Virginia Department of Health Professions

VIRGINIA BOARD OF DENTISTRY
REGULATORY COMMITTEE MEETING AGENDA
FEBRUARY 27, 2026

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY
REGULATORY MEETING MINUTES
May 16, 2025

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 10:01 a.m., on May 16, 2025, at the Perimeter Center, 9960 Mayland Drive, in Board Room 4, Henrico, Virginia 23233.

PRESIDING: Sidra Butt, D.D.S., Secretary-Treasurer

MEMBERS PRESENT:
Sultan E. Chaudhry, D.D.S., President
William C. Bigelow, D.D.S.
Margaret F. Lemaster, R.D.H.
J. Michael Martinez de Andino, J.D.

MEMBERS ABSENT: Jamiah Dawson, D.D.S.

STAFF PRESENT:
Jamie C. Sacksteder, Executive Director
Erin Weaver, Deputy Executive Director
Arne Owens, Director of the Department of Health Professions
Erin Barrett, Director of Legislative and Regulatory Affairs
Sarah Moore, Executive Assistant

QUORUM: With five members of the Board present, a quorum was established.

Ms. Sacksteder read the emergency evacuation procedures.

PUBLIC COMMENT: Dr. Butt explained the parameters for public comment and opened the public comment period.

Written Public Comment from Joyce Turcotte, Professional Learning Services, regarding Dental Hygiene Refresher Programs, was distributed to the Board prior to the meeting.

Tyler Craddock, VDHA, signed up for Public Comment and provided a written testimony from Dr. Misty L. Messimer, Program Director, Dental Assisting and Dental Hygiene, Germanna Community College, regarding the Eligibility of Dental Hygienists for Dental Assistant II Registration.

Dr. Butt closed the Public Comment Period.

APPROVAL OF MINUTES: Dr. Butt asked for a motion to approve the October 27, 2023, Regulatory Meeting Minutes. Mr. Martinez made the motion, it was seconded and passed unanimously.

LEGISLATION, REGULATION AND GUIDANCE:

Discussion of Regulatory Changes for Restorative Pathway for Dental Hygienists - Ms. Barrett explained the regulatory changes necessary to create a pathway for dental hygienists to perform restorative procedures without registering as a dental assistant II (DAII). She addressed the necessary changes in the draft amendments to Chapters 21,25, and 30 included in the provided agenda, and the research presented in the Dental Hygienists Restorative Duties - State charts. This was discussed by the Board. The Board noted these changes would make a less burdensome and less costly process for the dental hygienists and be impactful in the dental community.

DECISION:

Dr. Chaudhry made a motion to recommend to the full Board at the June 2025, Board Meeting, to adopt fast-track regulatory amendments to create a pathway for dental hygienists to perform restorative procedures without registering as a DA II. The motion was seconded and passed unanimously.

Recommendation of next steps for regulatory action from 2022 Petition for Rulemaking - Ms. Barrett reviewed with the Board the recommendation of next steps for regulatory action following effective date of fast-track regulatory action. She explained that the Petition for Rulemaking regarding refresher courses required for reinstatement was received and submitted in January 2022. The NOIRA related to the petition to amend Chapters 21 and 25 was received from the Executive Branch and published on August 21, 2024, and public comment was received and considered.

- **Review of Refresher Course Program Information** – Ms. Sacksteder explained the CODA accredited Refresher Course and ADA/ADHA/AADH Refresher Course program information. She advised there have been no complaints received regarding the inability to locate a CODA Accredited refresher course. She also noted the responses from many other states indicating their approval of only CODA Accredited programs, due to CODA's accreditation process include peer reviews to evaluate the quality of dental education programs vs. ADA/ADHA/AADH vs. ADA/ADHA/AADH does not endorse or approve individual courses or instructors.

DECISION:

After a Board discussion, Dr. Chaudhry made a motion to recommend the Board's current position that CODA Accredited Programs would be the only approved refresher programs in the Commonwealth of Virginia, to withdraw the NOIRA, and to present the recommendation to the full Board at the June 2025, Board Meeting. The motion was seconded and passed unanimously.

COMMITEE DISCUSSION TOPICS:

Consideration of Public Comments – Dr. Butt asked for any Board Member's wanting to discuss the Public Comments and none were requested.

Review of the need of adding more radiological providers Ms. Sacksteder led the Board in discussion of the potential need of adding more radiological providers for dental staff to obtain radiation certification, topic was referred to the regulatory committee from the December 2024 Board Meeting. She noted there have been no complaints received regarding lack of radiological providers and training. Committee members agreed that there wasn't a shortage of radiological providers in the Commonwealth of Virginia. Mr. Martinez made a motion that the Board maintain the current status of providers. The motion was seconded and passed unanimously.

ADJOURNMENT: With all business concluded, the panel adjourned at 10:40 a.m.

Sultan F. Chaudhry, D.D.S., Vice-President

Jamie C. Sacksteder, Executive Director

Date

Date

AI

Why is the creation of regulations regarding the use of AI important for the protection of patient safety?

1. Patient Safety

AI systems can assist in diagnosis, treatment planning, and even surgical procedures. Without proper regulations:

- Incorrect or biased algorithms could lead to misdiagnosis or inappropriate treatment.
- Patients could be exposed to unnecessary risks or harm.

Regulations ensure that AI tools meet rigorous safety and accuracy standards before being used clinically.

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2. Ethical Standards

AI introduces concerns about:

- **Privacy**: Dental records and imaging contain sensitive health data.
- **Consent**: Patients should know when AI is involved in their care. Regulations enforce compliance with laws like HIPAA and ensure ethical use of patient data.

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3. Accountability

If an AI system makes an error, who is responsible—the dentist, the software developer, or the institution? Regulations clarify:

- Liability
- Professional oversight This protects patients from negligence and ensures accountability.

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4. Quality of Care

AI can improve efficiency, but unregulated use might prioritize speed over quality. Standards ensure:

- AI complements professional judgment, not replaces it.
- Continuous monitoring and updates to maintain performance.

5. Public Trust

Clear rules build confidence that AI is safe, effective, and used responsibly. Without trust, patients may avoid beneficial technologies.

Potential AI Regulations

18VAC60-XX-XXX. Use of Artificial Intelligence in Dental Practice.

A. Purpose and Applicability

1. The purpose of this chapter is to establish standards governing the use of artificial intelligence (AI) by dentists licensed by the Virginia Board of Dentistry.
2. This chapter applies to any use of AI systems in the provision of dental services, including but not limited to diagnostic support, treatment planning, image analysis, clinical documentation, scheduling, billing, and patient communications.

B. Definitions

For the purposes of this chapter, the following terms shall have the meanings ascribed to them:

1. **"Artificial intelligence (AI) system"** means any software, model, or tool that performs tasks that typically require human intelligence, including machine learning, deep learning, natural language processing, computer vision, or generative technologies used in clinical or administrative contexts.
2. **"Clinical decision support (CDS)"** means tools or systems intended to assist, but not replace, clinical judgment in diagnosis, treatment planning, or patient management.
3. **"Dentist of record"** means the licensed dentist responsible for the patient's diagnosis, treatment plan, and delivery of care for the encounter or course of treatment.
4. **"Protected health information (PHI)"** has the meaning set forth under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing regulations.
5. **"De-identified data"** means data that has been de-identified in accordance with HIPAA standards such that it does not identify and cannot reasonably be used to identify an individual.
6. **"AI vendor"** means any third party that provides or supports AI systems used by a dental practice, including subcontractors.
7. **"Use" of AI** includes inputting, processing, transmitting, storing, or outputting data through an AI system for any purpose related to dental practice.
8. **Business Associate Agreement (BAA)** is a legally binding contract required under the Health Insurance Portability and Accountability Act (HIPAA) between a covered entity (such as a dental practice) and a business associate (such as an AI vendor) that will have access to Protected Health Information (PHI). The BAA establishes each party's responsibilities for safeguarding PHI and ensures compliance with HIPAA privacy and security rules.

C. Clinical Oversight and Independent Professional Judgment

1. A dentist shall retain ultimate responsibility for all diagnoses, treatment plans, and care decisions. AI systems shall not make autonomous clinical determinations.
2. A dentist shall review, evaluate, and confirm any AI-generated analysis, recommendation, or output prior to relying upon it in clinical care.
3. Documentation of final diagnosis and treatment plan. The dentist shall contemporaneously document in the patient record:
    - a. That the final diagnosis and treatment plan are made by the dentist, not by AI;
    - b. Whether any AI system was used (name/version if known), the purpose of its use (e.g., radiographic triage, risk scoring, chart summarization), and the basis for the dentist's clinical conclusions;
    - c. Any material limitations identified in the AI output and how those limitations were addressed.
4. Delegation to auxiliary personnel of tasks involving AI does not relieve the dentist of responsibility for clinical oversight and final decision-making.

D. Patient Privacy, Data Governance, and Confidentiality

1. **HIPAA compliance.** All use of AI must comply with HIPAA and applicable federal and Virginia privacy and security requirements, including the minimum necessary standard, access controls, and breach notification obligations.
2. **Prohibition on sale of patient information.** A licensee shall not sell, barter, or otherwise transfer patient information or PHI to AI companies or vendors, nor permit any secondary use by vendors that is unrelated to treatment, payment, healthcare operations, or other legally authorized purposes without explicit, informed patient authorization.
3. **Business Associate Agreements (BAA).** Prior to transmitting or granting access to PHI to any AI vendor, the dentist or practice shall execute a HIPAA-compliant BAA that:
    - a. Prohibits sale or secondary use of PHI for advertising, model training, or other non-authorized purposes;
    - b. Requires appropriate **administrative, physical, and technical safeguards**, including **encryption in transit and at rest**, role-based access controls, audit logging, data retention and disposal standards, and prompt breach reporting;
    - c. Requires AI vendors to flow down these obligations to any subcontractors.

4. **De-identification and minimization.** When feasible, a dentist shall use de-identified data and minimum necessary PHI for AI processing, consistent with clinical requirements.

5. **Storage and residency.** PHI processed or stored by AI systems shall be maintained in secure environments with documented controls. Cloud storage must meet industry-standard security certifications. Data residency or localization requirements must be observed if applicable.

6. **Auditability.** The practice shall maintain audit trails of AI use sufficient to reconstruct what data was processed, when, by whom, for what purpose, and what outputs were generated.

E. Validation, Safety, and Quality Management of AI Systems

1. **Pre-implementation evaluation.** Prior to clinical use, the dentist or practice shall evaluate AI systems for intended use, performance characteristics, limitations, bias risks, and safety using manufacturer documentation, published evidence, or internal validation appropriate to the risk.

2. **Ongoing review.** AI systems shall be periodically reviewed to confirm continued performance, relevance, and safety, especially after model updates or changes in workflow.

3. **Change management.** Material changes to an AI system or its configuration shall be documented, tested, and approved before routine clinical use.

4. **Risk controls.** AI use in clinical care shall incorporate human oversight, clear error handling, and escalation procedures when AI outputs are incongruent with clinical findings.

F. Transparency and Patient Communication

1. Patients shall be informed, in a manner understandable to them, when AI is used as part of care (e.g., image triage, summarization, or risk scoring).

2. If AI processing involves uses beyond treatment, payment, or healthcare operations or requires patient authorization under HIPAA, the dentist shall obtain prior informed consent or authorization consistent with law.

3. Upon request, the practice shall provide patients with a summary of AI use in their care and any limitations relevant to their diagnosis or treatment plan.

G. Prohibited Practices

1. A dentist shall not rely solely on AI outputs for diagnosis, treatment planning, prescription decisions, or surgical interventions without independent clinical assessment.

2. A dentist shall not use AI systems that lack sufficient evidence of safety and effectiveness for the intended clinical context.

3. A dentist or practice shall not enable AI features that permit vendor access to PHI for training generalized models or advertising profiles, unless explicitly authorized by the patient under applicable law and regulation and permitted by HIPAA (and then only to the minimum necessary extent).

H. Training and Competency

1. Dentists and auxiliary personnel who use AI shall receive initial and annual training commensurate with their roles, covering system capabilities, limitations, privacy/security requirements, documentation standards, and incident reporting.

2. Training shall be documented and retained for a minimum of three years.

I. Incident Management and Reporting

1. The practice shall maintain procedures for prompt identification, mitigation, and documentation of privacy incidents, security events, and adverse clinical outcomes associated with AI use.

2. Breaches of PHI, material AI malfunctions that contribute to patient harm, or persistent performance failures shall be reported to the Board in accordance with Board rules within 15 days of discovery, and to other authorities as required by law.

3. Corrective actions and remediation efforts shall be documented.

J. Dentist-in-Charge / Dentist of Record Accountability

1. The Dentist-in-Charge (or equivalent supervisory dentist) shall be responsible for establishing and maintaining policies and procedures governing AI use, privacy and security controls, validation, training, documentation, and incident response.

2. The Dentist of Record remains professionally accountable for the clinical application of AI in each patient encounter, including the documentation required by Subsection C(3).

K. Recordkeeping

1. Records related to AI use—including validation evidence, policies and procedures, audit logs, training records, BAAs, and incident reports—shall be retained for six years unless otherwise required by law.

2. Patient records shall include the documentation specified in Subsection C(3).

A. Purpose and Applicability

- Does the scope of this regulation adequately cover all potential uses of AI in dental practice?

B. Definitions

- Are the definitions clear and comprehensive enough for regulatory enforcement?
- Should "AI vendor" definition include cloud service providers or only those directly providing AI functionality?

C. Clinical Oversight

- Is the requirement for dentists to retain ultimate responsibility sufficient to prevent over-reliance on AI?
- Should we want to create a guidance document for a standardized format for documenting AI use in patient records? Consent?

D. Patient Privacy and Data Governance

- Are the proposed HIPAA compliance and BAA requirements practical for small dental practices?
- Should the Board mandate specific security certifications for AI vendors (e.g., SOC 2, HITRUST)?

E. Validation and Safety

- How should dentists evaluate AI systems—should the Board issue guidance or require third-party validation?
- Should there be a minimum frequency for ongoing performance reviews?

F. Transparency and Patient Communication

- What level of detail should be provided to patients about AI use—general disclosure or specific system details?
- Should informed consent be required for all AI use or only for uses beyond treatment/payment/operations?

G. Prohibited Practices

- Are the prohibitions clear enough to prevent unsafe or unethical AI use?

- Should there be penalties for enabling vendor access to PHI for model training without consent?

H. Training and Competency

- Should the Board develop or approve standardized AI training programs for dentists and staff?
- Is annual training sufficient given the pace of AI technology changes?

I. Incident Management

- Are the 15-day reporting requirements reasonable for practices to comply with?
- Should the Board define what constitutes a "material AI malfunction" more precisely?

J. Accountability

- Does the division of responsibility between Dentist-in-Charge and Dentist of Record need further clarification?
- Should practices be required to designate an AI compliance officer?

K. Recordkeeping

- Is the six-year retention period appropriate, or should it align with other dental record retention requirements?
- Should audit logs include AI system version history for traceability?

LEGAL NAME

Considerations for making a regulation regarding the use of a legal name (this should be considered for Dentists and Dental Hygienists). Possible requirements for name tags? (Does Nursing Require this?)

Proposed Regulation (Virginia Board of Dentistry): Use of Exact Legal Name in Advertising and Public Representations

Agency: Virginia Board of Dentistry
Chapter: 18VAC60-21. Regulations Governing the Practice of Dentistry
New Section: 18VAC60-21-8X. Use of Legal Name in Advertising, Online Presence, Email, and Signage
Statutory Authority: § 54.1-2400, Code of Virginia (general powers and duties of health regulatory boards).

Effective Date: [Insert date]

1. Authority and Intent

Pursuant to § 54.1-2400 of the Code of Virginia, the Board is authorized to promulgate regulations that are reasonable and necessary to administer the regulatory system, including standards for licensee advertising and public representations. This section ensures the public can reliably identify and verify dental licensees by requiring use of the exact legal name on file with the Board in all public-facing materials.

2. Applicability

This section applies to all dentists, dental hygienists, entities, and permit holders regulated by the Board of Dentistry who advertise or otherwise present themselves to the public in Virginia, including practice locations, mobile or portable operations, and any affiliated business units.

3. Definitions

For purposes of this section:

- **"Licensee"** means any individual or entity holding a license, certificate, registration, or permit issued by the Board of Dentistry.
- **"Legal Name"** means the name exactly as it appears in the Board's licensure record (including first name, middle name or initial, last name, suffix, and any punctuation or spacing).

- **"Public Advertising"** means any communication directed to the public, including print, broadcast, electronic, and social media, consistent with usage in existing Board advertising rules.

- **"Online Presence"** means any website, profile, directory listing, or app controlled or authorized by the licensee.
- **"Signage"** means physical signs on premises or vehicles used to promote services, consistent with existing posting requirements.
- **"Exact Match"** means an identical rendering of the Legal Name as it appears in the Board's record, allowing only typographical styling (e.g., capitalization, font) but no omissions, abbreviations, nicknames, or reorderings.
- **"Searchable"** means present in machine-readable text (not solely an image) such that the Legal Name can be located through text-based search and public licensure verification tools.

4. General Requirement: Use of Legal Name

A. A licensee shall use and conspicuously display the **Exact Match Legal Name** in all Public Advertising, Online Presence, Email communications, and Signage.
B. A licensee shall not use any nickname, shortened name, alias, or other variation that deviates from the Exact Match Legal Name on file with the Board.
C. Where services are advertised under an entity registration (e.g., professional corporation), the entity's Legal Name shall be used; if an individual licensee is named, the individual's Legal Name shall also be displayed.
D. This section supplements, and does not replace, existing Board requirements regarding advertising and posting (e.g., two-year retention of advertisements; display of name and license in the office).

5. "Searchable" Presentation (Electronic Materials)

A. The Legal Name must appear in **searchable text** on any Online Presence and in electronic communications, including email signatures and digital ads; image-only presentations are insufficient.
B. The Legal Name shall appear on the **homepage** of any practice website and on **primary landing pages** advertising services, in plain text (not solely within a logo image).
C. Licensees shall implement reasonable technical measures to ensure the Legal Name is **indexable**, including avoidance of image-only name displays and inclusion of on-page text featuring the Legal Name.

D. Online Presence should provide a **direct link** or clear instructions to the Commonwealth's **License Lookup** for licensure verification.

6. Placement and Prominence

A. **Signage:** The Legal Name must be conspicuously displayed at each practice location's main public entrance and in the primary reception or patient-facing area, consistent with existing posting requirements.
B. **Digital and Print Ads:** The Legal Name must be displayed with prominence equal to or greater than any trade name or DBA.
C. **Email Communications:** The Legal Name must appear in the sender's display name or email signature block.
D. **Business Cards and Stationery:** The Legal Name must be present and not replaced by a nickname or shortened name.

7. Use of Trade Names or DBAs

A. A licensee may use a trade name or DBA **in addition to** (but not in place of) the Legal Name.
B. If a trade name or DBA is displayed, the Legal Name must be **adjacent** and **equally prominent**, accompanied by a descriptor such as "Legal name on file with the Virginia Board of Dentistry."
C. A trade name or DBA shall not create confusion about licensure or the identity of the licensee, consistent with the Board's prohibition of deceptive or misleading advertising.

8. License Number and Verification Statement (Encouraged)

A. Where feasible, Public Advertising and Online Presence should include the license number alongside the Legal Name.
B. Licensees are encouraged to include a verification statement such as:

"Licensed by the Virginia Board of Dentistry. Legal name: [Exact Match Legal Name]. License No. [####]. Verify at: https://dhp.virginiainteractive.org/lookup/"

9. Name Changes and Updates

A. A licensee shall notify the Board of any **legal name change** and obtain an updated license in accordance with the Board's requirements for maintaining accurate records.
B. A licensee shall update all Public Advertising, Online Presence, Email, and Signage to reflect the new Legal Name within **30 calendar days** of the licensure record update.
C. During the transition, the former Legal Name may be displayed **only** with a notice of the updated Legal Name and effective date, and only for up to **60 calendar days**.

10. Recordkeeping

A. Licensees shall retain prerecorded or archived copies/samples of Public Advertising and screenshots of Online Presence and email signature formats for **two (2) years** and produce them to the Board upon request, consistent with existing advertising retention requirements.
B. Records must be sufficient to demonstrate compliance with the Exact Match and Searchable requirements.

Discussion Questions

1. **Patient Safety and Trust**
    - How does using a legal, searchable name help maintain transparency and trust between dental professionals and patients?
    - What risks could arise if a dentist or hygienist uses a nickname or unregistered name in professional settings?
2. **Regulatory Compliance**
    - Why do licensing boards and regulatory agencies require dental professionals to use their legal names in official records?
    - How does this requirement support accountability and enforcement of professional standards?
3. **Public Access and Verification**
    - How does the ability to search a provider's legal name in a public database benefit patients and the public?
    - What challenges might patients face if providers use non-legal names in advertising or practice?
4. **Professional Identity and Ethics**
    - In what ways does using a legal name uphold ethical standards in healthcare?
    - Should there be exceptions for cultural or personal reasons? Why or why not?
5. **Legal and Liability Considerations**
    - How could using a non-legal name impact malpractice claims or legal proceedings?
    - What role does accurate identification play in protecting both the provider and the patient?
6. **Technology and Record-Keeping**
    - What potential errors could occur if aliases or nicknames are used in official documentation?

OMS AUDIT

Would like to repeal these quality assurance reviews.

18VAC60-21-390. Quality assurance review for procedures performed by certificate holders.

A. On a schedule of no less than once every three years, the board shall conduct a random audit of charts for patients receiving cosmetic procedures that are performed by a certificate holder in a facility not accredited by Joint Commission on Accreditation of Healthcare Organizations or other nationally recognized certifying organization as determined by the board.

B. Oral and maxillofacial surgeons certified to perform cosmetic procedures shall maintain separate files, an index, coding, or other system by which such charts can be identified by cosmetic procedure.

C. Cases selected in a random audit shall be reviewed for quality assurance by a person qualified to perform cosmetic procedures according to a methodology determined by the board.

Reasoning

- The Board has being doing these audits every 3 years since 2002
- The audits have never revealed any systemic or egregious issues
- These audits cost the board approximately $37,053 dollars
    - 39 Cosmetic procedure permits
    - Approximate hours of investigator/inspector- approximately12 hours at $58.34 per hour
    - Then an expert must review each case 39 cases at approximately 2.5 hours each at $100 per hour.

DENTIST-IN-CHARGE

Purpose of creating Dentist-in-Charge regulations

1. Clear Accountability

- **Avoids enforcement ambiguities**: When violations (e.g., incomplete records or infected instruments) occur within a DSO-run facility, investigators need a clearly designated responsible dentist to hold accountable. In Virginia, you are not required to be a licensed dentist to own a dental practice.
- **Aligns responsibility with actual oversight**: If the licensed dentist isn't directly supervising DSO operations, assigning accountability to whoever *does* oversee clinical and operational activities ensures fair responsibility.

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2. Enhanced Patient Safety & Oversight

- **Ensures direct clinical oversight**: Regulations for a Dentist-In-Charge would mandate hands-on oversight, supervision of delegated duties, and compliance with infection control — closing gaps left by remote or fragmented DSO management.
- **Supports safe delegation**: Current Virginia rules require dentists to supervise hygienists and assistants under general/indirect supervision

A designated in-charge dentist would ensure these requirements are met in DSO settings.

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3. Regulatory Clarity & Consistency

- **Standardizes management across practices**: Clear rules about the Dentist-In-Charge role would set uniform expectations for delegation, emergency protocols, and documentation — promoting consistency across all practice models, including DSOs.
- **Eases regulatory burden**: Regulators could focus on compliance and enforcement, knowing which specific dentist holds daily responsibility, simplifying investigations and disciplinary processes.

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4. Patient Transparency & Trust

- **Identifies clinical leadership**: For patient confidence, it's critical to know which licensed dentist is responsible for treatment decisions — particularly when business or administrative control is exercised by non-dental entities.
- **Discloses true operational leaders**: Naming a Dentist-In-Charge clarifies who patients are trusting with their care, as opposed to leaving that ambiguous under DSO arrangements.

5. Keeps Pace with Trends in Teledentistry & DSOs

- **Adapts to evolving practice models**: With expansions like teledentistry and digital scan technicians, Virginia already reinforces dentist oversight in remote supervision settings
- **Meets modern patient safety needs**: Entirely new oversight roles should be established to ensure that new practice environments – including DSOs – still comply with core standards of care.

Formally defining and regulating a **Dentist-In-Charge** role will:

- Establish **clear accountability** for those overseeing day-to-day clinical and operational functions.
- Maintain **patient safety**, especially as delegation to DSOs grows.
- Provide **regulatory clarity**, reducing ambiguities for both providers and the Board.
- Enhance **public trust** by clearly identifying who is responsible for a patient's care.
- Align Virginia's oversight with **emerging care models**, including teledentistry and DSO-driven practices.

Dentist-in-Charge Proposal Regulations

Proposed Regulation: Dentist-in-Charge

18VACXX-XX-XXX. Dentist-in-Charge

A. Designation of Dentist-in-Charge

1. Each dental practice location shall designate one licensed dentist licensed by the Virginia Board of Dentistry as the Dentist-in-Charge.
2. The Dentist-in-Charge shall accept responsibility for compliance with all applicable laws and regulations governing the practice of dentistry at that location.

B. Responsibilities The Dentist-in-Charge shall:

1. Ensure that all dental personnel comply with state and federal regulations related to patient care, billing, infection control, personnel, and recordkeeping.
2. Ensure that all required licenses, registrations, and permits for the dental practice are current and properly displayed.
3. Develop and implement policies and procedures for:
    - Patient safety and quality of care.
    - Proper handling and disposal of hazardous materials.
    - Emergency preparedness and response.
    - Proper and ethical billing in accordance with 18VAC60-21-60.B

C. Notification Requirements

1. The Dentist-in-Charge shall notify the Board in writing within 14 days of:
    - Appointment as Dentist-in-Charge.
    - Termination of such designation.
2. Failure to notify the Board may result in disciplinary action.

D. Accountability

1. The Dentist-in-Charge shall be professionally responsible for the operation of the dental practice in compliance with applicable laws and regulations.
2. Delegation of duties does not relieve the Dentist-in-Charge of ultimate responsibility.

Discussion Questions for Dentist-in-Charge

General Understanding

1. What is the primary purpose of designating a Dentist-in-Charge at each dental practice location?

Designation & Accountability

3. Should there be specific qualifications or experience requirements for a dentist to serve as Dentist-in-Charge beyond being licensed?
4. How should accountability be enforced when responsibilities are delegated but ultimate responsibility remains with the Dentist-in-Charge? This is not for regulation- more for the sake of discussion
5. What mechanisms should be in place to monitor compliance without creating excessive administrative burden? More for discussion and not creation of regulations

Responsibilities

6. Are the listed responsibilities comprehensive enough to ensure patient safety and regulatory compliance? If not, what additional responsibilities should be included?
7. How should the Dentist-in-Charge ensure proper training and compliance among all dental personnel?- recommended to not put this in regulations- could be too burdensome. Just thoughtful discussion to ensure the regulation is not too burdensome.
8. Should there be standardized templates or guidelines for policies and procedures (e.g., emergency preparedness, hazardous material handling)? This would be done in a guidance document/ not regulation.

Impact & Implementation

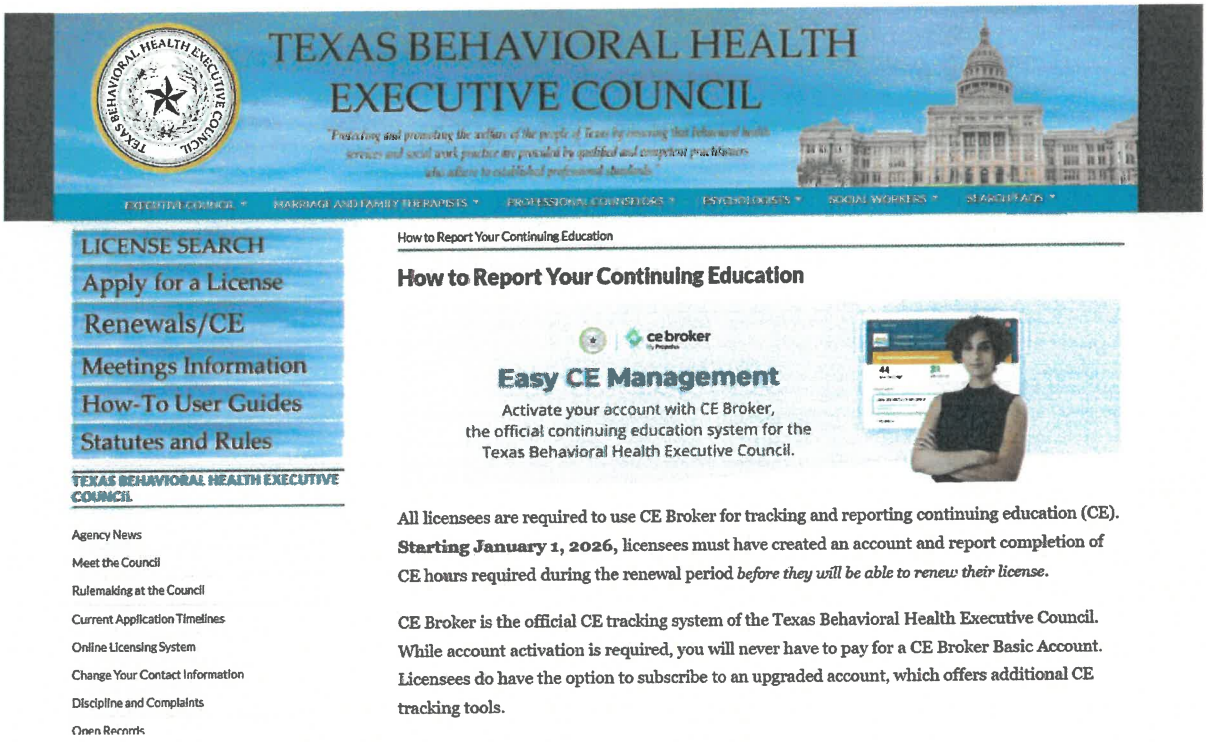
11. How might this regulation impact small practices versus large multi-location practices?
12. What challenges could arise in implementing this regulation, and how can they be mitigated?

Ethical & Legal Considerations

14. How does this regulation strengthen ethical billing practices and compliance with 18VAC60-21-60.B?

CE BROKER

Examples of State Implementation of CE Broker for licensure renewal



New Hampshire

Plc 308.04 Continuing Competence; Documentation and Audits.

(a) Each licensee shall comply with all continuing competence requirements specified in applicable law.

(b) Upon being notified by the OPLC that an on-line system administered by a third party organization is available to manage continuing competence compliance, each licensee shall use the on-line system to track and report the completion of continuing competence activities unless a profession-specific on-line system is specifically authorized by the executive director based on the system being:

(1) Available to all licensees in the profession at no charge to the licensee; and

(2) Accessible by the OPLC at no additional charge to the licensee or the OPLC.

(c) Each licensee shall retain documentation of participating in and successfully completing continuing competence activities as described in applicable law for the specific course or activity for the longer of the time specified in applicable law or the current license term and most recent renewal period, which may be retained in the on-line system when available.

(d) Unless otherwise required by statute, 10% of licensees renewing in a given year shall be audited to determine continuing education compliance for each board. Each licensee shall provide such information as is requested as part of an audit conducted pursuant to this section or other applicable law.

States that require CE Broker for licensure renewal

Texas

Board Behavioral Health Executive Council (BHEC)

Source BHEC CE Reporting Guidance

Requirement Summary CE must be reported in CE Broker; required for renewal beginning Jan 1, 2026.

New Hampshire

Board OPLC – Multiple professions

Source Plc 308.04 – Continuing Competence

Requirement Summary Licensees must use CE Broker to track and report CE for renewal.

Florida

Board DOH & DBPR boards (nursing, medicine, pharmacy, etc.)

Source Board CE rules; CE Broker system

Requirement Summary CE must be reported to CE Broker; CE verified before renewal.

Alabama

Board State Board of Occupational Therapy

Regulation Source Board CE guidance

Requirement Summary CE must be reported in CE Broker; official CE tracking for renewal.

Arizona

Board of Occupational Therapy Examiners

Regulation: Source Board CE guidance

Requirement Summary CE must be reported in CE

Ohio

Counselor, Social Worker, & Marriage and Family Therapist Board (CSWMFT)

- Requires all CSWMFT licensees to upload 30 approved CE hours into a free basic CE Broker account *before* renewing their license.
- If CE records are entered into CE Broker, you may be exempt from audits. However, renewal still must be completed through the Board's online portal.

CE Broker Discussion Questions

1. Compliance and Accountability

- How could requiring CE Broker improve compliance with continuing education requirements for dental professionals?
- Would a centralized CE tracking system reduce errors or fraudulent reporting compared to manual audits?

2. Efficiency and Administrative Burden

- How might CE Broker streamline the renewal process for both licensees and the Board?
- Could automation through CE Broker reduce staff time spent on verifying CE credits?

3. Transparency and Audit Readiness

- How would CE Broker enhance transparency in CE reporting for licensees and regulators?
- Would real-time CE tracking make audits easier and less disruptive?

4. Licensee Experience

- How could CE Broker simplify the process for licensees to monitor their CE progress?

5. Public Protection

- How might accurate and timely CE reporting through CE Broker contribute to better patient care and public safety?
- Could CE Broker help ensure that all practitioners meet competency standards before renewal?

6. Cost

- What potential cost savings could the Board realize by reducing manual verification?

SCOPE OF PRACTICE

Current definition of Dentistry in 54.1-2700

"Dentistry" means the evaluation, diagnosis, prevention, and treatment, through surgical, nonsurgical, or related procedures, of diseases, disorders, and conditions of the oral cavity and the maxillofacial, adjacent, and associated structures and their impact on the human body.

Current regulations regarding OMS

In **18VAC60-21-350. Certification to perform cosmetic procedures; applicability.**

A. In order for an oral and maxillofacial surgeon to perform aesthetic or cosmetic procedures, he shall be certified by the board pursuant to § 54.1-2709.1 of the Code. Such certification shall only entitle the licensee to perform procedures above the clavicle or within the head and neck region of the body.

18VAC60-XX-XXX. Scope of Practice for Dentists

A. General Scope

1. A dentist licensed by the Virginia Board of Dentistry is authorized to practice dentistry, which includes the evaluation, diagnosis, prevention, and treatment—by surgical or nonsurgical means—of diseases, disorders, and conditions of the oral cavity, maxillofacial area, and adjacent and associated structures.
2. The scope of practice for a dentist shall be limited to above the clavicle or within the **head and neck region**, including:
    - a. Teeth and supporting structures;
    - b. Oral and maxillofacial tissues;
    - c. Temporomandibular joint and associated musculature;
    - d. Adjacent and contiguous structures of the head and neck that impact oral health.

B. Permitted Procedures

1. Dentists may perform procedures necessary for the restoration, maintenance, and improvement of oral health, including:

- a. Diagnosis and treatment of oral and maxillofacial diseases and conditions;
- b. Surgical and nonsurgical procedures involving the oral cavity and contiguous structures above clavicle or within the region of the head and neck;
- c. Administration of anesthesia and sedation in accordance with Board regulations;
- d. Prescribing medications related to dental and oral health conditions.

C. Limitations

1. Dentists shall not perform procedures below the clavicle or outside the head and neck region unless specifically authorized by law or regulation.
2. Procedures involving systemic conditions, below the clavicle, or areas beyond the head and neck shall be referred to an appropriate medical specialist.

Discussion Questions- Scope of Practice

1. **Why is it essential to clearly define the scope of practice for dental professionals?**
    - How does this impact patient safety and quality of care?
2. **What risks might arise if dental practitioners operate outside their defined scope of practice?**
    - Can you think of Board case examples?
3. **How does defining scope of practice help prevent malpractice or ethical violations in dentistry?**
4. **In what ways does a well-defined scope of practice protect both patients and dental professionals?**
5. **How does scope of practice relate to patient trust and confidence in dental care?**
6. **What role do regulatory bodies play in establishing and enforcing scope of practice standards?**
    - Why is this oversight important for public health?
7. **How can continuing education and training help ensure dental professionals stay within their scope of practice? How can it hurt it?**
8. **What challenges might arise when new technologies or procedures are introduced in dentistry?**
    - How should scope of practice adapt to these changes?

SEXUAL MISCONDUCT

Do we need to add to the already exiting regulations for dentists?, but we do need to add similar regulations that is in dentistry regulations to the Dental Hygienist regulations.

Proposed Regulation: Sexual Misconduct by Dental Hygienists

Title: *18VAC60-25-XXX — Sexual Misconduct by Dental Hygienists*

A. General Prohibition

A dental hygienist shall not engage in sexual misconduct with a patient, including but not limited to:

1. Sexual contact, sexual intercourse, or any behavior intended for sexual gratification during or in connection with the provision of dental hygiene services.
2. Soliciting or encouraging sexual contact with a patient under the hygienist's care.

B. Exploitation of Professional Relationship

A dental hygienist shall not use the influence of the professional relationship to:

- Initiate or maintain a sexual relationship with a current patient.
- Engage in conduct that could reasonably be interpreted as sexual harassment or exploitation.

C. Post-Treatment Restrictions

A dental hygienist shall not engage in a sexual relationship with a former patient if:

- The relationship began within six months of the last professional service, or
- The hygienist used confidential information obtained during treatment to initiate or maintain the relationship.

D. Consent Not a Defense

Consent by the patient shall not be a defense to a charge of sexual misconduct under this section.

E. Mandatory Reporting

Anyone which he becomes aware acting in his official capacity, after review, and if necessary, and investigation or consultation with the appropriate internal boards or committees become aware of sexual misconduct by a dental hygienist shall report such conduct to the Board in accordance with § 54.1-2400.6 of the Code of Virginia.

F. Sanctions

Violations of this section constitute unprofessional conduct and are grounds for disciplinary action, including suspension or revocation of license, under § 54.1-2706 of the Code of Virginia.

Current Regulation for Dentist

18VAC60-21-70. Unprofessional practice.

A. No dentist shall commit any act that violates provisions of the Code of Virginia that reasonably relate to the practice of dentistry, including:

1. Delegating any dental service or operation that requires the professional competence or judgment of a dentist to any person who is not a licensed dentist or dental hygienist or a registered dental assistant II.

2. Violating any applicable statute or regulation governing ionizing radiation in the Commonwealth of Virginia, including current regulations promulgated by the Virginia Department of Health.

3. Failing to maintain and dispense scheduled drugs as authorized by the Virginia Drug Control Act (Chapter 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia) and the regulations of the Board of Pharmacy.

4. Failing to cooperate with an employee of the Department of Health Professions in the conduct of an investigation or inspection.

B. Sexual conduct with a patient, employee, or student.

1. Sexual contact with a patient, employee, or student shall constitute unprofessional conduct if:

a. The sexual contact is unwanted or nonconsensual; or

b. The sexual contact is a result of the exploitation of trust, knowledge, or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

2. The determination of when a person is a patient for purposes of this section will be made on a case-by-case basis, with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that the person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the practitioner-patient relationship is terminated.

3. Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact

is a result of the exploitation of trust, knowledge, or influence derived from the professional relationship.

4. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is the result of the exploitation of trust, knowledge, or influence derived from the professional relationship or if the contact has had or is likely to cause an adverse effect on patient care. For purposes of this section, "key third party" shall mean spouse, partner, parent, child, guardian, or legal representative of a patient.

This should also be included for Dental Assistants

Sexual Misconduct Discussion Questions

1. Importance of Regulation

- Why is it critical to have clear regulations addressing sexual misconduct in the dental profession?
- How do these regulations protect patients and maintain public trust in dental care?
- What role do professional ethics play in shaping these regulations?
- How might the absence of strict regulations impact the reputation of the dental profession?

2. Professional Boundaries

- What constitutes appropriate professional boundaries between dental professionals and patients?
- How can dental professionals ensure they maintain these boundaries in everyday practice?
- Should there be mandatory training on sexual misconduct prevention for all dental staff? Why or why not?

3. Reporting and Accountability

- What challenges do patients face when reporting sexual misconduct by dental professionals?
- How can dental boards and regulatory agencies improve reporting mechanisms and support for victims?
- Should disciplinary actions for sexual misconduct be publicly disclosed? What are the pros and cons?

4. Prevention Strategies

- What proactive steps can dental practices take to prevent sexual misconduct?
- How can workplace culture influence the likelihood of misconduct occurring?
- Should dental offices implement chaperone policies during certain procedures? Why or why not?

5. Broader Implications

- How do sexual misconduct cases affect the mental health and career of accused professionals (whether guilty or innocent)?
- What impact do these cases have on patient confidence and willingness to seek dental care?
- How do regulations in dentistry compare to those in other healthcare professions?

ETHICS

Standards for Professional Conduct In The Practice of Dentistry

Preamble

The Standards for Professional Conduct for licensees of the Virginia Board of Dentistry establishes a set of principles to govern the conduct of licensees in the profession of dentistry. Licensees must respect that the practice of dentistry is a privilege which requires a high position of trust within society. The Board maintains that adherence to these standards will safeguard patients, uphold the laws and regulations governing practice and maintain the public trust. The standards are an expression of types of conduct that are either required or encouraged and that are either prohibited or discouraged to provide further guidance on the requirements for practice set out in the Code of Virginia and the Regulations Governing the Practice of Dentistry and Dental Hygiene.

Scope of Practice

- Keep knowledge and skills current. The privilege, professional status, and a license to practice derive from the knowledge, skill, and experience needed to safely serve the public and patients.
- Seek consultation, if possible, whenever the welfare of patients will be safeguarded or advanced by utilizing the knowledge and skills of those who have special skills, knowledge and experience, or advanced training.
- Do not prescribe treatment or use diagnostic techniques or diagnose, cure, or alleviate diseases, infections or other conditions that are not within the scope of the practice of dentistry or that are not based upon accepted scientific knowledge or research.
- Do not treat or prescribe for yourself.

Treating or Prescribing for Family

- Only treat and prescribe based on a bona-fide practitioner-patient relationship, and prescribe by criteria set forth in §54.1-3303 of the Code of Virginia.
- Do not prescribe to a family member a controlled substance or a medicine outside the scope of dentistry.
- When treating a family member or a patient maintain a patient record documenting a bona-fide practitioner-patient relationship.

Staff Supervision

- Protect the health of patients by only assigning to qualified auxiliaries those duties which can be legally delegated.
- Prescribe and supervise the patient care provided by all auxiliary personnel in accordance with the correct type of supervision.
- Maintain documentation that staff has current licenses, certificates for radiology, up-to-date vaccinations, CPR training, HIPPA training, and OSHA training in personnel files.

- Display documents that are required to be posted in the patient receiving area so that all patients might see and read them.
- Be responsible for the professional behavior of staff towards patients and the public at all times.
- Avoid unprofessional behavior with staff
- Provide staff with a safe environment at all times.
- Provide staff with opportunities for continuing education that will keep treatment and services up-to-date and allow staff to meet continuing education requirements
- Supervise staff in dispensing, mixing and following the instruction for materials to be used during treatment.
- Instruct the staff to inform the dentist of any event in the office concerning the welfare of the patient regarding exposures or blood borne pathogens

Practitioner-Patient Communications

- Before performing any dental procedure, accurately inform the patient or the guardian of a minor patient of the diagnoses, prognosis and the benefits, risks, and treatment alternatives to include the consequences of doing nothing.
- Inform the patient of proposed treatment and any reasonable alternatives, in understandable terms to allow the patient to become involved in treatment decisions.
- Acquire informed consent of a patient prior to performing any treatment.
- Refrain from harming the patient and from recommending and performing unnecessary dental services or procedures.
- Specialists must inform the patient that there is a need for continuing care when they complete their specialized care and refer patients to a general dentist or another specialist to continue their care.
- Immediately inform any patient who may have been exposed to blood or other infectious material in the dental office or during a procedure about the need for post exposure evaluation and follow up and to immediately refer the patient to a qualified health care professional
- Do not represent the care being provided in a false or misleading manner
- Inform the patient orally and note in the record any deviation in a procedure due to the dentist's discretion or a situation that arises during treatment that could delay completion of treatment or affect the prognosis for the condition being treated.
- Inform the patient about the materials used for any restoration or procedure such as crowns, bridges, restorative materials, ingestibles, and topicals as to risks, alternatives, benefits, and costs, as well as describing the materials, procedures, or special circumstances in the patient's notes.
- Refrain from removing amalgam restorations from a non-allergic patient for the alleged purpose of removing toxic substances from the body. The same applies to removing any other dental materials.

Patient of Record

- A patient becomes a patient of record when the patient is seated in the dental chair and examination and diagnosis of the oral cavity is initiated.

- In §54.1-2405(B) of the Code of Virginia, "current patient" means a patient who has had a patient encounter with the provider or his professional practice during the two-year period immediately preceding the date of the record transfer.

Patient Records

- Maintain treatment records that are timely, accurate, legible and complete.
- Note all procedures performed as well as substances and materials used.
- Note all drugs with strength and quantity administered and dispensed.
- Safeguard the confidentiality of patient records.
- Upon request of a patient or an authorized dental practitioner, provide any information that will be beneficial for the welfare and future treatment of that patient.
- On request of the patient or the patient's new dentist timely furnish gratuitously or at a reasonable cost, legible copies of all dental and financial records and readable copies of x-rays. This obligation exists whether or not the patient's account is paid in full.
- Comply with §32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.
- Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.
- Maintain records for not less than six years from the last date of treatment as required by the Board of Dentistry and maintain records for longer periods of time to meet contractual obligations or requirements of federal law.
- When closing, selling or relocating a practice, meet the requirements of §54.1-2405 of the Code of Virginia for giving notice and providing records.

Financial Transactions

- Do not accept or tender "rebates" or split fees with other health professionals.
- Maintain a listing of customary fees and represent all fees being charged clearly and accurately.
- Do not use a different fee without providing the patient or third party payers a reasonable explanation which is recorded in the record.
- Return fees to the patient or third party payers in a timely manner if a procedure is not completed or the method of treatment is changed.
- Do not accept a third party payment in full without disclosing to the third party that the patient's payment portion will not be collected.
- Do not increase fees charged to a patient who is covered by a dental benefit plan.
- Do not incorrectly describe a dental procedure in order to receive a greater payment or reimbursement or incorrectly make a non-covered procedure appear to be a covered procedure on a claim form.
- Do not certify in a patient's record or on a third party claim that a procedure is completed when it is not completed.
- Do not use inaccurate dates that are to benefit the patient; false or misleading codes; change the procedure code to justify a false procedure; falsify a claim not having done the procedure, or expand the claim.
- Avoid exploiting the trust a patient has in the professional relationship when promoting or selling a product by: advising the patient or buyer if there is a financial incentive for

the dentist to recommend the product; providing the patient with written information about the product's contents and intended use as well as any directions and cautions that apply to its use; and, informing the patient if the product is available elsewhere.

- Do not misrepresent a product's value or necessity or the dentist's professional expertise in recommending products or procedures.

Relationships with Practitioners

- Upon completion of their care, specialists or consulting dentists are to refer back to the referring dentist, or if none, to the dentist of record for future care unless the patient expresses a different preference.
- A dentist who is rendering a second opinion regarding a diagnosis or treatment plan should not have a vested interest in the patient's case and should not seek to secure the patient for treatment unless selected by the patient for care.

Practitioner Responsibility

- Once a course of treatment is undertaken, the dentist shall not discontinue that treatment without giving the patient adequate notice and the opportunity to obtain the services of another dentist. Emergency care must be provided during the notice period to make sure that the patient's oral health is not jeopardized or to stabilize the patient's condition.
- Only prescribe, dispense, and utilize those devices, drugs, dental materials and other agents accepted for dental treatment.
- Make reasonable arrangements for the emergency care of patients of record.
- Exercise reasonable discretion in the selection of patients. Dentists may not refuse patients because of the patient's race, creed, color, sex, or national origin.
- Do not refuse to treat a patient because the individual has AIDS, is HIV positive, or has had hepatitis. Use a proper protocol in the office to protect the public and staff.
- Follow the rules and regulations of HIPAA, OSHA, FDA, and the laws governing health practitioners in the Code of Virginia.
- Follow the applicable CDC infection control guidelines and recommendations. See https://www.cdc.gov/oralhealth/infectioncontrol/index.html
- Be knowledgeable in providing emergency care and have an acceptable emergency plan with delegated duties to the staff in written form, maintain accurate records and be current in basic CPR.
- Avoid interpersonal relationships with patients and staff that could impair professional judgment or risk the possibility of exploiting the veracity and confidence placed in the doctor-patient relationship.

Advertising Ethics

- Do not hold out as exclusive any devise agent, method, or technique if that representation would be false or misleading in any material respect to the public or patients.
- When you advertise, fees must be included stating the cost of all related procedures, services and products which to a substantial likelihood are necessary for the completion of the service as it would be understood by an ordinarily prudent person.
- Disclose the complete name of a specialty board or other organization which conferred certification or another form of credential.

- Do not claim to be a specialist or claim to be superior in any dental specialty or procedure unless you have attained proper credentials from an advanced postgraduate education program accredited by the Commission on Dental Accreditation of the American Dental Association.

Reports and Investigations

- Cooperate with any investigation initiated by an investigator or inspector from the Department of Health Professions on behalf of the Board and timely provide information and records as requested.
- Allow staff to cooperate with any investigation initiated by an investigator or inspector from the Department of Health Professions on behalf of the Board.
- Report the adverse reaction of a drug or dental device to the appropriate medical and dental community and in the case of a serious event to the Food and Drug Administration or Board of Dentistry.
- Provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.
- Become familiar with the special signs of child abuse and report suspected cases to the proper authorities.
- Report to the Board of Dentistry instances of gross or continually faulty treatment by other dentists.

Notice

This guidance document does not address every law and regulation which governs the practice of dentistry. To fully understand your legal responsibilities you should periodically review the laws, regulations, notices and guidance documents provided on the Board of Dentistry webpage, www.dhp.virginia.gov/dentistry.

Adopted: December 4, 2009
Revised: March 13, 2015, September 16, 2016

18VAC60-XX-XXX. Standards for Professional Conduct in the Practice of Dentistry

Maintenance of Competence & Scope

1. Licensees shall **not diagnose or treat** conditions outside the scope of dentistry or without accepted scientific basis.
2. Licensees shall **not self-prescribe**, nor prescribe for themselves.

Staff Supervision & Office Environment

1. Licensees must ensure staff records include licensure, certifications (radiology, CPR, HIPAA, OSHA), and vaccinations.
2. Ensure a **safe, professional work environment**, avoid unprofessional behavior, and promote continuing education.
3. Supervise staff in **dispensing, mixing, and use** of materials.
4. Staff must report any patient safety exposures or bloodborne incidents to the dentist immediately.

Informed Consent & Patient Communication

1. Present treatment information clearly, enabling informed patient decision-making.
2. Obtain **informed consent** before any procedure.
3. **Avoid unnecessary treatment**, and provide only clinically indicated services.
4. Specialists must inform patients of the need for continuing care and ensure appropriate referral.
5. Immediately notify patients of any exposure to infectious material and facilitate post-exposure care.
6. Provide accurate representations of care.
7. Note deviations or delays during procedures, informing patients and documenting in records.
8. Disclose materials used (e.g., crowns, restoratives), including risks, benefits, alternatives, and costs, and document accordingly.
9. Avoid removing restorations for unsubstantiated "toxicity" claims.

Patient of Record

1. A patient becomes a patient of record when seated and diagnostic evaluation begins.

Financial Integrity & Claims

1. Prohibit **rebates, split fees**, or deceptive financial arrangements.
2. Maintain and transparently post customary fees.
3. Any fee changes must be documented and explained.
4. Refund for unperformed procedures or changed treatments promptly.
5. Disclose patient cost responsibilities even when third-party pays.
6. Do not alter fees for insured patients or manipulate billing codes for reimbursement.
7. Do not certify or bill for incomplete work.
8. Disclose any personal financial interest in products recommended; provide full information on product content, use, risks, benefits, and alternatives.
9. Avoid misrepresentation of expertise or product necessity.

Collaboration with Other Practitioners

1. Upon completing care, specialists must refer back to referring dentists or patient-chosen providers.
2. Second-opinion dentists should have no conflicting interests and must not solicit patients.

Professional Responsibility & Continuity of Care

1. Upon initiating treatment, licensees must not withdraw without notice and reasonable transition; **emergency care** must be provided during any notice period. (18VAC60-21-60.A5)
2. Use only **approved dental materials, medications, and devices**.
3. Maintain availability for **emergency patient care**.
4. Do not refuse patients based on discrimination (race, creed, color, sex, origin), or HIV/hepatitis status.
5. Follow HIPAA, OSHA, FDA, state law, and CDC infection control guidelines (per CDC protocol).

Advertising & Ethics

1. Do not falsely claim exclusivity of any methods or techniques.

Impaired, Dishonest, or Unethical Colleagues

- Addressing peers who are impaired (e.g., due to substance abuse, mental health, cognitive impairment, or physical impairment), incompetent, or engaging in unethical behavior by reporting it to the Board.

Clinical Errors and Transparency

Dentists have an ethical duty to disclose mistakes, apologize when appropriate, and take corrective action.