Indiana Society of Oral and Maxillofacial Surgeons
2026 Anesthesia Reevaluation

Dear Examinee:

Thank you for inviting a colleague into your office for your anesthesia reevaluation. This effort reveals your commitment to quality, safe anesthesia care for your patients as well as satisfies the membership requirements of both the ISOMS and AAOMS.

Only through these ongoing quality of care reexaminations can we as oral and maxillary surgeon anesthesiologists demonstrate to all concerned that in-office general anesthesia/deep sedation is a safe and effective procedure for our patients.

As a reminder, it is YOUR responsibility to have an active ISOMS member (dues paying or life member) perform this evaluation. You cannot use a retired member or a member of your own practice, even if they do not practice in the same office as you.

In addition, make sure you receive a signed, completed copy of your evaluation from your examiner. It is important that you keep a maintain a copy of this evaluation in your records at all times as it may be requested from time to time.

Thank you,

ISOMS Board of Directors

Date of Evaluation:_____2026 Initials of Examiner:_____

Indiana Society of Oral and Maxillofacial Surgeons
2026 Anesthesia Reevaluation

Date of Exam: _____, 2026

Examinee: _____
(Printed Name)

Location of Exam: _____
(Street Address)

_____
(City, State, Zip)

_____
(Phone)

Examiner: _____
(Printed Name)

_____
(Phone)

Dear Examiner:

Thank you for agreeing to perform this quality-of-care reexamination for your colleague on behalf of the Indiana Society of Oral and Maxillofacial Surgeons. Although there is no formal compensation to you, by continuing this same process every five years, a more formal (and costly) reexamination by a formed committee is not required. **Please do not continue to perform this evaluation if you are a partner of the examinee or a retired member of the ISOMS.**

Of note, please make sure you fill out all components of this evaluation. Failure to do so will make this evaluation null and void and will need to be redone.

Once you have completed the form, please do the following:

1. Provide a signed copy to the examinee
2. Email a signed copy to: isoms4489@gmail.com
3. Mail the **ORIGINAL** copy to:
   ISOMS
   c/o Laney Dezelan
   11307 Reflection Point Drive
   Fishers, IN 46037

FACILITY EVALUATION

Include the anesthesia record, anesthesia delivery system, monitors, and dated/labeled drugs

Present	Absent		
		1	Available drugs are to be examined for outdates, availability, and appropriateness.
		2	Reserve oxygen supply checked
		3	Monitoring equipment **MUST** include at least the following: EKG Pulse oximeter Blood pressure apparatus End-tidal carbon dioxide monitor
		4	Reserve suction (other than electrically powered) available and in operating condition.
		5	Laryngoscope checked regularly for function.
		6	Nasopharyngeal tubes.
		7	Oropharyngeal airways.
		8	Endotracheal tubes and connectors.
		9	Anesthesia records.
		10	Trained personnel in recommended numbers.
		11	Preoperative history, physical, blood pressure, pulse, weight.
		12	Safety-indexed fittings on all piped gas connections to prevent transpositions.
		13	Accuracy of anesthesia machines or O_2 and anesthetic agent monitors checked regularly.
		14	Patient transportation equipment.
		15	Instrument sterilization.
		16	Preparation of medications.
		17	Record of Hepatitis vaccinations.
		18	Gas storage facility appropriate and safe.
		19	Record of mock emergency drills with staff.
		20	Defibrillator.
		21	Auxiliary lighting system.

OBSERVE, SIMULATE, OR DISCUSS THREE ANESTHETIC TECHNIQUE CASES

Include a child <5 years of age. Describe patient profile and list medications with dosages used or proposed:

Case 1 - Adult

1. Proposed procedure(s):_____
2. Patient profile (age/weight/medical history):_____
3. Monitors used:_____
4. Anesthetic technique: ___ general ___ deep sedation ___ conscious sedation ___ intubated
5. Induction agents:_____
6. Maintenance agents:_____
7. Recovery procedure:_____

Case 2 - Adult

1. Proposed procedure(s):_____
2. Patient profile (age/weight/medical history):_____
3. Monitors used:_____
4. Anesthetic technique: ___ general ___ deep sedation ___ conscious sedation ___ intubated
5. Induction agents:_____
6. Maintenance agents:_____
7. Recovery procedure:_____

Case 3 - Child

1. Proposed procedure(s):_____

_____

2. Patient profile (age/weight/medical history):_____

_____

3. Monitors used:_____
4. Anesthetic technique: ___ general ___ deep sedation ___ conscious sedation ___ intubated
5. Induction agents:_____

_____

6. Maintenance agents:_____

_____

7. Recovery procedure:_____

_____

DISCUSS EMERGENCY SITUATIONS

Present a scenario that requires full office mobilization of the emergency plan. Suggest having a written list of functions for each staff member to efficiently manage the situation. The following may be used as a guideline. The examination may consider current ACLS certification as part of the proficiency in discussing emergency situations suggested.

YOU MUST INDICATE WHICH SCENARIOS YOU GO OVER OR LIST ANYTHING NOT INCLUDED BELOW:

SIMULATED EMERGENCIES

___ Largyngospasm
___ Emesis and Aspiration of Vomitus
___ Angina Pectoris
___ Cardiopulmonary Resuscitation
  a. Bradycardia
  b. Ventricular Tachycardia
  c. Ventricular fibrillation
  d. Asystole
  e. Pulseless Electrical Activity (PEA)

___Bronchospasm
___ Foreign Bodies in Airway
___ Myocardial Infarction
___ Hypotension
___ Hypertensive Crisis
___ Acute Allergic Reaction
___ Hyperventilation Syndrome
___ Convulsion of Unknown Etiology

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DEFICIENCIES and CORRECTIONS NEEDED

_____

_____

_____

SUGGESTIONS

_____

_____

_____

REMARKS:

_____

_____

_____

_____

_____

EXAMINER'S
SIGNATURE:_____ **DATE:**_____

Thank you again, Examiner, for completing this quality-of-care reexamination. Please note above and discuss any deficiencies noted and make recommendations for their correction. Please also note anything you note, any techniques, or other equipment that you find that may be helpful for you and your colleagues.

Again, please mail the original copy of this evaluation to:

ISOMS
c/o Laney Dezelan
11307 Reflection Point Drive
Fishers IN 46037

Also, email a copy to: isoms4489@gmail.com and provide a copy to the examinee

AFFIDAVIT

I hereby certify that all offices in which I administer anesthesia services to my patients meet the same guidelines as those found in my primary office.

Primary office inspected on _____, 20____.

_____
Street Address, City, State, Zip Code

Other office locations where I administer anesthesia:

_____
Street Address, City, State, Zip Code

_____
Street Address, City, State, Zip Code

_____
Street Address, City, State, Zip Code

_____
Street Address, City, State, Zip Code

_____ _____
Printed Name Signature