Application forms for permits may be obtained online or from the department and must be fully completed and include the current application fee.

(2) A permit of authorization is valid for three years from the date of issuance and must be renewed prior to the expiration date.

(3) In addition to the renewal application form, the permit holder must:

(a) Demonstrate continuing compliance with this chapter.

(b) Submit satisfactory evidence of continuing education hours as required by this chapter.

The dentist must maintain records that can be audited and must submit course titles, instructors, dates of attendance, sponsors and number of hours for each course every three years as required by this chapter.

(c) Pay the applicable renewal fee.

(4) Site visits may be conducted at the DQAC discretion. Site visits will be conducted by an anesthesia provider permitted at the same level, in conjunction with a department of health investigator. Site visits may include the evaluation of equipment, medications, patient records, documentation of training of personnel, and other items as determined necessary.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 09-04-042, § 246-817-774, filed 1/30/09, effective 3/2/09.]

WAC 246-817-776 Discharge criteria for all levels of sedation/general anesthesia. The anesthesia provider must assess patient responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met:

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

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

(3) The patient can talk and respond coherently to verbal questioning as appropriate to age and preoperative psychological status;

(4) The patient can sit up unassisted;

(5) The patient can walk with minimal assistance;

(6) The patient does not have uncontrollable nausea or vomiting and has minimal dizziness;

(7) A discharge entry must be made in the patient's record by the anesthesia provider indicating the patient's condition upon discharge, and the name of the responsible party to whom the patient is released (if a patient is required to be released to a responsible party);

(8) If the patient does not meet established discharge criteria, the anesthesia provider must evaluate the patient and

determine if the patient has safely recovered to be discharged. The evaluation determining that the patient can be safely discharged must be noted in the patient's record.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 09-04-042, § 246-817-776, filed 1/30/09, effective 3/2/09.]

WAC 246-817-778 Nondental anesthesia providers. (1) A licensed dentist, certified registered nurse anesthetist (CRNA) or physician anesthesiologist may provide anesthesia services in dental offices where dentists do not have an anesthesia permit when the anesthesia provider ensures that all equipment, facility, monitoring and assistant training requirements as established within this chapter related to anesthesia have been met. The anesthesia provider is exclusively responsible for the pre, intra, and post operative anesthetic management of the patient.

(2) The dentist without a general anesthesia permit must establish a written contract with the anesthesia provider to guarantee that when anesthesia is provided, all facility, equipment, monitoring and training requirements, for all personnel, as established by DQAC related to anesthesia, have been met.

(a) The dentist and the anesthesia provider may agree upon and arrange for the provision of items such as facility, equipment, monitoring and training requirements to be met by either party, provided the delineation of such responsibilities is written into the contract.

(b) Any contract under this section must state that the anesthesia provider must ensure anesthesia related requirements as set forth in this chapter have been met.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 09-04-042, § 246-817-778, filed 1/30/09, effective 3/2/09.]

WAC 246-817-780 Mandatory reporting of death or significant complication as a result of any dental procedure. All licensees engaged in the practice of dentistry must submit a report of any patient death or other life-threatening incident or complication, permanent injury or admission to a hospital that results in a stay at the hospital for more than twenty-four hours, which is or may be a result of a dental procedure caused by a dentist or dental treatment.

(1) The dentist involved must notify the department of health/DQAC, by telephone, e-mail or fax within seventy-two hours of discovery and must submit a complete written report to the DQAC within thirty days of the incident.

(2) When a patient comes into an office with an existing condition, and hospital admission is the result of that condition and not the dental procedure, it is not reportable.

(3) The written report must include the following:

(a) Name, age, and address of the patient.

(b) Name of the dentist and other personnel present during the incident.

(c) Address of the facility or office where the incident took place.

(d) Description of the type of sedation or anesthetic being utilized at the time of the incident.

(e) Dosages, if any, of drugs administered to the patient.

(f) A narrative description of the incident including approximate times and evolution of symptoms.

(g) Additional information which the DQAC may require or request.

[Statutory Authority: RCW 18.32.640 and 18.32.0365. 09-04-042, § 246-817-780, filed 1/30/09, effective 3/2/09. Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-780, filed 10/10/95, effective 11/10/95.]

WAC 246-817-790 Application of chapter 18.130 RCW. The provisions of the Uniform Disciplinary Act, chapter 18.130 RCW, apply to the permits of authorization that may be issued and renewed under this chapter.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-790, filed 10/10/95, effective 11/10/95.]

SUBSTANCE ABUSE MONITORING PROGRAMS

WAC 246-817-801 Intent. It is the intent of the legislature that the DQAC seek ways to identify and support the rehabilitation of dentists where practice or competency may be impaired due to the abuse of drugs including alcohol. The legislature intends that these dentists be treated so that they can return to or continue to practice dentistry in a way which safeguards the public. The legislature specifically intends that the DQAC establish an alternate program to the traditional administrative proceedings against such dentists.

In lieu of disciplinary action under RCW 18.130.160 and if the DQAC determines that the unprofessional conduct may be the result of substance abuse, the DQAC may refer the license holder to a voluntary substance abuse monitoring program approved by the DQAC.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-801, filed 10/10/95, effective 11/10/95.]

WAC 246-817-810 Terms used in WAC 246-817-801 through 246-817-830. "Aftercare" is that period of time after intensive treatment that provides the dentist or the dentist's family with group or individual counseling sessions, discussions with other families, ongoing contact and participation in self-help groups, and ongoing continued support of treatment and/or monitoring program staff.

"Approved substance abuse monitoring program" or **"approved monitoring program"** is a program the DQAC has determined meets the requirements of the law and the criteria established by the DQAC in the Washington Administrative Code which enters into a contract with dentists who have substance abuse problems regarding the required components of the dentist's recovery activity and oversees the dentist's compliance with these requirements. Substance abuse monitoring programs may provide evaluation and/or treatment to participating dentists.

"Approved treatment facility" is a facility approved by the bureau of alcohol and substance abuse, department of social and health services according to RCW 18.130.175.

"Contract" is a comprehensive, structured agreement between the recovering dentist and the approved monitoring program wherein the dentist consents to comply with the monitoring program and the required components for the dentist's recovery activity.

"Dentist support group" is a group of dentists and/or other health professionals meeting regularly to support the recovery of its members. The group provides a confidential setting with a trained and experienced facilitator in which participants may safely discuss drug diversion, licensure

issues, return to work, and other professional issues related to recovery.

"Random drug screens" are laboratory tests to detect the presence of drugs of abuse in bodily fluids collected under observation which are performed at irregular intervals not known in advance by the person to be tested.

"Substance abuse" is the impairment, as determined by the DQAC, of a dentist's professional services by an addiction to, a dependency on, or the use of alcohol, legend drugs, or controlled substances.

"Twelve-steps groups" are groups such as Alcoholics Anonymous, Narcotics Anonymous, and related organizations based on a philosophy of anonymity, belief in a power outside of oneself, peer group association, and self-help.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-810, filed 10/10/95, effective 11/10/95.]

WAC 246-817-820 Approval of substance abuse monitoring programs. The DQAC will approve the monitoring program(s) which will participate in the recovery of dentists. The DQAC will enter into a contract with the approved substance abuse monitoring program(s) on an annual basis.

(1) An approved monitoring program may provide evaluations and/or treatment to the participating dentists.

(2) An approved monitoring program staff must have the qualifications and knowledge of both substance abuse and the practice of dentistry as defined in this chapter to be able to evaluate:

(a) Drug screening laboratories;

(b) Laboratory results;

(c) Providers of substance abuse treatment, both individual and facilities;

(d) Dentists' support groups;

(e) The dentists' work environment; and

(f) The ability of the dentist to practice with reasonable skill and safety.

(3) An approved monitoring program shall enter into a contract with the dentist and the DQAC to oversee the dentist's compliance with the requirements of the program.

(4) An approved monitoring program staff shall evaluate and recommend to the DQAC, on an individual basis, whether a dentist will be prohibited from engaging in the practice of dentistry for a period of time and restrictions, if any, on the dentist's access to controlled substances in the work place.

(5) An approved monitoring program shall maintain records on participants.

(6) An approved monitoring program shall be responsible for providing feedback to the dentist as to whether treatment progress is acceptable.

(7) An approved monitoring program shall report to the DQAC any dentist who fails to comply with the requirements of the monitoring program.

(8) An approved monitoring program shall provide the DQAC with a statistical report on the program, including progress of participants, at least annually, or more frequently as requested by the DQAC.

(9) The approved monitoring program shall receive from the DQAC guidelines on treatment, monitoring, and/or limitations on the practice of dentistry for those participating in the program.

(10) An approved monitoring program shall provide for the DQAC a complete financial breakdown of cost for each individual dental participant by usage at an interval determined by the DQAC in the annual contract.

(11) An approved monitoring program shall provide for the DQAC a complete annual audited financial statement.

(12) An approved monitoring program shall enter into a written contract with the DQAC and submit monthly billing statements supported by documentation.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-820, filed 10/10/95, effective 11/10/95.]

WAC 246-817-830 Participation in approved substance abuse monitoring program. (1) In lieu of disciplinary action, the dentist may accept DQAC referral into an approved substance abuse monitoring program.

(a) The dentist shall undergo a complete physical and psychosocial evaluation before entering the approved monitoring program. This evaluation shall be performed by health care professionals with expertise in chemical dependency.

(b) The dentist shall enter into a contract with the approved substance abuse monitoring program to comply with the requirements of the program which shall include, but not be limited to the following:

(i) The dentist shall agree to remain free of all mind-altering substances, including alcohol, except for medications prescribed by an authorized prescriber, as defined in RCW 69.41.030 and 69.50.101.

(ii) The dentist shall submit to random drug screening as specified by the approved monitoring program.

(iii) The dentist shall sign a waiver allowing the approved monitoring program to release information to the DQAC if the dentist does not comply with the requirements of this contract.

(iv) The dentist shall undergo intensive substance abuse treatment in an approved treatment facility.

(v) The dentist must complete the prescribed aftercare program of the approved treatment facility, which may include individual and/or group psychotherapy.

(vi) The treatment counselor(s) shall provide reports, as requested by the dentist, to the approved monitoring program at specified intervals. Reports shall include treatment prognosis and goals.

(vii) The dentist shall attend dentists' support groups and/or twelve-step group meetings as specified by the contract.

(viii) The dentist shall comply with specified practice conditions and restrictions as defined by the contract.

(ix) Except for (b)(i) through (iii) of this subsection, an approved monitoring program may make an exception to the foregoing comments on individual contracts.

(c) The dentist is responsible for paying the costs of the physical and psychosocial evaluation, substance abuse treatment, random drug screens, and therapeutic group sessions.

(d) The dentist may be subject to disciplinary action under RCW 18.130.160 and 18.130.180 if the dentist does not consent to be referred to the approved monitoring program, does not comply with specified practice restrictions, or does not successfully complete the program.

(2) A dentist who is not being investigated by the DQAC or subject to current disciplinary action, not currently being monitored by the DQAC for substance abuse, may voluntarily participate in the approved substance abuse monitoring program without being referred by the DQAC. Such voluntary participants shall not be subject to disciplinary action under RCW 18.130.160 and 18.130.180 for their substance abuse, and shall not have their participation made known to the DQAC if they meet the requirements of the approved monitoring program:

(a) The dentist shall undergo a complete physical and psychosocial evaluation before entering the approved monitoring program. This evaluation shall be performed by health care professional(s) with expertise in chemical dependency.

(b) The dentist shall enter into a contract with the approved substance abuse monitoring program to comply with the requirements of the program which may include, but not be limited to the following:

(i) The dentist shall undergo approved substance abuse treatment in an approved treatment facility.

(ii) The dentist shall agree to remain free of all mind-altering substances, including alcohol, except for medications prescribed by an authorized prescriber as defined in RCW 69.41.030 and 69.50.101.

(iii) The dentist must complete the prescribed aftercare program of the approved treatment facility, which may include individual and/or group psychotherapy.

(iv) The dentist must cause the treatment counselor(s) to provide reports to the approved monitoring program at specified intervals. Reports shall include treatment prognosis and goals.

(v) The dentist shall submit to random observed drug screening as specified by the approved monitoring program.

(vi) The dentist shall attend dentists' support groups and/or twelve-step group meetings as specified by the contract.

(vii) The dentist shall comply with practice conditions and restrictions as defined by the contract.

(viii) The dentist shall sign a waiver allowing the approved monitoring program to release information to the DQAC if the dentist does not comply with the requirements of this contract.

(c) The dentist is responsible for paying the costs of the physical and psychosocial evaluation, substance abuse treatment, random drug screens, and therapeutic group sessions.

(3) Treatment and pretreatment records shall be confidential as provided by law.

[Statutory Authority: RCW 18.32.035. 95-21-041, § 246-817-830, filed 10/10/95, effective 11/10/95.]

PAIN MANAGEMENT

WAC 246-817-901 Pain management—Intent. These rules govern the use of opioids in the treatment of patients for chronic noncancer pain.

[Statutory Authority: RCW 18.32.785 and 18.32.0365. 11-10-061, § 246-817-901, filed 5/2/11, effective 7/1/11.]

WAC 246-817-905 Exclusions. The rules adopted under WAC 246-817-901 through 246-817-965 do not apply to:

(1) The provision of palliative, hospice, or other end-of-life care; or

(2) The management of acute pain caused by an injury or surgical procedure.

[Statutory Authority: RCW 18.32.785 and 18.32.0365. 11-10-061, § 246-817-905, filed 5/2/11, effective 7/1/11.]

WAC 246-817-910 Definitions. The definitions in this section apply in WAC 246-817-901 through 246-817-965 unless the context clearly requires otherwise.

(1) "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. It is generally time-limited, often less than three months in duration, and usually less than six months.

(2) "Addiction" means a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include:

(a) Impaired control over drug use;

(b) Craving;

(c) Compulsive use; or

(d) Continued use despite harm.

(3) "Chronic noncancer pain" means a state in which noncancer pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.

(4) "Comorbidity" means a preexisting or coexisting physical or psychiatric disease or condition.

(5) "Episodic care" means medical care provided by a practitioner other than the designated primary care practitioner in the acute care setting, for example, urgent care or emergency department.

(6) "Hospice" means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less. Hospice involves an interdisciplinary approach to provide health care, pain management, and emotional and spiritual support. The emphasis is on comfort, quality of life and patient and family support. Hospice can be provided in the patient's home as well as freestanding hospice facilities, hospitals, nursing homes, or other long-term care facilities.

(7) "Morphine equivalent dose" means a conversion of various opioids to a morphine equivalent dose by the use of accepted conversion tables.

(8) "Multidisciplinary pain clinic" means a clinic or office that provides comprehensive pain management and includes care provided by multiple available disciplines or treatment modalities, for example, medical care through physicians, physician assistants, osteopathic physicians, osteopathic physician assistants, advanced registered nurse practitioners, and physical therapy, occupational therapy, or other complementary therapies.

(9) "Palliative" means care that improves the quality of life of patients and their families facing life-threatening illness. With palliative care particular attention is given to the prevention, assessment, and treatment of pain and other symptoms, and to the provision of psychological, spiritual, and emotional support.

[Statutory Authority: RCW 18.32.785 and 18.32.0365. 11-10-061, § 246-817-910, filed 5/2/11, effective 7/1/11.]

WAC 246-817-915 Patient evaluation. The dentist shall obtain, evaluate, and document the patient's health history and physical examination in the health record prior to treating for chronic noncancer pain.

(1) The patient's health history shall include:

(a) Current and past treatments for pain;

(b) Comorbidities; and

(c) Any substance abuse.

(2) The patient's health history should include:

(a) A review of any available prescription monitoring program or emergency department-based information exchange; and

(b) Any relevant information from a pharmacist provided to the dentist.

(3) The initial patient evaluation shall include:

(a) Physical examination;

(b) The nature and intensity of the pain;

(c) The effect of the pain on physical and psychological function;

(d) Medications including indication(s), date, type, dosage, and quantity prescribed;

(e) A risk screening of the patient for potential comorbidities and risk factors using an appropriate screening tool. The screening should address:

(i) History of addiction;

(ii) Abuse or aberrant behavior regarding opioid use;

(iii) Psychiatric conditions;

(iv) Regular concomitant use of benzodiazepines, alcohol, or other central nervous system medications;

(v) Poorly controlled depression or anxiety;

(vi) Evidence or risk of significant adverse events, including falls or fractures;

(vii) Receipt of opioids from more than one prescribing practitioner or practitioner group;

(viii) Repeated visits to emergency departments seeking opioids;

(ix) History of sleep apnea or other respiratory risk factors;

(x) Possible or current pregnancy; and

(xi) History of allergies or intolerances.

(4) The initial patient evaluation should include:

(a) Any available diagnostic, therapeutic, and laboratory results; and

(b) Any available consultations.

(5) The health record shall be maintained in an accessible manner, readily available for review, and should include:

(a) The diagnosis, treatment plan, and objectives;

(b) Documentation of the presence of one or more recognized indications for the use of pain medication;

(c) Documentation of any medication prescribed;

(d) Results of periodic reviews;

(e) Any written agreements for treatment between the patient and the dentist; and

(f) The dentist's instructions to the patient.

[Statutory Authority: RCW 18.32.785 and 18.32.0365. 11-10-061, § 246-817-915, filed 5/2/11, effective 7/1/11.]

WAC 246-817-920 Treatment plan. (1) The written treatment plan shall state the objectives that will be used to determine treatment success and shall include, at a minimum:

(a) Any change in pain relief;

(b) Any change in physical and psychosocial function; and

(c) Additional diagnostic evaluations or other planned treatments.

(2) After treatment begins the dentist should adjust drug therapy to the individual health needs of the patient. The dentist shall include indications for medication use on the prescription and require photo identification of the person picking up the prescription in order to fill. The dentist shall advise the patient that it is the patient's responsibility to safeguard all medications and keep them in a secure location.

(3) Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

[Statutory Authority: RCW 18.32.785 and 18.32.0365. 11-10-061, § 246-817-920, filed 5/2/11, effective 7/1/11.]

WAC 246-817-925 Informed consent. The dentist shall discuss the risks and benefits of treatment options with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is without health care decision-making capacity.

[Statutory Authority: RCW 18.32.785 and 18.32.0365. 11-10-061, § 246-817-925, filed 5/2/11, effective 7/1/11.]

WAC 246-817-930 Written agreement for treatment. Chronic noncancer pain patients should receive all chronic pain management prescriptions from one dentist and one pharmacy whenever possible. If the patient is at high risk for medication abuse, or has a history of substance abuse, or psychiatric comorbidities, the prescribing dentist shall use a written agreement for treatment with the patient outlining patient responsibilities. This written agreement for treatment shall include:

(1) The patient's agreement to provide biological samples for urine/serum medical level screening when requested by the dentist;

(2) The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills;

(3) Reasons for which drug therapy may be discontinued (e.g., violation of agreement);

(4) The requirement that all chronic pain management prescriptions are provided by a single prescriber or multidisciplinary pain clinic and dispensed by a single pharmacy or pharmacy system;

(5) The patient's agreement to not abuse alcohol or use other medically unauthorized substances;

(6) A written authorization for:

(a) The dentist to release the agreement for treatment to local emergency departments, urgent care facilities, and pharmacies; and

(b) Other practitioners to report violations of the agreement back to the dentist.

(7) A written authorization that the dentist may notify the proper authorities if he or she has reason to believe the patient has engaged in illegal activity;

(8) Acknowledgment that a violation of the agreement may result in a tapering or discontinuation of the prescription;

(9) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and

(10) Acknowledgment that if the patient violates the terms of the agreement, the violation and the dentist's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

[Statutory Authority: RCW 18.32.785 and 18.32.0365. 11-10-061, § 246-817-930, filed 5/2/11, effective 7/1/11.]

WAC 246-817-935 Periodic review. The dentist shall periodically review the course of treatment for chronic noncancer pain, the patient's state of health, and any new information about the etiology of the pain. Generally, periodic reviews shall take place at least every six months. However, for treatment of stable patients with chronic noncancer pain involving non-escalating daily dosages of forty milligrams of a morphine equivalent dose (MED) or less, periodic reviews shall take place at least annually.

(1) During the periodic review, the dentist shall determine:

(a) Patient's compliance with any medication treatment plan;

(b) If pain, function, or quality of life have improved or diminished using objective evidence, considering any available information from family members or other caregivers; and

(c) If continuation or modification of medications for pain management treatment is necessary based on the dentist's evaluation of progress towards treatment objectives.

(2) The dentist shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with current treatment plan is unsatisfactory. The dentist shall consider tapering, changing, or discontinuing treatment when:

(a) Function or pain does not improve after a trial period;

(b) There is evidence of significant adverse effects;

(c) Other treatment modalities are indicated; or

(d) There is evidence of misuse, addiction, or diversion.

(3) The dentist should periodically review information from any available prescription monitoring program or emergency department-based information exchange.

(4) The dentist should periodically review any relevant information from a pharmacist provided to the dentist.

[Statutory Authority: RCW 18.32.785 and 18.32.0365. 11-10-061, § 246-817-935, filed 5/2/11, effective 7/1/11.]

WAC 246-817-940 Long-acting opioids, including methadone. Long-acting opioids, including methadone, should only be prescribed by a dentist who is familiar with its risks and use, and who is prepared to conduct the necessary careful monitoring. Special attention should be given to patients who are initiating such treatment. Dentists prescribing long-acting opioids or methadone should have a one-time (lifetime) completion of at least four hours of continuing education relating to this topic.

[Statutory Authority: RCW 18.32.785 and 18.32.0365. 11-10-061, § 246-817-940, filed 5/2/11, effective 7/1/11.]

WAC 246-817-945 Episodic care. (1) When evaluating patients for episodic care, such as emergency or urgent care, the dentist should review any available prescription monitoring program, emergency department-based information exchange, or other tracking system.

(2) Episodic care practitioners should avoid providing opioids for chronic pain management. However, if opioids are provided, the practitioner should limit the use of opioids for a chronic noncancer pain patient to the minimum amount necessary to control the pain until the patient can receive care from a primary care practitioner.

(3) Prescriptions for opioids written by an episodic care practitioner shall include indications for use or the International Classification of Diseases (ICD) code and shall be written to require photo identification of the person picking up the prescription in order to fill.

(4) If a patient has signed a written agreement for treatment and has provided a written authorization to release the agreement under WAC 246-817-930(6) to episodic care practitioners, then the episodic care practitioner should report known violations of the agreement back to the patient's treatment practitioner who provided the agreement for treatment.

[Statutory Authority: RCW 18.32.785 and 18.32.0365. 11-10-061, § 246-817-945, filed 5/2/11, effective 7/1/11.]

WAC 246-817-950 Consultation—Recommendations and requirements. (1) The dentist shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic noncancer pain patients who are under eighteen years of age, or who are at risk for medication misuse, abuse, or diversion. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.

(2) The mandatory consultation threshold for adults is one hundred twenty milligrams morphine equivalent dose (MED) (oral). In the event a dentist prescribes a dosage amount that meets or exceeds the consultation threshold of one hundred twenty milligrams MED (orally) per day, a consultation with a pain management specialist as described in WAC 246-817-965 is required, unless the consultation is exempted under WAC 246-817-955 or 246-817-960. Great caution should be used when prescribing opioids to children with chronic noncancer pain and appropriate referrals to a specialist is encouraged.

(a) The mandatory consultation shall consist of at least one of the following:

(i) An office visit with the patient and the pain management specialist;

(ii) A telephone consultation between the pain management specialist and the dentist;

(iii) An electronic consultation between the pain management specialist and the dentist; or

(iv) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the dentist or a licensed health care practitioner designated by the dentist or the pain management specialist.

(b) A dentist shall document each mandatory consultation with the pain management specialist. Any written record of the consultation by the pain management specialist shall be maintained as a patient record by the specialist. If the specialist provides a written record of the consultation to the dentist, the dentist shall maintain it as part of the patient record.

(3) Nothing in this chapter shall limit any person's ability to contractually require a consultation with a pain management specialist at any time. For the purposes of WAC 246-817-901 through 246-817-965, "person" means an individual, a trust or estate, a firm, a partnership, a corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district.

[Statutory Authority: RCW 18.32.785 and 18.32.0365. 11-10-061, § 246-817-950, filed 5/2/11, effective 7/1/11.]

WAC 246-817-955 Consultation—Exemptions for exigent and special circumstances. A dentist is not required to consult with a pain management specialist as described in WAC 246-817-965 when he or she has documented adherence to all standards of practice as defined in WAC 246-817-901 through 246-817-965 and when any one or more of the following conditions apply:

(1) The patient is following a tapering schedule;

(2) The patient requires treatment for acute pain which may or may not include hospitalization, requiring a temporary escalation in opioid dosage, with expected return to or below their baseline dosage level;

(3) The dentist documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty milligrams morphine equivalent dose (MED) per day without first obtaining a consultation; or

(4) The dentist documents the patient's pain and function is stable and the patient is on a non-escalating dosage of opioids.

[Statutory Authority: RCW 18.32.785 and 18.32.0365. 11-10-061, § 246-817-955, filed 5/2/11, effective 7/1/11.]

WAC 246-817-960 Consultation—Exemptions for the dentist. The dentist is exempt from the consultation requirement in WAC 246-817-950 if one or more of the following qualifications are met:

(1) The dentist is a pain management specialist as described in WAC 246-817-965; or

(2) The dentist has successfully completed, within the last two years, a minimum of twelve continuing education hours on chronic pain management approved by the profession's continuing education accrediting organization, with at least two of these hours dedicated to long acting opioids, to include methadone; or

(3) The dentist is a pain management practitioner working in a multidisciplinary chronic pain treatment center, or a multidisciplinary academic research facility; or

(4) The dentist has a minimum three years of clinical experience in a chronic pain management setting, and at least thirty percent of his or her current practice is the direct provision of pain management care.

[Statutory Authority: RCW 18.32.785 and 18.32.0365. 11-10-061, § 246-817-960, filed 5/2/11, effective 7/1/11.]

WAC 246-817-965 Pain management specialist. A pain management specialist shall meet one or more of the following qualifications:

(1) If a physician or osteopathic physician:

(a) Board certified or board eligible by an American Board of Medical Specialties-approved board (ABMS) or by the American Osteopathic Association (AOA) in physical medicine and rehabilitation, rehabilitation medicine, neurology, rheumatology, or anesthesiology; or

(b) Has a subspecialty certificate in pain medicine by an ABMS-approved board; or

(c) Has a certification of added qualification in pain management by the AOA; or

(d) A minimum of three years of clinical experience in a chronic pain management care setting; and

(i) Credentialed in pain management by an entity approved by the Washington state medical quality assurance commission for physicians or the Washington state board of osteopathic medicine and surgery for osteopathic physicians; and

(ii) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years; and

(iii) At least thirty percent of the physician's or osteopathic physician's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

(2) If a dentist: Board certified or board eligible in oral medicine or orofacial pain by the American Board of Oral Medicine or the American Board of Orofacial Pain.

(3) If an advanced registered nurse practitioner (ARNP):

(a) A minimum of three years of clinical experience in a chronic pain management care setting;

(b) Credentialed in pain management by a Washington state nursing care quality assurance commission-approved national professional association, pain association, or other credentialing entity;

(c) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years; and

(d) At least thirty percent of the ARNP's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

(4) If a podiatric physician:

(a) Board certified or board eligible in a specialty that includes a focus on pain management by the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, or other accredited certifying board as approved by the Washington state podiatric medical board; or

(b) A minimum of three years of clinical experience in a chronic pain management care setting; and

(c) Credentialed in pain management by a Washington state podiatric medical board-approved national professional

association, pain association, or other credentialing entity; and

(d) Successful completion of a minimum of at least eighteen hours of continuing education in pain management during the past two years, and at least thirty percent of the podiatric physician's current practice is the direct provision of pain management care.

[Statutory Authority: RCW 18.32.785 and 18.32.0365. 11-10-061, § 246-817-965, filed 5/2/11, effective 7/1/11.]

FEES

WAC 246-817-990 Dentist fees and renewal cycle. (1) Licenses must be renewed every year on the practitioner's birthday as provided in chapter 246-12 WAC, Part 2, except faculty and resident licenses. The secretary may require payment of renewal fees less than those established in this section if the current level of fees is likely to result in a surplus of funds. Surplus funds are those in excess of the amount necessary to pay for the costs of administering the program and to maintain a reasonable reserve. Notice of any adjustment in the required payment will be provided to practitioners. The adjustment in the required payment shall remain in place for the duration of a renewal cycle to assure practitioners an equal benefit from the adjustment.

(2) Faculty and resident licenses must be renewed every year on July 1 as provided in chapter 246-12 WAC, Part 2. The secretary may require payment of renewal fees less than those established in this section if the current level of fees is likely to result in a surplus of funds. Surplus funds are those in excess of the amount necessary to pay for the costs of administering the program and to maintain a reasonable reserve. Notice of any adjustment in the required payment will be provided to practitioners. The adjustment in the required payment shall remain in place for the duration of a renewal cycle to assure practitioners an equal benefit from the adjustment.

(3) The following nonrefundable fees will be charged:

Title of Fee	Fee
Original application by examination*	
Initial application	$700.00
Original application - Without examination	
Initial application	700.00
Initial license	700.00
Faculty license application	560.00
Resident license application	115.00
License renewal:	
Renewal	551.00
Surcharge - Impaired dentist	25.00
Late renewal penalty	288.00
Expired license reissuance	300.00
Inactive renewal	125.00
Inactive late renewal penalty	50.00
Duplicate license	15.00
Certification of license	25.00
Anesthesia permit	
Initial application	150.00
Renewal - (Three-year renewal cycle)	150.00
Late renewal penalty	75.00
Expired permit reissuance	50.00
On-site inspection fee	To be determined by future rule adoption.

* In addition to the initial application fee above, applicants for licensure via examination will be required to submit a separate application and examination fee directly to the dental testing agency accepted by the dental quality assurance commission.

[Statutory Authority: RCW 43.70.110, 43.70.250, and 2010 c 37. 10-19-071, § 246-817-990, filed 9/16/10, effective 10/15/10. Statutory Authority: RCW 43.70.110, 43.70.250 and 2008 c 329. 08-16-008, § 246-817-990, filed 7/24/08, effective 7/25/08. Statutory Authority: RCW 43.70.250, [43.70.]280 and 43.70.110. 05-12-012, § 246-817-990, filed 5/20/05, effective 7/1/05. Statutory Authority: RCW 18.32.0365 and 43.70.250. 01-11-166, § 246-817-990, filed 5/23/01, effective 7/1/01. Statutory Authority: RCW 43.70.250. 99-08-101, § 246-817-990, filed 4/6/99, effective 7/1/99. Statutory Authority: RCW 43.70.280. 98-05-060, § 246-817-990, filed 2/13/98, effective 3/16/98. Statutory Authority: RCW 43.70.040. 95-16-122, § 246-817-990, filed 8/2/95, effective 9/1/95.]

WAC 246-817-99005 Dental assistant, dental anesthesia assistant, and expanded function dental auxiliary fees and renewal cycle. (1) Credentials must be renewed every year on the practitioner's birthday as provided in chapter 246-12 WAC, Part 2.

(2) The following nonrefundable fees will be charged for dental assistant, dental anesthesia assistant, and expanded function dental auxiliary credentials:

Title of Fee - Dental Professionals	Fee
Registered dental assistant application	$40.00
Registered dental assistant renewal	21.00
Registered dental assistant late renewal	21.00
Registered dental assistant expired reactivation	20.00
Certified dental anesthesia assistant application	100.00
Certified dental anesthesia assistant renewal	75.00
Certified dental anesthesia assistant late renewal	50.00
Certified dental anesthesia assistant expired reactivation	75.00
Licensed expanded function dental auxiliary application	175.00
Licensed expanded function dental auxiliary renewal	160.00
Licensed expanded function dental auxiliary late renewal	80.00
Licensed expanded function dental auxiliary expired reactivation	50.00
Duplicate credential	15.00
Certification of credential	25.00

[Statutory Authority: 2012 c 208, 2012 c 23, 2012 c 137, 2012 c 153, RCW 43.70.110, and 43.70.250. 12-24-015, § 246-817-99005, filed 11/27/12, effective 7/1/13. Statutory Authority: RCW 43.70.110, 43.70.250, and 2010 c 37. 10-19-071, § 246-817-99005, filed 9/16/10, effective 10/15/10. Statutory Authority: RCW 43.70.250. 08-13-069, § 246-817-99005, filed 6/13/08, effective 7/1/08.]