

# THE DENTAL FORUM

## NC State Board of Dental Examiners

Spring, 2007

Clifford O. Feingold, D.D.S., Editor

### Cone Beam Imaging

The use of cone beam computer tomography (CBCT) represents a major advancement in radiologic imaging for dentists. Many consider CBCT, with its enhanced computer graphics and 3-D capability, to be the most significant advancement in dental imaging since the development of the panoramic image. The use of CBCT has progressed more rapidly than initially anticipated and with this expansion inevitably come more questions than answers.

Since the CBCT reveals more data than the panoramic or intra-oral images, how should these images best be used for patient treatment and care? For example, if you intend to use the image data solely for implant placement or orthodontic planning, what are the risks associated with that mentality? Also, what about training and education in the use of the machine itself? Does the manufacturer provide sufficient training in use and interpretation of the data, or should you consider an additional course in CBCT offered by a dental school or other organization independent from the company making the sale? What about setting up an "imaging center" and offering imaging services to practitioners outside your practice to help offset the cost of the CBCT

system? These and other questions will arise as this, as well as other, relatively new technologies make their way into the diagnostic arsenal of dentists.

To date, the Board does not have special statutes or rules governing the use of CBCT, nor does the Board anticipate the need for such at this time, as its use falls into current categories governing the standard of care applicable to other diagnostic tools. As such, if used improperly, a practitioner assumes the same degree of risk as with other emerging technologies in dentistry. For example, if you use the CBCT primarily to

determine the placement of an implant and a tumor is present in the image, such a scenario could result in a complaint being filed with the Board. The Board would then evaluate the merits of the complaint using the same standard that it applies to the interpretation of radiographs.

It is the Board's understanding that some CBCT manufacturers emphasize that the machine may be used to evaluate a single region of interest (orthodontic planning for example), and that patient release/consent forms will absolve you from all responsibility from any outside specific narrowly tailored usage. This, of course, is a legal rather than a medical question and the Board urges you to consult your legal counsel for advice before risking exposure to potential liability. However, you should always remember that the Board views the use of CBCT under the rules applicable to radiographs. Therefore, if you acquire a volume of data, you should be able to interpret the data for a complete and accurate diagnosis. If you are unfamiliar with the full potential of this emerging technology, should consider consulting with a Board certified oral and maxillofacial radiologist.

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SPRING, 2007

THE PRACTICE OF DENTISTRY IN THE STATE OF NORTH CAROLINA IS HEREBY DECLARED TO AFFECT THE PUBLIC HEALTH SAFETY AND WELFARE AND TO BE SUBJECT TO REGULATION AND CONTROL IN THE PUBLIC INTEREST. IT IS FURTHER DECLARED TO BE A MATTER OF PUBLIC INTEREST AND CONCERN THAT THE DENTAL PROFESSION MERIT AND RECEIVE THE CONFIDENCE OF THE PUBLIC AND THAT ONLY QUALIFIED INDIVIDUALS BE PERMITTED TO PRACTICE DENTISTRY IN NORTH CAROLINA.

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*The Dental Forum* is published for the primary purpose of educating and informing licensees about the laws, rules and standards governing the dental profession. From time to time, the Board may publish articles and letters expressing the opinions or views of their authors. These opinions and views may not necessarily reflect those of the Board or its staff, but are expressly those of the author.

Letters to the Editor regarding any topic covered in this publication are gladly received and may be published in whole or in edited form, as space allows. It is requested that all letters include the writer's full name, address and telephone number.

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### —Cone Beam Imaging

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As in all dental diagnostic technologies, appropriate training in the use of the equipment and proper reading of the images produced are essential to correct and prudent utilization of CBCT technology. And, as we have already stated, unfamiliarity with the wealth of data presented by the images may result in increased risks which would be greatly reduced with appropriate training and/or consultation from expert dentists in the field with respect to image interpretation when necessary. As a matter of guidance rather than rule, the Board strongly encourages dentists considering the use of CBCT technology to attend courses and/or seminars offered by appropriate experts in order to familiarize themselves with all aspects of this emerging technology.

There are several points necessary to consider with regard to developing stand alone "imaging centers." First, the rules governing the use of x-rays by dental auxiliaries apply to dental assistants and hygienists who use the CBCT. This means appropriate Board approved course work in the use of such must be completed, and direct supervision regulations remain in place. Second, having a financial interest in an imaging center separate from your dental office creates the risk of violating the NC law against self-referral. (NC Gen. Stat. 90-406). Again, the Board encourages you to seek legal counsel from your attorney to familiarize yourself with this statute and eliminate the risk of a violation.



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## From the President

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Dr. Joseph Burnham



It is a historical fact that those individuals who are entrusted by their state dental practice acts to regulate dental licensure frequently come under fire for their examination and licensure procedures. In order to effectively protect the public and the profession it is completely appropriate for examination and licensure Boards to come under scrutiny from those in the profession, new licensees, and the proper governmental officials. However, there is a compelling yet misleading movement to undermine the authority of dental Boards and weaken their one and only mandate – public protection. The North Carolina State Board of Dental Examiners (NCSBDE) is of one mind and that is to carry out this mandate effectively: we must, and always should, control entry-level licensure by means of an independent third-party examination process. In lieu of adequate developments in testing methods, this means we must continue to have human patients participate in this examination format.

As you all know, in an effort to provide a thorough and fair examination we have endorsed a Curriculum Integrated Format (CIF) for our third and fourth year students. This allows for the several modules of the exam to be taken during the school year on patients of record with a

supervised treatment plan in mind. Individuals that are unsuccessful on any one module may remediate with faculty and retake this section at a later date. Last year was the first full year that the CIF was given at UNC and 99% of the graduating class received their license immediately after graduation. They did not have to participate in the high-pressure, high-stakes, one time only examination in June that we are all very familiar with. Also, in an effort to approach the access to care issues and ease the licensure process, the N.C. Legislature wisely passed laws that allow dentists with five years and hygienists with two years experience and a clean record from their respective jurisdictions to apply for and receive a license by credentials. To date approximately 250 dentists and 290 dental hygienists have been licensed to practice in N.C. by credentials. In order to properly protect the public, the Secretary/Treasurer of the NCSBDE reviews each of these applications, and licenses are granted only after the scrutiny of the full Board.

In another effort to increase the portability of a North Carolina dental license, the NCSBDE has joined the Council of Interstate Testing Agencies (CITA). Individuals who take and pass the CITA examination have the ability to apply for licensure in thirteen jurisdictions that currently recognize the CITA exam. CITA continues its efforts to increase the number of states that will accept the CITA test results for licensure. The NCS-

BDE chose CITA over other regional examinations when the four major regional testing agencies failed in their efforts to create a truly national licensure exam. CITA was the only agency that guaranteed each member state Board the opportunity to have a voice in test construction, criteria, scoring, and administration. All other regionals had no place for members of the NCSBDE to serve as active participants in these crucial areas of the testing process. The CITA exam, as it is now formatted and continues to evolve, has its roots in the American Board of Dental Examiners (ADEX), but with improved scoring and processing protocols. Members of the NCSBDE spent many hours away from home in various cities working for the ADEX construct only to be refused positions in the governance and administration of this exam as is required under North Carolina law. Once it became clear that the NC Board would have no control or input into the clinical exam to be offered in our state, it became impossible to continue supporting ADEX. Nonetheless, in CITA we know we have a valid, legally defensible, and psychometrically reliable exam without the redundancy found in others. The level of cooperation and collaboration among the CITA member states has been unparalleled, and the CITA exam is truly state-of-the-art.

Now, back to the aforementioned threats to the independent third-party examination process.

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**—From the President**

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Many dental educators, dental students, and some ADA leaders think that this examination has no merit. School is over, let's go to work. They contend licensure by diploma or postgraduate year one (PGY-1) should be sufficient to effectively say to the public that these new dentists are deemed competent. And the new ADA president has lauded New York for eliminating licensure exams in favor of PGY-1 beginning in 2007. In the opinion of the NCSBDE this is a dreadful mistake. It has been our experience that the clinical licensure examination continues to demonstrate that a small percentage of dental school and PGY-1 graduates con-

tinues to exhibit sub-par clinical skills.

The question is often posed that since a high percentage of all dental school graduates passes their licensure exams, why bother? The answer can be found in that small percentage that does not. It is these who run the greatest risk of injuring patients and bringing our profession into disrepute. With the increasing pressure on our dental schools to graduate every student, who, other than the state licensing agencies will provide assurance to the public that our licensees are at least minimally competent?

The summation of all this is that in the interest of public pro-

tection, independent third-party examinations must be retained to serve as a portal to admit competent new dentists into this profession and exclude those who cannot meet minimum standards. The bottom line is that we, the practicing dentists of NC, set the standard of care for our state and that we all must follow. We cannot and must not allow those who would weaken or question our moral, ethical, and professional standards to win the day. Who loses if we abrogate this authority? First, the public, then our profession, which historically has enjoyed the highest esteem for our ethics and professionalism.



## **We've Moved.**

**Please make a note of our new address and contact information.**

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## Two Earn Volunteer Service Awards

Dr. Jay Jefferson and Dr. William Rabe were awarded the inaugural Volunteer Service Awards by the North Carolina State Board of Dental Examiners. The Volunteer Service Award was created by the Board to recognize those who have given over 100 hours of volunteer service to assist the Board in its work of protecting the public. Both Dr. Rabe and Dr. Jefferson have been tireless when called on by the Board for case evaluations, offering expert opinions, and providing crucial assistance to the Board in developing policy.



**Dr. William Rabe**

Dr. Rabe established his solo practice in oral surgery in Asheboro NC in 1998. Prior to that he practiced oral surgery with a group in the High Point area. He received his D.M.D. from the University of Pennsylvania in 1973 and completed his residency at Duke University Medical Center. When asked why he had volunteered so much time assisting the Board, Dr. Rabe stated that it is crucial for individuals to serve in order to preserve dentistry's system of self-governance. He expressed gratitude for all those who serve in organized dentistry and stated that in his experience, "The Board always seeks what is right and fair. They don't approach issues assuming they know everything. That's why input from practitioners is crucial."

**Dr. Jay Jefferson**



Dr. Jefferson grew up in the railroad and steel town of Portsmouth, Ohio. After finishing his undergraduate degree in microbiology at Ohio State University, he was one of two out-of-state students accepted into the University of Kentucky College of Dentistry. He earned his D.M.D. with distinction from Kentucky in 1983 and while in dental school completed an internship in anesthesiology at Southwestern Medical Center, University of Texas/Parkland Memorial Hospital in Dallas. He returned to Parkland

Memorial for his Oral and Maxillofacial residency. After finishing his OMS residency in 1987 he was invited to Raleigh to join a practice started by another Parkland resident, Dr. John Pearson. By 1991 Dr. Jefferson was involved in helping the Board with anesthesia issues and has remained a dedicated volunteer. Why does he do it? "Everyone has expertise. We all have to put in effort to help our profession."

The Board congratulates Drs. Rabe and Jefferson on being the initial recipients of the Volunteer Service Award and deeply appreciates their continued commitment to the profession.



## YOU'RE INVITED

This year the NC State Board of Dental Examiners is scheduling another of its regular meetings away from its home office in Morrisville. The purpose is to offer licensees an easier opportunity to attend the Board's business session. The next opportunity will be October 19, 2007 in Morehead City. As the date draws nearer, individual invitations will be sent to all dentists and dental hygienists in the area giving the specifics of where the meeting will occur. Although we have not yet lined up the place, we do know that the Board will conduct public business between 3 and 5 p.m. on October 19th and we encourage all dentists and dental hygienists in the area to attend. After the business session the Board will host a reception to allow an informal time for all in attendance to meet and mingle.

All we ask is that you contact the Board's office (919 678-8223 x1780) at least one week in advance and let us know if you plan to attend.

## BOARD ELECTIONS

It will soon be election time again. Each year two positions for dentists become open on the Board and nominees for these positions must stand for general election. To place one's name in nomination requires only "a written petition signed by not less than 10 dentists licensed to practice in North Carolina and residing or practicing in North Carolina." [N.C.G.S. § 90-22(c)(4)] The deadline for filing a nomination is midnight, May 20, 2007.

The system of self-regulation of the dental profession in this state depends on competent and qualified dentists and dental hygienists being willing to serve on the Board. Dedicated members of the profession have always been called upon and been willing to take time away from their practices and families to serve the public and the profession. Now, there is another requirement facing candidates for election as well as sitting members of the Board.

Among its many sweeping provisions, the newly adopted North Carolina State Government Ethics Act requires members of the Dental Board and candidates for election to file financial disclosure statements with the North Carolina Ethics Commission. The disclosure statements, known as SEIs (Statement of Economic Interest) are public documents and must be updated annually. The SEI requires disclosure of assets and income not only for the member/candidate but also for members of his or her immediate family. The form also calls for disclosure of business relationships, felony convictions and certain gifts from lobbyists. Failure to file the form in a timely manner may result in a fine. Making a false disclosure is a felony.

Candidates for election to the Board must file their SEIs with the Ethics Commission within 10 days after the election filing deadline. **Even if elected, a new Board member may not be sworn in until approved by the Ethics Commission.** A copy of the SEI may be obtained at the Ethics Commission's website: [www.doa.state.nc.us/doa/ethics](http://www.doa.state.nc.us/doa/ethics)

## BOARD MEETING DATES

**(Subject to Change)**

April 20 -21	Board Office, Morrisville
May 4-5	Board Office, Morrisville
May 17	Ocean Ridge Plantation, Brunswick Co., NC
June 7-9	Exams, Chapel Hill
July 13-14	Board Office, Morrisville
August 10-11	Board Office, Morrisville
September 14-15	Exams, Chapel Hill
October 19 – 20	TBA, Morehead City
November 16-17	Board Office, Morrisville
December 7-8	Board Office, Morrisville

## Candidates for Board Positions

Currently, three nominations have been received for the two Board positions that will be opening this year. Dr. Dewey G. Carter, of Burlington, Dr. W. Stan Hardesty, Jr. of Raleigh, and Dr. Brad Morgan of Canton have announced their intentions to run for the Board. Nomination must be received by midnight May 20, 2007 in order to meet the filing deadline.



## Dissolving Dental Practices

The Dental Board realizes that dissolving a dental practice or the departure of a dentist from a practice can create a number of problems and concerns. If mishandled, the process can disrupt patient care and even lead to disciplinary problems. The Board of Dental Examiners provides the following guidance for practitioners:

- **Inform Patients Promptly**

Current patients should be informed of the changes in the practice as soon as possible, to permit them to secure other dental care if necessary. If at all possible, at least 30 days notice should be given. Letters to existing patients and newspaper advertisements are often the most effective means of communicating practice changes.

- **Permit Patient Choice**

The notice to patients should make it clear that the choice of a dental provider is the patient's. The notice should also explain how patients can have their records transferred and when the changes in the practice go into effect. Ideally, all dentists in the practice should agree on the text of the notice, who sends it and when. If no agreement can be reached, a dentist must ensure that his or her own patients receive appropriate notice.

- **Provide Contact Information**

Patients should also be given current contact information of the dentists remaining in the practice, if any, as well as the departing dentists. This will ensure that patients have a meaningful choice about who will provide the dental care and that they have prompt access to their records.

- **Handle Patient Records Requests Properly**

A patient's dental records must be transferred to a successor dentist upon request of the patient. The records must include originals or copies of radiographs and a summary of the patient's treatment records. The treatment summary must be provided within 30 days of the request.

- **Dealing With Old Patient Records**

Dental records must continue to be maintained by the treating dentist for at least 10 years. Ideally, patients should be given an opportunity to pick up records that are more than 10 years old. Unclaimed records that are more than 10 years old should be destroyed in a manner that preserves confidentiality, such as by shredding.

- **Fees For Providing Records**

A reasonable fee may be charged for duplicating radiographs and diagnostic materials if the dentist chooses to forward copies instead of the originals to a successor dentist. Records may not be withheld because a patient has not paid some or all of a charge owed to a dentist.

- **Notify the Dental Board**

The N.C. Board of Dental Examiners should immediately be notified of address changes for dentists and hygienists. The Board should also be told of changes in a practice's corporate or business structure.

- **Cooperation a Plus**

Though from time to time hard feelings may erupt, always keep in mind that greater cooperation results in greater savings of time, money, and energy. Therefore, practitioners should strive to cooperate with each other in the dissolution process and avoid conduct that could harm patients or bring the profession into disrepute.

The most recent disciplinary actions are posted in their entirety on the Board's website: [www.ncdentalboard.org](http://www.ncdentalboard.org). Disciplinary action may also be checked by using the verification tab on the main menu and searching under the licensee's name. For older disciplinary orders simply contact the Board's office and a copy of the entire order will be forwarded to you.



# The Role of the Dental Hygienist

Nepuls Hall



As dental hygienists, we are always licensed professionals with an ethical obligation to our patients and the public. Sometimes, it does not matter how hard we try, conflict develops. For example, what do you do when a patient whose physician has prescribed antibiotic pre-medication arrives at the office without having taken the prescribed pre-medication? How does the hygienist protect the patient when the patient insists on going forward with the hygiene appointment? Where do you look for guidance in making ethical choices? First, always remember that you are part of a treatment team. Consult the dentists and other team members. Keep everyone fully informed of the situation and make an entry on the patient chart. But there are other sources you can look to for guidance as well.

The ADA and ADHA offer guidelines on this delicate and serious subject. (The new AHA guidelines are included with this article.) Both speak of ethical consciousness in decision-making, ethical choices and accepting the responsibility for knowing and applying ethical choices. One key element that jumped out in both statements was that relating to the public trust.

Some patients may sign a waiver or consent form just to get the hygiene treatment completed. But is that enough? We all know that a patient cannot consent to negligent

treatment. Our patients trust us to protect them and do no harm. They know that their physician has told them they need the antibiotic for their heart condition. What will the patients think about the professional who provided hygiene services for them, even if they do not get infective endocarditis as a result of the treatment? Will they trust our advice in the future? Probably not. And, if they do get sick, they will blame it on the person who treated them.

When you Google bacterial endocarditis on the internet, you will find several interesting articles and research from the American Heart Association about studies conducted all over the world. These studies have been carried out on patients whose

heart abnormalities require prophylactic antibiotics and pose the potential for life-threatening infective endocarditis. The odds of getting IE with unprotected procedures are 1 in 46,000, as contrasted with 1 in 150,000 for protected procedures. To make an interesting analogy, let's compare it to the lottery. Would you rather have a 1:46,000 chance or a 1:150,000 chance? The answer depends on what you win. Although the risks of a patient contracting IE may seem minimal, they are still very real. Why take a chance on the trust you have worked hard to establish with patients and staff? Why risk the patient's safety and a potential complaint to the Board?

There are several very simple ways to prevent the problem from even occurring. First, you should

always flag patients who need pre-medication, so they can be reminded to take their meds when their appointment is confirmed. Second, ask all new patients about any pre-medication requirements. Third, make sure you keep a supply of the necessary antibiotics for pre-mediations in the office, so they can be administered on site, with the proper time allotted before treatment. And, when confirming and mailing re-care cards, remind patients to take their pre-medication. Finally, in morning "huddles," review patients' charts to flag and discuss medical concerns, including pre-medication needs.

As licensed dental hygienists, we are expected to contribute to the safety and well being of the patient. As our mentor and author of "Clinical Practice of the Dental Hygienist," Ester Wilkins, BS, RDH, DMD, says "we should never jeopardize a person's health." The people we serve expect us to protect and provide them with competent dental hygiene care. Saving one hour is not worth facing a Board prosecution, a lawyer, losing your license or the trust and respect of your patients and staff.





## **New guidelines regarding antibiotics to prevent infective endocarditis**

The American Heart Association recently updated its guidelines regarding which patients should take a precautionary antibiotic to prevent infective endocarditis (IE) before a trip to the dentist.

The guidelines, published in *Circulation: Journal of the American Heart Association*, are based on a growing body of scientific evidence that shows that, for most people, the risks of taking prophylaxis antibiotics for certain procedures outweigh the benefits. These guidelines represent a major change in philosophy.

The new guidelines show taking preventive antibiotics is not necessary for most people and, in fact, might create more harm than good. Unnecessary use of antibiotics could cause allergic reactions and dangerous antibiotic resistance.

Only the people at greatest risk of bad outcomes from infective endocarditis — an infection of the heart's inner lining or the heart valves — should receive short-term preventive antibiotics before common, routine dental and medical procedures.

Patients at the greatest danger of bad outcomes from IE and for whom preventive antibiotics are worth the risks include those with:

- artificial heart valves
- a history of having had IE
- certain specific, serious congenital (present from birth) heart conditions, including:
  - unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits
  - a completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter interventions, during the first six months after the procedure
  - any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or prosthetic device
- a cardiac transplant which develops a problem in a heart valve.

## Pending Legislation

*The Senate Health Care Committee passed the following Senate Bill on May 2, 2007. To follow the bill's progress you may visit the General Assembly's website [www.ncga.state.nc.us] or contact the office of your local elected representative. New language is underlined.*

GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2007

SENATE BILL 1337

Health Care Committee Substitute Adopted  
5/2/07

Third Edition Engrossed 5/3/07

March 26, 2007

A BILL TO BE ENTITLED

AN ACT AMENDING THE NORTH CAROLINA DENTAL HYGIENE ACT TO PROVIDE FOR CERTAIN ACTIVITIES TO BE PERFORMED BY LICENSED HYGIENISTS OUTSIDE THE DIRECT SUPERVISION OF A DENTIST.

The General Assembly of North Carolina enacts:

**SECTION 1.** G.S. 90-221 reads as rewritten:

**“§ 90-221. Definitions.**

(a) “Dental hygiene” as used in this Article shall mean the performance of the following functions: Complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medications prescribed by a licensed dentist, preparation of diagnostic aids, and written records of oral conditions for interpretation by the dentist, together with such other and further functions as may be permitted by rules and regulations of the Board not inconsistent herewith.

(b) “Dental hygienist” as used in this Article, shall mean any person who is a graduate of a Board-accredited school of dental hygiene, who has been licensed by the Board, and who practices dental hygiene as prescribed by the Board.

(c) “License” shall mean a certificate issued to any applicant upon completion of requirements for admission to practice dental hygiene.

(d) “Renewal certificate” shall mean the annual certificate of renewal of license to continue practice of dental hygiene in the State of North Carolina.

(e) “Board” shall mean π“The North Carolina State Board of Dental Examiners” created by Chapter 139, Public Laws of 1879, and Chapter 178, Public Laws of 1915 as continued in existence by G.S. 90-22.

(f) “Supervision” as used in this Article shall mean that acts are deemed to be under the supervision of a licensed dentist when performed in a locale where a licensed dentist is physically present during the performance of such acts, except those acts performed under direction and in compliance with G.S. 90-233(a) or G.S. 90-233(a1), and such acts are being performed pursuant to the dentist’s order, control and approval.”

**SECTION 2.** G.S. 90-233 reads as rewritten:

**“§ 90-233. Practice of dental hygiene.**

(a) A dental hygienist may practice only under the supervision of one or more licensed dentists. This subsection shall be deemed to be complied with in the case of dental hygienists employed by or under contract with a local health department or State government dental public health program and especially trained by the Dental Health Section of the Department of Health and Human Services as public health hygienists, while performing their duties for the persons officially served by the local health department or State government program under the direction of a duly licensed dentist employed by that program or by the Dental Health Section of the Department of Health and Human Services.

(a1) A dental hygienist who has three years of experience in clinical dental hygiene or a minimum of 2,000 hours performing primarily prophylaxis or periodontal debridement under the supervision of a licensed dentist, who completes annual CPR certification, who completes six hours each year of Board-approved continuing education in medical emergencies in addition to the requirements of G.S. 90-225.1, and who is designated by the employ-

ing dentist as being capable of performing clinical hygiene procedures without the direct supervision of the dentist, may perform one or more dental hygiene functions as described in G.S. 90-221(a) without a licensed dentist being physically present if all of the following conditions are met:

(1) A licensed dentist directs in writing the hygienist to perform the dental hygiene functions.

(2) The licensed dentist has personally conducted an evaluation of the patient which shall include a complete oral examination of the patient, a thorough analysis of the patient's health history, a diagnosis of the patient's condition, and a specific written plan for treatment.

(3) The dental hygiene functions directed to be performed in accordance with this subsection shall be conducted within 120 days of the dentist's evaluation.

(4) The services are performed in nursing homes; rest homes; long-term care facilities; rural and community clinics operated by Board-approved nonprofits; rural and community clinics operated by federal, State, county, or local governments; and any other facilities identified by the Office of Rural Health and approved by the Board as serving dental access shortage areas.

(a2) A dental hygienist shall not establish or operate a separate care facility that exclusively renders dental hygiene services.

(a3) A dental hygienist who has been disciplined by the Board may not practice outside the direct supervision of a dentist under G.S. 90-233(a1). A dentist who has been disciplined by the Board may not allow a hygienist to work outside of that dentist's direct supervision under G.S. 90-233(a1).

(a4) Each dentist who chooses to order dental hygiene services under G.S. 90-233(a1) shall report annually to the Board the number of patients who were treated outside the direct supervision of the dentist, the location in which the services were performed by the hygienist, and a description of any adverse circumstances which occurred during or after the treatment, if any. The dentist's report shall not identify hygienists or patients by name or any other identifier.

(a5) Clinical dental hygiene services shall be provided in compliance with both CDC and OSHA standards for infection control and patient treatment.

(b) A dentist in private practice may not employ more than two dental hygienists at one and the same time who are employed in clinical dental hygiene positions.

(c) Dental hygiene may be practiced only by the holder of a license or provisional license currently in effect and duly issued by the Board. The following acts, practices, functions or operations, however, shall not constitute the practice of dental hygiene within the meaning of this Article:

(1) The teaching of dental hygiene in a school or college approved by the Board in a board-approved program by an individual licensed as a dental hygienist in any state in the United States.

(2) Activity which would otherwise be considered the practice of dental hygiene performed by students enrolled in a school or college approved by the Board in a board-approved dental hygiene program under the direct supervision of a dental hygienist or a dentist duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3), acting as an instructor.

(3) Any act or acts performed by an assistant to a dentist licensed to practice in this State when said act or acts are authorized and permitted by and performed in accordance with rules and regulations promulgated by the Board.

(4) Dental assisting and related functions as a part of their instructions by students enrolled in a course in dental assisting conducted in this State and approved by the Board, when such functions are performed under the supervision of a dentist acting as a teacher or instructor who is either duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3)."

**SECTION 3.** This act is effective when it becomes law.

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**ALWAYS KEEP THE BOARD INFORMED OF YOUR CURRENT ADDRESS. CORRESPONDENCE FROM THE BOARD IS ALWAYS SENT TO THE LAST ADDRESS OF RECORD. FAILURE TO KEEP A CURRENT ADDRESS ON FILE MAY RESULT IN LICENSEES FAILING TO RECEIVE IMPORTANT INFORMATION OR NOTICE OF IMPORTANT DEADLINES.**

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**North Carolina State Board of Dental Examiners**

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