State Dental Board

Infection Control Evaluation

Name: _____ Date: _____

Address: _____

Practice name: _____ Phone #: _____

Investigator: _____ Case #: _____ County #: _____

A) Heat Sterilization: ☐ Yes ☐ No Steam # _____ Chemical # _____ Dry # _____

B) Weekly Biological Testing: ☐ Yes ☐ No If No – How often _____

Independent Entity _____ In-Office _____ Control: ☐ Yes ☐ No

C) Chemical Sterilization: ☐ Yes ☐ No ☐ N/A What Brand _____

D) Disposables (not disposed of): _____

		Heat Sterilized			Other
E)	High speed handpieces: # _____	☐ Yes	☐ No		_____
	Slow speed Contra-Angles	☐ Yes	☐ No	☐ N/A	_____
	Nose Cones/Hyg. Handpieces	☐ Yes	☐ No	☐ N/A	_____
	Burs	☐ Yes	☐ No	☐ N/A	_____
	Endodontic Files/Reamers	☐ Yes	☐ No	☐ N/A	_____
	Hand Instruments	☐ Yes	☐ No	☐ N/A	_____
	Orthodontic Instruments	☐ Yes	☐ No	☐ N/A	_____
	Prophy Angles	☐ Yes	☐ No	☐ N/A	_____
	Air/Water Syringe Tips	☐ Yes	☐ No	☐ N/A	_____
	Metal Impression Trays	☐ Yes	☐ No	☐ N/A	_____
	Ultra Sonic Scalers	☐ Yes	☐ No	☐ N/A	_____
	Intra-Oral Radiography Equip	☐ Yes	☐ No	☐ N/A	_____
F)	Wrap utilized (when needed):	☐ Yes	☐ No	☐ N/A	
	Changed Between Pts:	☐ Yes	☐ No		
G)	Surface Disinfectant Used:	☐ Yes	☐ No	What Kind/Brand	_____
	Used According to Manf. Inst.	☐ Yes	☐ No		
H)	Sharps Container (Approved):	☐ Yes	☐ No	If No -Type	_____
I)	Gloves:	☐ Yes	☐ No	If No – Who	_____
	Masks (when needed):	☐ Yes	☐ No	If No – Who	_____
	Eye Protection w/Side Shields and/or Chin Length Face Shield	☐ Yes	☐ No	If No – Who	_____

Dentists	HBV	License #	Posted	OARRS	CS #	GA #

Hygienists	HBV	License #	OARRS Delegate	Local Anes	N_2O (A)	N_2O (M)	EFDA	PU

Assistants/Other DHCW's	HBV	Certificate #	OARRS Delegate	CDA	Sealants	CP	N_2O (M)	EFDA	PU

Dentist Signature

Person assisting with evaluation

Print Name

For Official Use Only Date of Last ICE: _____

Send Certificate ☐ No Certificate ☐ Verbal Warning ☐
Warning Letter ☐ Enforcement ☐ Prior IC Violations ☐