

ADDENDUM TO INTERIM GUIDANCE DURING COVID-19

RETURN TO ROUTINE PATIENT CARE

AMERICAN SOCIETY OF DENTIST ANESTHESIOLOGISTS

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OVERVIEW

This pandemic has brought the dental community together and the ASDA is committed to sharing information and making recommendations based on the most current science and the guidance of the American Dental Association (ADA), American Society of Anesthesiologists (ASA), Anesthesia Patient Safety Foundation (APSF), Society for Ambulatory Anesthesia (SAMBA) and governmental agencies such as the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA).

This addendum to the interim guidance was written to facilitate dentist anesthesiologists providing scheduled care in the office-based setting. Many intricate details will vary by geographic area and individual dental practices so this is written as a broad overview and will require professional judgment of each practitioner. Please refer to the original document for more extensive explanations.

The COVID-19 pandemic will continue as we provide care so it is essential to implement COVID-safe practices. We must continue to adapt to our circumstances and prioritize the safety of our colleagues and patients.

TIMING OF RESUMPTION

- Authorization by the appropriate state or county health authority.
- Sustained reduction in the rate of new COVID-19 cases for 14 days (one incubation period) in your immediate area.
- Ability of local hospitals to safely treat patients without resorting to crisis standards of care.
- State capability to test all people with COVID-19 symptoms and capacity to conduct active monitoring of all confirmed cases and their contacts.
- Adequate availability of PPE and other essential resources at the local hospitals for front line workers without jeopardizing surge capacity.
- Availability of anesthetic agents, which may be in short supply for the foreseeable future.

DENTAL HEALTHCARE PERSONNEL SAFETY

- Assess the workforce availability at each office (e.g., health status, exposure to COVID-19, underlying medical conditions).
- Wear a mask at all times in the dental office.
- Ensure adequate availability of appropriate PPE for all personnel.

- Provide adequate patient screening prior to scheduling the appointment *and* prior to the entering the dental office (see Appendix). Patients will be asked to socially distance and wear a face covering once in the dental office.
- Strict adherence to hand hygiene.
 - upon entry into the workplace
 - before and after contact with patients
 - after contact with a contaminated surface or piece of equipment
 - before donning and after doffing PPE
- Implement a strategy to follow up with all patients within at least 7 days and up to 14 days after the procedure regarding COVID-19 symptoms to determine if dental anesthesia personnel may have been exposed. A plan will need to be developed for those patients with COVID-19 symptoms.

PPE RECOMMENDATIONS FOR DENTIST ANESTHESIOLOGISTS

The minimum recommended equipment for aerosol-generating procedures (AGP) includes:

- N95 or higher-level respirator
- Surgical mask worn over the N95
- Eye protection-face shield or goggles with side shields (no personal glasses)
- Disposable head covering (e.g., bouffant, surgical cap)
- Disposable fluid-resistant long-sleeved gown
- Non-sterile gloves (double gloves are recommended during anesthesia procedures)
- Shoe coverings

SCREENING RECOMMENDATIONS FOR PROSPECTIVE PATIENTS AND ESCORTS

- In the past 14 days, have you
 - Tested positive or been diagnosed with COVID-19?
 - Been under investigation for possible coronavirus infection?
 - Experienced a loss of taste or smell or flu-like symptoms such as fever, cough, shortness of breath, body aches or diarrhea?
 - Have you been in close contact with another person who has been diagnosed with or under investigation for COVID-19?

Patients who respond 'yes' to any of these questions should not come into the dental office and should be encouraged to contact their primary care physician (PCP) for treatment recommendations. They can also be referred to dental facilities with airborne precautions (e.g., dental schools or hospital dental services) for emergency dental care.

- On the day of the procedure, ask screening questions again and take the temperature of the patient and the escort.
 - If 99-100.4° F (37.2-38° C), consider the source of the fever (e.g., dental infection) and decide clinical course.
 - If ≥ 100.4° F (38° C), assess any difficulty with breathing.
 - If none, defer treatment and have the patient follow up with their PCP if things worsen.
 - If breathing difficulty is observed, consider calling 911 or referring the patient to the emergency room.

WHEN A PATIENT SHOWS SYMPTOMS OR TESTS POSITIVE FOR COVID-19 FOLLOWING A PROCEDURE

- Have the patient seek medical treatment immediately if symptoms worsen.
- Try to determine who may have had contact with the individual who is COVID-19 positive.
- Notify any staff or other patients who were potentially exposed.
- Monitor the symptoms of all exposed staff members and patients.
- Conduct a risk assessment to determine the need for quarantine, testing and/or implementation of any work restrictions.

PATIENT SAFETY

Many dental patients will expect transparency with new controls to assure their safety.

- Establish and implement new infection control guidelines with each dental office.
- Ensure proper functioning of mobile equipment and all fixed equipment at each office.
- Consider simulated cases with staff to become familiar with any new guidelines and materials.
- Place PPE in the emergency kit in case of a complication.
- Continue with distancing strategies in the waiting room and with subsequent patients.
- When adequate and reliable point-of-care testing is available, each patient should be tested before each procedure.
- Implement special considerations for people at high risk for severe complications with COVID-19.

ENVIRONMENTAL INFECTION CONTROL RECOMMENDATIONS FOR DENTIST ANESTHESIOLOGISTS

- Wait at least 30-60 minutes for the aerosolized particles to descend before routine cleaning and disinfection of anesthesia equipment and supplies. The actual time needed to wait before routine cleaning is variable based on room size, room isolation, ventilation and other parameters. Use professional judgment.
- All surfaces should be disinfected in a top-down format with an EPA approved disinfectant, including the floors.
- The use of disposable transparent plastic drapes to cover anesthesia equipment likely limits contamination.
- Keep additional airway supplies in anesthesia cart until necessary for use (unless a difficult airway is anticipated).
- Single-use and disposable equipment are preferred.
- Unused but potentially exposed consumables should be discarded or appropriately disinfected.
- Utilize a high-quality viral filter to protect the anesthesia machine from contamination.
- Gas sampling tubing should be discarded after each patient. The viral filter should be placed in a location to prevent virus transmission via gas sampling tubing.

PRIORITIZATION OF PROCEDURES & RESCHEDULING CASES

- Continue to prioritize urgent cases because of the risk of a potential resurgence of COVID-19.
- When scheduling a patient who was diagnosed with COVID-19, adequate time after the resolution of symptoms should pass and it may be prudent to obtain a medical consultation prior to scheduling.
- Consider the use of an additional advisory/consent form (See Appendix) to discuss the risk of transmission in the dental setting.

AIRWAY MANAGEMENT RECOMMENDATIONS FOR DENTIST ANESTHESIOLOGISTS

- Consider a pre-procedural mouth rinse (1.5% hydrogen peroxide or 0.2% povidone-iodine) for cooperative patients. If this is not possible, consider swabbing the oral cavity prior to the dental procedure.
- Intubation with a cuffed endotracheal tube will result in decreased exhalation of patient gases and is considered the most certain way to minimize virus aerosolization from exhaled patient gases.
- For short cases, especially if aerosolization will be kept to a minimum, a natural or open airway can be considered.
- Nasal intubation is not contraindicated.
- Double gloves will enable one to shed the outer gloves after intubation and minimize subsequent environmental contamination.

INDUCTION RECOMMENDATIONS FOR DENTIST ANESTHESIOLOGISTS

- Consider moderate sedation instead of general anesthesia (or brief general anesthesia for local anesthetic administration followed by moderate sedation) if possible.
- Preoxygenate for an adequate period of time with 100% O₂ prior to induction when possible.
- Depending on the clinical condition and planned airway management, the recommended rapid sequence induction will need to be modified. If manual ventilation is necessary, apply small tidal volumes.
- Ensure there is a high-quality viral filter at either the expiratory limb connection to the anesthesia machine and/or between the facemask and breathing circuit. Ensure the gas sampling line is also protected.
- Video laryngoscopes may allow further patient distancing. Others have suggested clear plastic drapes or other barriers over the patient during intubation.
- Re-sheath the laryngoscope immediately post intubation (use outer glove in double glove technique).
- After removing PPE, avoid touching your hair or face and perform hand hygiene.

MAINTENANCE AND EMERGENCE RECOMMENDATIONS FOR DENTIST ANESTHESIOLOGISTS

- If a non-intubated general anesthetic is chosen and the patient requires airway support to maintain adequate ventilation, this places the dentist anesthesiologist close to aerosol generation and consideration for intubation should be made.
- A well-fitted rubber dam with individual holes punched for teeth in the area of operation will minimize virus aerosolization and limit patient gas escape in an open airway case. Other isolation devices (e.g., Isolite®) likely provide some minimization of virus aerosolization but the degree of benefit is unclear.
- High volume evacuation should be used meticulously throughout the dental procedure to minimize aerosol spread.
- If deep extubation is an option, it should be considered. If awake extubation is planned, adequate analgesia may prevent bucking, coughing and post-operative sore throat.
- In order to minimize virus transfer to surfaces, have a receptacle close to the patient where the extubated endotracheal tube can be immediately discarded.

RECOVERY RECOMMENDATIONS FOR DENTIST ANESTHESIOLOGISTS

- Keep a full coverage mask over the patient's airway during emergence and recovery and remain vigilant to ensure adequate ventilation.
- Use the procedure room for recovery to avoid contaminating another space.
- If the escort comes into the contaminated procedure room, be sure they are part of the patient's quarantined circle (during this time of social distancing).
- Wait at least 30-60 minutes for the aerosolized particles to descend before disinfecting anesthesia equipment and supplies (as well as the procedure room by DHCP) with an EPA approved disinfectant while wearing appropriate PPE. The actual time needed to wait before routine cleaning is variable based on room size, room isolation, ventilation and other parameters. Use professional judgment.
- Doffing all PPE (except for the N95) should be done prior to leaving the procedure room when recovery takes place in the treatment room.
- If the dentist anesthesiologist needs to leave the room before final disinfection, consider a dedicated room adjacent to the treatment area where doffing of PPE can take place.
- Be sure to continue wearing all necessary PPE if the patient is transferred to a dedicated recovery area.

APPENDIX A: ADA® PATIENT SCREENING FORM

APPENDIX B: ADA® DAILY SCREENING LOG

APPENDIX C: LIMITED TO ONLY **EMERGENT/URGENT PROCEDURES**

EXAMPLE 1: DISCLOSURE/CONSENT

EXAMPLE 2: ADVISORY/ACKNOWLEDGMENT (FROM MEDPRO)

APPENDIX D: DENTAL OFFICES OPEN TO **SCHEDULED CASES**

EXAMPLE 1: DISCLOSURE/CONSENT

EXAMPLE 2: ADVISORY/ACKNOWLEDGMENT (FROM MEDPRO)

Patient Screening Form

ADA®

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they having shortness of breath or other difficulties breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they experienced recent loss of taste or smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your/their age over 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of [State and Territorial Health Department Websites](#) for your specific area's information.

COVID-19 Daily Screening Log

DATE	NAME	TEMPERATURE <100.4°F	COUGH	NEW SHORTNESS OF BREATH	ASKED TO GO HOME (Note Time Dismissed)
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Time: <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Time: <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Time: <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Time: <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Time: <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Time: <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Time: <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Time: <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Time: <input type="checkbox"/> No
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			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Time: <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Time: <input type="checkbox"/> No
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			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Time: <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Time: <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes, Time: <input type="checkbox"/> No

COVID-19 (Coronavirus) Disclosure/Consent

Patient Name: _____

The Centers for Disease Control and Prevention (CDC), the American Dental Association (ADA), and the state dental board have all issued a strong recommendation to postpone any non-emergent dental care until further notice during the COVID-19 pandemic.

Current studies indicate that some dental procedures create aerosolized particles (similar to a sneeze), which can linger in the air for minutes to sometimes hours, which can result in transmission of COVID-19.

I understand and acknowledge these recommendations and hereby declare that I have an emergent or urgent dental condition that requires prompt care (or I have a child with an emergent or urgent dental condition). _____ (Initial)

I hereby affirm that my dentist/surgeon and anesthesiologist have offered me the opportunity to reschedule dental treatment under general anesthesia to a subsequent date pending recommendation changes. _____ (Initial)

I also affirm that I have freely elected to proceed with the procedure due to pain/infection that are unmanageable at home with medications. I have consulted the treating dentist for other alternatives. _____ (Initial)

I fully understand that proceeding with the treatment today increases my exposure/my child's exposure and therefore risk of contracting community acquired COVID-19 (Coronavirus) infection. Acquiring such infection can lead to symptoms such as fever, chest pain, shortness of breath and further respiratory complications. Severe disease can also lead to: prolonged hospitalization, intensive care admission, mechanical ventilation, and/or possible death.

I also affirm that neither I/my child, nor any of my family members have been exposed to or had any of the following symptoms in the past 14 days:

- 1) Fever ($\geq 100.4^{\circ}$ F)
- 2) Shortness of breath
- 3) Dry cough
- 4) Fatigue and body aching
- 5) Chest pain
- 6) Confirmed or suspected COVID-19 (Coronavirus) infection

I am consenting to this procedure with full understanding and disclosure of such risks and alternatives, and all my questions were answered to my satisfaction.

Name (printed): _____

Signature: _____

Relationship to patient (if applicable): _____

Date: _____

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have presented to the office today because you have an urgent dental condition which must be treated at this time and cannot be postponed until the current COVID-19 risk period abates. Please be advised of the following:

While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of “screening” questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY

DATE

PLEASE ANSWER “YES” OR “NO” WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	_____	YES	_____	NO
DO YOU HAVE A FEVER?	_____	YES	_____	NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	_____	YES	_____	NO
DO YOU HAVE A DRY COUGH?	_____	YES	_____	NO
DO YOU HAVE A RUNNY NOSE?	_____	YES	_____	NO
DO YOU HAVE A SORE THROAT?	_____	YES	_____	NO
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	_____	YES	_____	NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	_____	YES	_____	NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	_____	YES	_____	NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	_____	YES	_____	NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES?	_____	YES	_____	NO
IF SO, WHERE?	_____			

COVID-19 (Coronavirus) Disclosure/Consent

Patient Name: _____

Current studies indicate that some dental procedures create aerosolized particles (similar to a sneeze) of the virus that causes COVID-19, which can linger in the air for minutes to sometimes hours, which can result in transmission of COVID-19 (Coronavirus) from an infected person.

I understand and acknowledge this information and hereby declare that I have a dental condition that requires prompt care or I have a child with a dental condition that requires prompt care.

_____ (Initial)

I hereby affirm that my dentist/surgeon and anesthesiologist have discussed with me the preventative measures being taken to minimize the risk of COVID-19 (Coronavirus) transmission.

_____ (Initial)

I fully understand that proceeding with the treatment today increases my exposure/my child's exposure and therefore my risk of contracting community acquired COVID-19 (Coronavirus) infection.

Acquiring such infection can lead to symptoms such as fever, chest pain, shortness of breath and further respiratory complications. Severe disease can also lead to: prolonged hospitalization, intensive care admission, mechanical ventilation, and/or possible death.

I also affirm that neither I/my child, nor any of my immediate family members have been exposed to or had any of the following symptoms in the past 14 days:

- 1) Fever ($\geq 100.4^{\circ}$ F)
- 2) Shortness of breath
- 3) Dry cough
- 4) Fatigue and body aching
- 5) Chest pain
- 6) Confirmed or suspected COVID-19 (Coronavirus) infection

I am consenting to this procedure with full understanding and disclosure of such risks and alternatives, and all my questions were answered to my satisfaction.

Name (printed): _____

Signature: _____

Relationship to patient (if applicable): _____

Date: _____

Patient Advisory and Acknowledgment

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY

DATE

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITIALS, TO THE FOLLOWING QUESTIONS:

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?	_____	YES	_____	NO
DO YOU HAVE A FEVER?	_____	YES	_____	NO
DO YOU HAVE ANY SHORTNESS OF BREATH?	_____	YES	_____	NO
DO YOU HAVE A DRY COUGH?	_____	YES	_____	NO
DO YOU HAVE A RUNNY NOSE?	_____	YES	_____	NO
DO YOU HAVE A SORE THROAT?	_____	YES	_____	NO
DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES?	_____	YES	_____	NO
HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?	_____	YES	_____	NO
HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?	_____	YES	_____	NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED TO ANY FOREIGN COUNTRY?	_____	YES	_____	NO
WITHIN THE LAST 14 DAYS, HAVE YOU TRAVELLED WITHIN THE UNITED STATES?	_____	YES	_____	NO
IF SO, WHERE?	_____			