Advisory Board on Athletic Training

Virginia Board of Medicine

October 23, 2025

10:00 a.m.

Virginia Department of Health Professions

Advisory Board on Athletic Training

Board of Medicine

Thursday, October 23, 2025, at 10:00 a.m.

9960 Mayland Drive, Suite 201, Henrico, VA

Training Room 1

Call to Order – David Pawlowski, AT, Chair

Emergency Egress Procedures – Kathleen LaMotte

Roll Call – Kathleen LaMotte

Introduction of Members – David Pawlowski, AT, Chair

Approval of minutes from June 12, 2025, Meeting

Adoption of the Agenda

Public Comment on Agenda Items (15 minutes)

New Business

1. Recommendation of draft amendments for licensure by endorsement – Erin Barrett
2. Election of Officers – David Pawlowski, AT, Chair
3. Report on AT Conference – David Pawlowski, AT, Chair
4. Approval of 2026 Meeting Calendar – David Pawlowski, AT, Chair
5. Orientation to the Board – William Harp, MD

Announcements

Next meeting: Thursday, February 5, 2026, at 10:00 a.m.

Adjournment

PERIMETER CENTER CONFERENCE CENTER
EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS
(Script to be read at the beginning of each meeting.)

PLEASE LISTEN TO THE FOLLOWING INSTRUCTIONS ABOUT EXITING THESE PREMISES IN THE EVENT OF AN EMERGENCY.

In the event of a fire or other emergency requiring the evacuation of the building, alarms will sound.

When the alarms sound, leave the room immediately. Follow any instructions given by Security staff

Training Room 1

Exit the room using one of the doors at the back of the room. (**Point**). Upon exiting the room, turn **LEFT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

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ADVISORY BOARD ON ATHLETIC TRAINING
Minutes
June 12, 2025

The Advisory Board on Athletic Training met on Thursday, June 12, 2025, at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: David Pawlowski, AT - Chair
Chris Casola, AT
William Scott Powers, AT
Virginia Wells, MD
Larry D'Shawn Wright – Citizen Member

MEMBERS ABSENT:

STAFF PRESENT: Arne Owens - Director, Department of Health Professions
Jennifer Deschenes, JD - Deputy Executive Director, Discipline
William L. Harp, MD - Executive Director
Michael Sobowale, LLM - Deputy Executive Director, Licensure
Colanthia Opher - Deputy Executive Director, Medical Licensure and Administration
Kathleen LaMotte - Board Administrator
Matthew Novak - DHP Policy and Economic Analyst
Roslyn Nickens - Licensing Supervisor
Joshlynn Jones - Licensing Specialist
Sonya Armstead - Licensing Specialist

GUESTS PRESENT: Debra Rodman - VATA

Call to Order

David Pawlowski called the meeting to order at 10:03 a.m.

Emergency Egress Procedures

Kathleen LaMotte announced the emergency egress instructions.

Roll Call

Kathleen LaMotte called the roll; a quorum was declared.

Introduction of Members

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Mr. Pawlowski asked everyone present to introduce themselves.

Approval of Minutes

Mr. Powers moved to approve the minutes from the June 10, 2024 meeting. Mr. Casola seconded, and the motion passed unanimously.

Adoption of Agenda

Mr. Powers moved to adopt the agenda as presented. The motion was seconded by Dr. Wells and passed unanimously.

Public Comment on Agenda Items

None received.

New Business

1. **Legislative Report**
   Matthew Novak reviewed items pertaining to the Board of Medicine from the 2025 General Assembly (GA) session. This included two vetoed bills supporting unconscious bias training, a new reporting system for threats made against healthcare professionals, a study to be completed by the DHP regarding the scope of practice of physician assistants, a new license type for anesthesiologist assistants, a faster regulatory pathway to allow for licensure by endorsement for professions that do not currently have one, a recommendation for education on communication with children diagnosed with autism spectrum disorder to be disseminated to DHP licensees, the elimination of the Board of Health Professions and the absorption of the Board's duties by boards and divisions of DHP.

2. **Report on Status of Regulatory /Policy Actions**

   There were no items to report

3. **Consideration of Petition for Rulemaking**
   The Advisory Board was asked to review a petition for rulemaking to allow dry needling by athletic trainers. The public comment period received a total of 764 comments, with 500 in favor, 250 opposed, and about 15 not describing a position.

   DHP staff advised that the athletic trainer scope of practice does not allow for dry needling, and this change must be made through legislation as opposed to the regulatory process.

   The Advisory Board was in favor of dry needling philosophically and wanted to vote "yes" to recommend the petition to the Board of Medicine. The Advisory understood

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the limitation of the rulemaking process and supported VATA in seeking a patron to add dry needling to the AT scope of practice.

MOTION: Mr. Powers moved to recommend the petition to the full Board. The motion was seconded by Mr. Wright and passed unanimously.

Licensing Report

Sonya Armstead provided the following licensing statistics

Athletic Trainer: Total Number Licensed: 1,826
Total Number Licensed since January 1, 2025 to Present: 87
Current Processing Time: 27 days
Clearance Rate: 97%

Announcements

Next Scheduled Meeting

The next scheduled meeting is Thursday, October 23, 2025 at 1:00 p.m.

Mr. Sobowale advised that at future meetings, there will be no paper agenda packet. Advisory members will have the agenda pre-loaded on a laptop. The agenda will also be projected for the public to view. Board staff will continue to send out notices of the meeting by email ahead of time.

Adjournment

David Pawlowski, Chair, adjourned the meeting at 10:55 a.m.

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William L. Harp, MD, Executive Director

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18VAC85-120-50. Requirements for licensure.

An applicant for initial licensure shall submit evidence of meeting the following requirements for licensure on forms provided by the board:

1. A completed application and fee as prescribed in 18VAC85-130-150;

2. Verification of professional activity as required on the application form;

3. Evidence of current NATABOC certification; and

4. If licensed or certified in any other jurisdiction, ~~documentation of practice as an athletic trainer and~~ verification as to whether there has been any disciplinary action taken or pending in that jurisdiction.

18VAC85-120-51. Requirements for licensure by endorsement.

An applicant for licensure by endorsement shall submit the following:

1. Evidence of a current, active license in a United States jurisdiction or Canada that is in good standing;
2. A completed application and fee;
3. Evidence of a current, active NATABOC certification; and
4. A current report from the National Practitioner Data Bank

18VAC85-120-90. Renewal of license.

A. Every athletic trainer intending to continue licensure shall biennially in each odd-numbered year in his birth month:

1. Register with the board for renewal of licensure;

2. Pay the prescribed renewal fee at the time he files for renewal; and

3. Attest to current NATABOC certification.

B. An athletic trainer whose license has not been renewed by the first day of the month following the month in which renewal is required shall pay a late fee as prescribed in 18VAC85-120-150.

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AT COMPACT

Athletic Trainer Interstate Compact

Barriers to Licensure Portability

Disparate, complex, and time intensive processes

Duplicative and burdensome requirements to maintain multiple licenses

Information sharing across states may be limited by infrastructure and processes

Primary beneficiaries of licensure portability

Health care provider shortage areas

Telehealth providers and patients

Mobile populations (students, military families, etc.)

Patients and practitioners living along state borders

Occupational Licensure Portability Policy Goals

- Facilitate Multistate Practice
- Public Health and Safety
- Preserve State Authority Over Professional Licensing

Common Licensure Portability Options

- Licensure by endorsement
- Universal licensure recognition
- Telehealth registries
- Reciprocity agreements
- Interstate compacts

PAT COMPACT

Interstate Compacts 101

The Council of State Governments

National Center for Interstate Compacts (NCIC)

NCIC is a technical assistance center within CSG that helps states work cooperatively on mutual issues and shared goals.

NCIC assists states with the review, revision, development and administration of interstate compacts.

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CSG-DoD Cooperative Agreement

- Partnership to fund and support the development of new interstate compacts for occupational licensure in support of military families
- Eight licensure compacts have been developed under the cooperative agreement to date
- BOC applied for technical assistance with compact development activities through this cooperative agreement

AT·COMPACT

What is an Interstate Compact?

A legal contract between two or more states that allows states to:

#1 Legislatively enacted agreement (contract) among states

#2 Enables states to cooperatively addresses shared problems

#3 Preserves state sovereignty over issues belonging to states

Interstate Compact Enactment History

275+ compacts

Each state has enacted between 20-80 compacts

43 compact enactments per state on average

2,200 total compact enactments

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Occupational Licensure Compacts

Licensure Compact Basics

- Compact legislation is developed for a particular profession(s)
- A state joins the compact by enacting the model legislation
- The provisions of the compact take effect once the prerequisite number of states have joined (7 is usually the minimum)

Licensure Compact Basics

- The compact legislation “pre-negotiates” the recognition of an out-of-state license through a compact authorization to practice

- Available to licensed practitioners only in the participating states

Limits of Licensure Compacts

- Licensure compacts are not “one size fits all”, they are custom built to the regulatory and portability needs of a profession
- Licensure compacts are voluntary, no practitioner will be required to join
- Compacts do not alter state scope of practice or other licensure pathways

14

Model Legislation

- Compacts are created through model legislation
- The model legislation is developed through a stakeholder driven, consensus-based process
- For a state to join the compact, it must enact the same model legislation
- Compacts include requirements a state must adhere to as a participating member

Model Legislation Components

- What a state must do as a participating member
- How a practitioner can qualify to use the compact
- How the compact will be governed

Policy Advantages of Licensure Compacts

- Two-way reciprocity
- Adaptability
- Compliance standards
- Opportunity for greater practitioner awareness
- Does not supplant existing pathways and scopes of practice
- Voluntary

Process Advantages of Licensure Compacts

- Uniform and centralized qualification and application process
- Expediency of process
- Streamlined maintenance requirements (CE, renewal cycles)
- State data sharing and cooperation regarding adverse actions

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Status of Occupational Licensure Compacts

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Licensure Compacts by the Numbers

37 states & territories have adopted at least 6 compacts.

400+ pieces of enacted compact legislation since 2016.

21 available compacts for occupational licensing.

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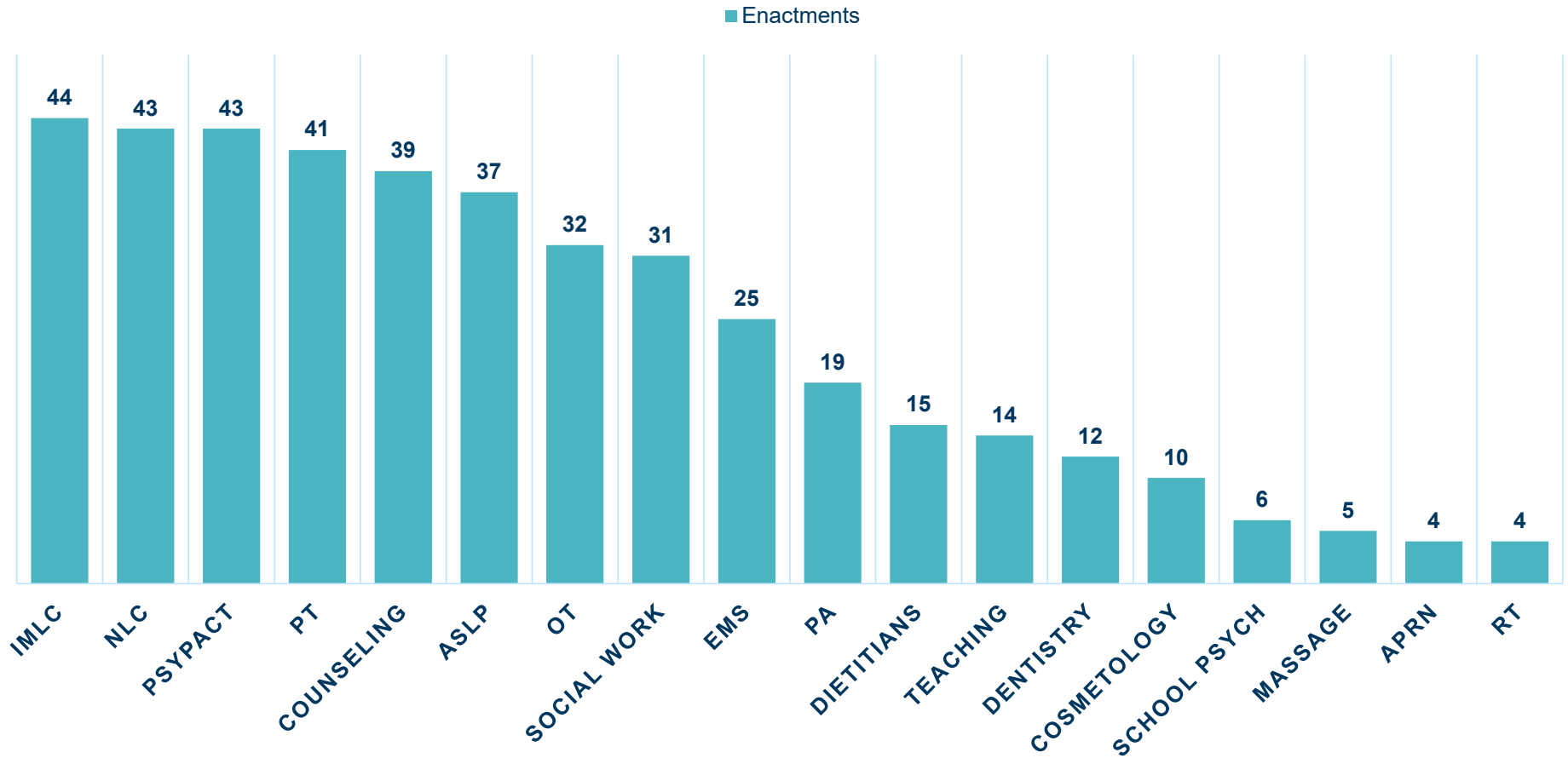
Occupational Licensure Compact Enactments



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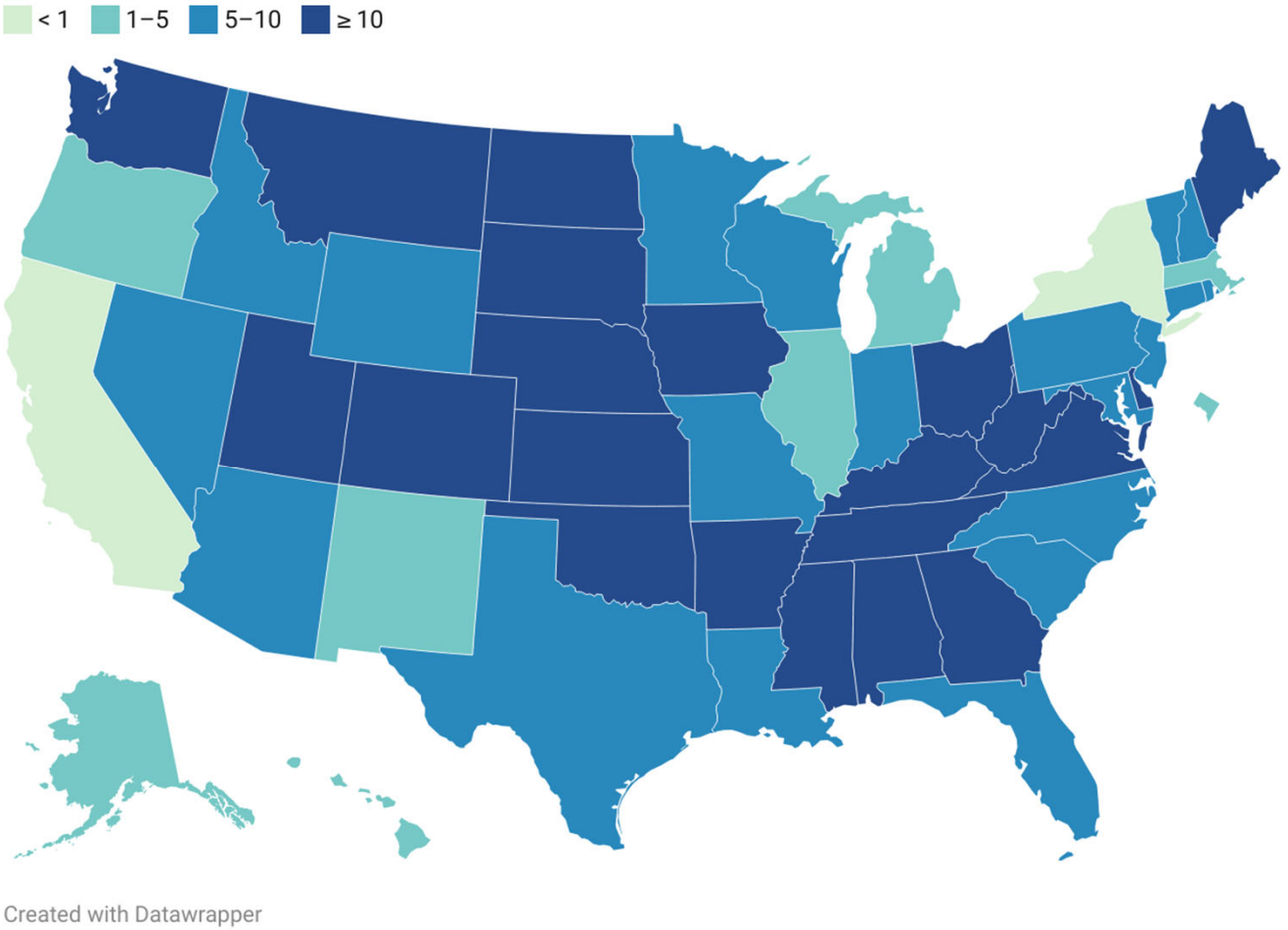
Licensure Compact Participation by State



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Compact Usage Numbers and Survey Data

- Since 2017, the Interstate Medical Licensure Compact has reported over 150,000 physician licenses being granted through the compact.
- The Physical Therapy Compact issued 8,372 compact privileges in 2023 (31 jurisdictions)
- IMLC found in a 2022-2024 survey that nearly 95% of survey respondents found the compact process beneficial.
  - The same survey found that 40% of survey respondents are using the compact to provide telehealth services.

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Occupational Licensure Compact Development

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Compact Development Considerations

- Size of the profession
- Number of states with licensure
- Existing licensure uniformity
- Resources required to develop, support legislative enactment, and compact operations
- Time constraints

Compact Timeline

- **Legislation Development: ~1 year**
  After the compact model legislation is finalized, it becomes available for state enactment.

- **Compact Activation: ~2 years**
  The compact activation threshold is defined in the model legislation.

- **Compact Operationalization: ~2 years**
  Operationalization includes establishing compact commission, data system, fee structures, etc.

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Compact Development Process

Phase I Development

TECHNICAL ASSISTANCE GROUP

- Composed of approx. 20 state officials, stakeholders and issue experts
- Examines issues, current policy, best practices and alternative structures
- Establishes recommendations as to the content of an interstate compact

COMPACT DOCUMENT TEAM

- Composed of 5 to 8 state officials, stakeholders, and issue experts
- Crafts compact based on recommendations
- Circulates draft compact to states and stakeholder groups for comment

FINAL PRODUCT

- Drafting team considers comments and incorporates into compact
- Final product sent to TA group
- Released to states for consideration

Phase II Education & Enactment

EDUCATION

- Develop comprehensive legislative resource kit
- Develop informational internet site with state-by-state tracking and support documents
- Convene "National Briefing" to educate legislators and key state officials

STATE SUPPORT

- Develop network of "champions"
- Provide on-site technical support and assistance
- Provide informational testimony to legislative committees

STATE ENACTMENTS

- Track and support state enactments
- Prepare for transition and implementation of compact
- Provide requested support as needed

Phase III Transition and Operation

TRANSITION

- Enactment threshold met
- State notification
- Interim Executive Board appointed
- Interim Committee's established
- Convene first Compact meeting
- Information system development (standards, security, vendors)

OPERATION

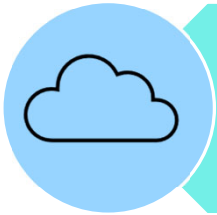
- Ongoing state control and governance
- Staff support
- Annual assessment, if necessary
- Annual business meeting
- Information system oversight (maintenance, security, training, etc.)
- Long-term enhancements / up-grades

AT COMPACT

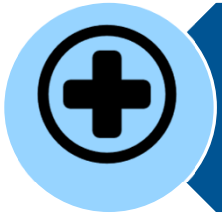
Athletic Trainer Compact – How it Works

Benefits to Licensing Boards

Agreement On Uniform Licensure Requirements



Shared Data System

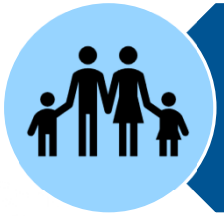


Retain control of scope of practice and initial licensure process

Benefits to Practitioners

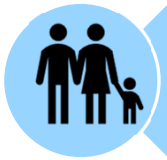
Reduced barriers to licensure portability

Allows for two-way reciprocity



Supports relocating military members and their families

Benefits to Patients



Enhances Public Protection

Improves Continuity of Care

Expands Health Care Access

Enhances availability of Telehealth

How much will a compact privilege cost?

- The compact member states and the compact commission will each set up a fee structure.
- An athletic trainer will pay a fee for each compact member state they wish to practice in.
- With other compacts, the fee for a compact privilege is typically equivalent or less than the fee for a license.

What does it cost for a state to participate?

- Staff time to implement (serve on compact commission, etc.)
- Possible compact assessment fee*
- Compact data system integration costs*
- Addition of an FBI background check and tracking into the process

What if a state does not require a criminal background check as a requirement for licensure?

How will the compact impact licensure requirements?

The Athletic Trainer Compact cannot dictate a state's requirements for initial license or license renewal.

The compact provides an alternative, optional pathway to practice by obtaining a compact privilege.

Does the licensee need to complete CE in every state where they practice?

Practitioners must complete the continuing education requirements to maintain their qualifying license. They do not need to complete additional continuing education in remote states where they hold compact privileges.

How does the compact compare to the Sports Medicine Licensure Clarity Act?

- SMLCA may provide licensure and insurance benefits for select practice scenarios
- AT Compact provides authorization to practice in all practice scenarios allowed by state laws
  - Additionally, it provides robust public protection safeguards

AT COMPACT

ATHLETIC TRAINER COMPACT

What is the Athletic Trainer Compact?

The Athletic Trainer Compact (AT Compact) is an interstate occupational licensure compact for athletic trainers. Athletic trainers across the United States currently face barriers when trying to provide services in other states because of the disparate and time-intensive licensure policies currently employed by states. The AT Compact facilitates multistate practice by streamlining licensure processes, reducing administrative burdens, and improving public protection through enhanced sharing of disciplinary and investigative information among states. The compact enables eligible athletic trainers to obtain a "compact privilege" to practice in other participating states while maintaining licensure in their state of qualifying licensure.

Interstate Compacts in Other Professions

Interstate Compacts are constitutionally authorized, legally binding, legislatively enacted contracts among states. Including the AT Compact, there are currently 21 occupational licensure compacts available for enactment. Occupational licensure compacts are most common in health care professions including nurses, physicians, physical therapists, occupational therapists, and psychologists, among others. The 21 occupational licensure compacts represent over 400 enactments in 51 states and territories.

Compact Benefits

Benefits for Practitioners

- Enables and provides a uniform process to practice in other compact member states
- Expands employment opportunities into new markets.
- Eases the burden of applying for and maintaining multiple licenses.
- Supports relocating military spouses and families.

Benefits for Licensing Authorities

- Reduces administrative burdens.
- Creates a compact data system which enables the exchange of athletic trainer licensure and discipline information.
- Facilitates cooperation among state licensure boards on investigations and disputes
- Allows regulators to retain jurisdiction over licensees practicing in their state.

Benefits for States

- Promotes workforce development and strengthens labor markets.
- Preserves state sovereignty

Benefits for Patients

- Provides greater access to care for qualified providers.
- Improves continuity of care.
- Enhances availability of telehealth services.

AT COMPACT

Overview of Athletic Trainer Compact Privileges

The Athletic Trainer Compact enables licensees to practice in other compact member states through a compact privilege. Compact privileges provide licensees the same benefits of licensure while not requiring duplicative continuing education and differing renewal cycles. To qualify for a compact privilege, licensees must meet the requirements of the compact, such as possessing an unrestricted license. Because the compact alleviates the duplication of primary source verification, the authorization to practice in another state can be granted much quicker than other licensure pathways.

Compact privileges can potentially be issued minutes after an application is received. The process is expedited by the compact's shared data system of licensees amongst compact member states. The privilege model is a similar approach other allied health professions have taken including compacts for counselors, dentists and dental hygienists, occupational therapists, physical therapists, and PA's.

How does the Athletic Trainer Compact work?

A licensed athletic trainer applies for a compact privilege in a compact member state. ▶ **Application processed** ▶ **Compact privilege is issued**

The athletic trainer has met the compact requirements, the primary of which being:

- holding an active, unencmbered license
- completing a criminal background check
- holding active BOC certification (or meeting the other pathway requirement established in the compact)

The practitioner's license and eligibility are verified through a streamlined process utilizing the commission's data system.

The practitioner pays fees and completes any necessary jurisprudence requirements.

The practitioner now has legal authorization to practice in the state where they hold privilege.

AT COMPACT

ATHLETIC TRAINER COMPACT
Frequently Asked Questions (FAQs)

1. What is the Athletic Trainer Compact?

The Athletic Trainer Compact is a legislative agreement among states which provides a streamlined pathway to interstate practice for licensed athletic trainers. A state must enact the compact model legislation via its legislative process to join.

2. What are the primary benefits of the compact?

- Promotes multistate practice through a streamlined and expedient process
- Strengthens public protection by setting robust safeguards and facilitating greater information sharing among states
- Reduces the burden of maintaining multiple licenses, by syncing renewal dates and avoiding duplicative continuing education requirements

3. When and why do licensed athletic trainers need to engage in interstate practice?

- Changes of residence by an athletic trainer. This is a particularly frequent occurrence among military spouses.
- Employment opportunities across state lines – including providing services for a sports team or sports team event.
- Continuity of care opportunities when either a patient or provider relocates.

4. How does the Athletic Trainer Compact work?

The Athletic Trainer Compact streamlines the traditional licensure process by establishing uniform eligibility criteria for states to join and for athletic trainers to use the compact. The compact eligibility criteria are reflective of the licensure uniformity that already exists among states, as well as prevailing compact law.

Athletic trainers who are licensed in one compact member state can practice in another member state by obtaining a compact privilege. The eligibility for a privilege to practice is confirmed by the exchange of data from the athletic trainer's state of qualifying licensure and the compact data system. Since the athletic trainer's eligibility is pre-determined through existing data sets, an athletic trainer can be issued a privilege to practice within the same day as applying, assuming all criteria is met.

5. Is the Athletic Trainer Compact similar to other licensure compacts?

Yes, the Athletic Trainer Compact uses the prevailing 'privilege to practice' model and is similar in form and function to other professional licensure compacts such as the PA Compact, Respiratory Care Interstate Compact, and the Occupational Therapy Compact.

6. What is a compact privilege?

A compact privilege is the legal authorization for an athletic trainer to practice in another compact member state where they are not licensed. An athletic trainer must hold an active and unencumbered license in their state of qualifying licensure (which must be a compact member state) and meet additional eligibility criteria to be eligible for a compact privilege.

7. Who can use the compact?

The primary requirements are for an athletic trainer to have an unencumbered license from a compact member state and have active BOC certification. If an athletic trainer does not have current BOC certification, there is an alternative pathway available through the compact by completing a number of requirements laid out in the compact.

8. When can licensed athletic trainers use the compact and get privileges to practice?

Once the compact has been enacted in at least seven states, the Athletic Trainer Compact Commission will be established to begin the work of operationalizing the compact for licensees. It typically takes 18 – 24 months for a compact commission to complete the operationalization process and begin issuing privileges to practice.

9. What does a compact privilege allow an athletic trainer to do in a remote state?

States retain their sovereignty over the practice of athletic trainers within their borders. An athletic trainer providing care in a remote state under a compact privilege will function within the scope of practice the same as individuals who are licensed in that state. Just as they are currently required to do if engaging in interstate practice, it is the athletic trainer's responsibility to know what they are authorized to do in the remote state based on that state's practice act.

10. How much will a compact privilege cost?

The compact member states will set up the fee structure once the compact reaches its activation threshold. The fee structure will include the option for both a compact commission fee and a compact member fee.

While the Athletic Trainer Compact is not currently active, for licensure compacts that are similar in model to the athletic trainer compact, the collective fee for a compact privilege is typically equivalent or less than the fee for a license.

11. What is a state of qualifying licensure?

A state of qualifying licensure refers to the compact member state in which an athletic trainer holds a license that meets the compact eligibility requirements. For instance, the license must be active, unencumbered, and issued by a state that satisfies the other criteria set forth in the compact. The qualifying license is what compact member states will recognize to grant a privilege to practice in their state.

12. How will the compact impact licensure requirements?

The Athletic Trainer Compact is an alternative, voluntary pathway to practice and will have no direct impact on a state's requirements for a single state license or scope of practice.

13. How will states know who is practicing in their state through the compact?

Just as state regulators can currently see who has a license in their state, regulators will also be able to know who has compact privileges to practice in their state. Athletic trainers need to obtain individual compact privileges in each state where they want to practice. States will have access to the compact's data system and will be able to view this information as needed.

14. Does the licensee need to complete CE in every state where they practice?

Practitioners must still complete the continuing education requirements to maintain their license from their state of qualifying licensure. However, they do not need to complete continuing education in the remote states where they hold compact privileges.

15. What is the compact commission?

The compact commission is an interstate government agency established by the compact which is comprised of one delegate from each member state. The compact commission writes rules and establishes the data system infrastructure to administer and implement the compact.

The compact commission is not a licensing board. It cannot affect state licensing requirements or act against a licensee.

16. When will the compact be finalized?

The model compact legislation is finalized and available to states for consideration and enactment in 2026.

17. How many licensure compacts exist?

As of 2025, there are 21 licensure compacts:

- Interstate Medical Licensure Compact (IMLC)
- Nurse Licensure Compact (NLC)
- Advanced Practice Registered Nurse Compact (APRN Compact)
- EMS Compact
- The Physical Therapy Compact (PT Compact)
- The Psychology Interjurisdictional Compact (PSYPACT)
- Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC)
- The Occupational Therapy Licensure Compact (OT Compact)
- The Counseling Compact
- Social Work Compact
- Interstate Teacher Mobility Compact (ITMC)
- Dentist and Dental Hygienist Compact
- Interstate Massage Compact (IMpact)
- Cosmetology Compact
- PA Compact
- Dietitian Compact
- School Psychology Compact
- Respiratory Care Interstate Compact
- Podiatry Compact
- Athletic Trainer Compact
- Esthetician Compact

18. How is the compact different from other state licensure portability policies, including universal licensure recognition laws (ULR)?

Other state licensure portability policies typically require a review by a state licensing board to determine substantial equivalency between the state's licensure requirements and an athletic trainer's existing license and qualifications. In the athletic trainer compact, the equivalency is predetermined through the terms of the compact and the information submitted by compact member states to the compact data system. Therefore, the time to be granted an authorization to practice would be far less than the average time to licensure through other state pathways.

In addition, other licensure portability policies just help facilitate licensure for an athletic trainer into one state. If an athletic trainer is wanting to practice in more than one state, they must navigate the disparate processes for licensure set by each state. This creates a burden even if they are pursuing licensure through a licensure portability law. Through the Athletic Trainer Compact, there is uniform eligibility criteria and processes by which an athletic trainer can receive an authorization to practice in another compact member state.

Further, the compact creates two-way reciprocity by benefiting both existing and prospective licensees in a compact member state.

Lastly, unlike other licensure portability laws, an athletic trainer does not have to meet continuing education requirements and track different renewal cycles if they are accessing interstate practice through the compact.

AT COMPACT

ATHLETIC TRAINER COMPACT
Benefits for Military Families

Military families are highly mobile and on average are reassigned to a new duty station every two to three years. This level of mobility particularly creates barriers to employment and career development for military spouses in licensed professions due to the time consuming, labor intensive, and costly process to apply for licensure in another state.

The Department of Defense is committed to supporting military spouses as an essential component of supporting military families. To recruit and retain military personnel and maintain readiness, the Department of Defense believes interstate compacts are the best solution for occupational license portability for military spouses.

Interstate compacts like the Athletic Trainer Compact enhance practitioner mobility by facilitating the recognition of an existing license. The reduction in barriers to licensure alleviates much of the time, costs, and effort that would otherwise be needed through a traditional licensure pathway.

The Athletic Trainer Compact provides active military members and their spouses the ability to designate a compact member state as their "state of qualifying licensure" through the duration of military service. This provision means that when active military members and their spouses relocate to another state, they will not be required to establish a new "state of qualifying licensure." The military member and their spouse may continue to use the license from their previous "state of qualifying licensure" to use the compact.

In addition, active military members and their spouses are not required to pay a fee to the commission for a compact privilege. Compact member states may choose to charge a reduced fee or no fee to active military members and their spouses for a compact privilege.

This project is funded by the Department of Defense.

CSG National Center for Interstate Compacts
THE COUNCIL OF STATE GOVERNMENTS

BYLAWS FOR

ADVISORY BOARDS OF THE BOARD OF MEDICINE

Article I - Members of the Advisory Board

The appointments and limitations of service of the members shall be in accordance with the applicable statutory provision of the advisory board governing such matters.

Article II - Officers

Section 1. Titles of Officers - The officers of the advisory board shall consist of a chairman and vice-chairman elected by the advisory board. The Executive Director of the Board of Medicine shall serve in an advisory capacity.

Section 2. Terms of Office - The chairman and vice-chairman shall serve for a one-year term and may not serve for more than two consecutive terms in each office. The election of officers shall take place at the first meeting after July 1, and officers shall assume their duties immediately thereafter.

Section 3. Duties of Officers.

(a) The chairman shall preside at all meetings when present, make such suggestions as may deem calculated to promote and facilitate its work, and discharge all other duties pertaining by law or by resolution of the advisory board. The chairman shall preserve order and conduct all proceedings according to and by parliamentary rules and demand conformity thereto on the part of the members. The chairman shall appoint all committees as needed.

The chairman shall act as liaison between the advisory board and the Board of Medicine on matters pertaining to licensing, discipline, legislation and regulation of the profession which the advisory board represents.

When a committee is appointed for any purpose, the chairman shall notify each member of the appointment and furnish any essential documents or information necessary.

(b) The vice-chairman shall preside at meetings in the absence of the chairman and shall take over the other duties of the chairman as may be made necessary by the absence of the chairman.

Article III - Meetings

Section 1. There shall be at least one meeting each year in order to elect the chairman and vice-chairman and to conduct such business as may be deemed necessary by the advisory board.

Section 2. Quorum - Three members shall constitute a quorum for transacting business.

Section 3. Order of Business - The order of business shall be as follows:

(a) Calling roll and recording names of members present
(b) Approval of minutes of preceding regular and special meetings
(c) Adoption of Agenda
(d) Public Comment Period
(e) Report of Officers
(f) Old Business
(g) New Business

The order of business may be changed at any meeting by a majority vote.

Article IV - Amendments

Amendments to these bylaws may be proposed by presenting the amendments in writing to all advisory board members prior to any scheduled advisory board meeting. If the proposed amendment receives a majority vote of the members present at that advisory board meeting, it shall be represented as a recommendation for consideration to the Board of Medicine at its next regular meeting.

Advisory Board on:

Behavioral Analysts			**10:00 a.m.**
Mon –February 2	May 11	September 28	
Genetic Counseling			**1:00 p.m.**
Mon –February 2	May 11	September 28	
Occupational Therapy			**10:00 a.m.**
Tues – February 3	May 12	September 29	
Respiratory Care			**1:00 p.m.**
Tues - February 3	May 12	September 29	
Acupuncture			**10:00 a.m.**
Wed - February 4	May 13	September 30	
Radiological Technology			**1:00 p.m.**
Wed - February 4	May 13	September 30	
Athletic Training			**10:00 a.m.**
Thurs - February 5	May 14	October 1	
Physician Assistants			**1:00 p.m.**
Thurs - February 5	May 14	October 1	
Midwifery			**10:00 a.m.**
Fri - February 6	May 15	October 2	
Polysomnographic Technology			**2:30 p.m.**
Fri - February 6	May 15	October 2	
Surgical Assisting			**10:00 a.m.**
Mon - February 7	May 18	October 5	

Orientation to the Board of Medicine & Your Advisory Board

October 2025

Executive Branch

- Governor Glenn Youngkin
- Secretary of Health and Human Resources – Janet Kelly
- DHP Director – Arne Owens
- Board of Medicine President – Peter Apel, MD
- Board members cannot speak for the Board or anyone in the Executive Branch.

Department of Health Professions

- Umbrella Agency for 13 Health Regulatory Boards
- Director Owens appointed by the Governor
- Administration, Communications, Finance, Enforcement, Administrative Proceedings, Prescription Monitoring, Health Practitioners' Monitoring, Healthcare Workforce Data Center, IT
- Medicine joined the Department in 1977

Today's Board of Medicine

18 members appointed by the Governor

1 MD from each Congressional District

1 DO

1 DPM

1 DC

4 citizen members

Today's Board

- Pure Board of Medicine – only licenses MD's
- Composite Board – licenses other professions as well
- Doctors of Medicine, Osteopathy, Podiatry & Chiropractic
- Physician Assistants, Acupuncturists, Athletic Trainers, Licensed Midwives, Occupational Therapists, Occupational Therapy Assistants, Radiologic Technologists, Radiologic Technologists-Limited, Radiologist Assistants, Respiratory Therapists, Polysomnographic Technologists, Behavior Analysts, Assistant Behavior Analysts, Genetic Counselors, Licensed Surgical Assistants, Certified Surgical Technologists, Anesthesiologist Assistants, Advanced Practice Registered Nurses & Licensed Certified Midwives

Today's Advisory Boards

Today's Advisory Boards

- 11 Advisory Boards
- Similar structure & function
- 5 members
    - 3 of the profession
    - 1 physician
    - 1 citizen member

Today's Advisory Boards

Today's Advisory Boards (cont.)

- Chair & Vice-Chair
- Meet at least once a year
- May attend 1 meeting a year electronically for good cause
- Advise the Board of Medicine on:
    - Licensing
    - Discipline
    - Regulations

THE BOARD'S MISSION

- The protection of the public by
- Licensing only qualified applicants
- Disciplining for unprofessional conduct
- Promulgating regulations to implement law

THE BOARD'S DISCIPLINARY PROCESS

Begins with a complaint or a report

Investigated by the Enforcement Division of DHP

Completed investigation sent to the Board

Probable Cause Review

PROBABLE CAUSE REVIEW

Board staff and Board members

Review to understand what happened in the case

Apply the law and the regulations to determine if a violation has occurred

Two Board members must agree on violations of standard of care for physicians

If specialized review is required, retain an expert reviewer for the standard of care

OPTIONS FOR RESOLVING THE MATTER

- 85% are closed administratively
- Other options
  - Advisory letters
  - Confidential Consent Agreements
  - Pre-Hearing Consent Orders
  - Informal Conferences
  - Formal Hearings
  - Summary Suspensions

DISCIPLINARY PROCEEDINGS

- Informal Conference
- Formal Hearing
- Summary Suspension

- When a proceeding is being held for a profession not represented on the Board of Medicine, there will be a member of the appropriate Advisory Board

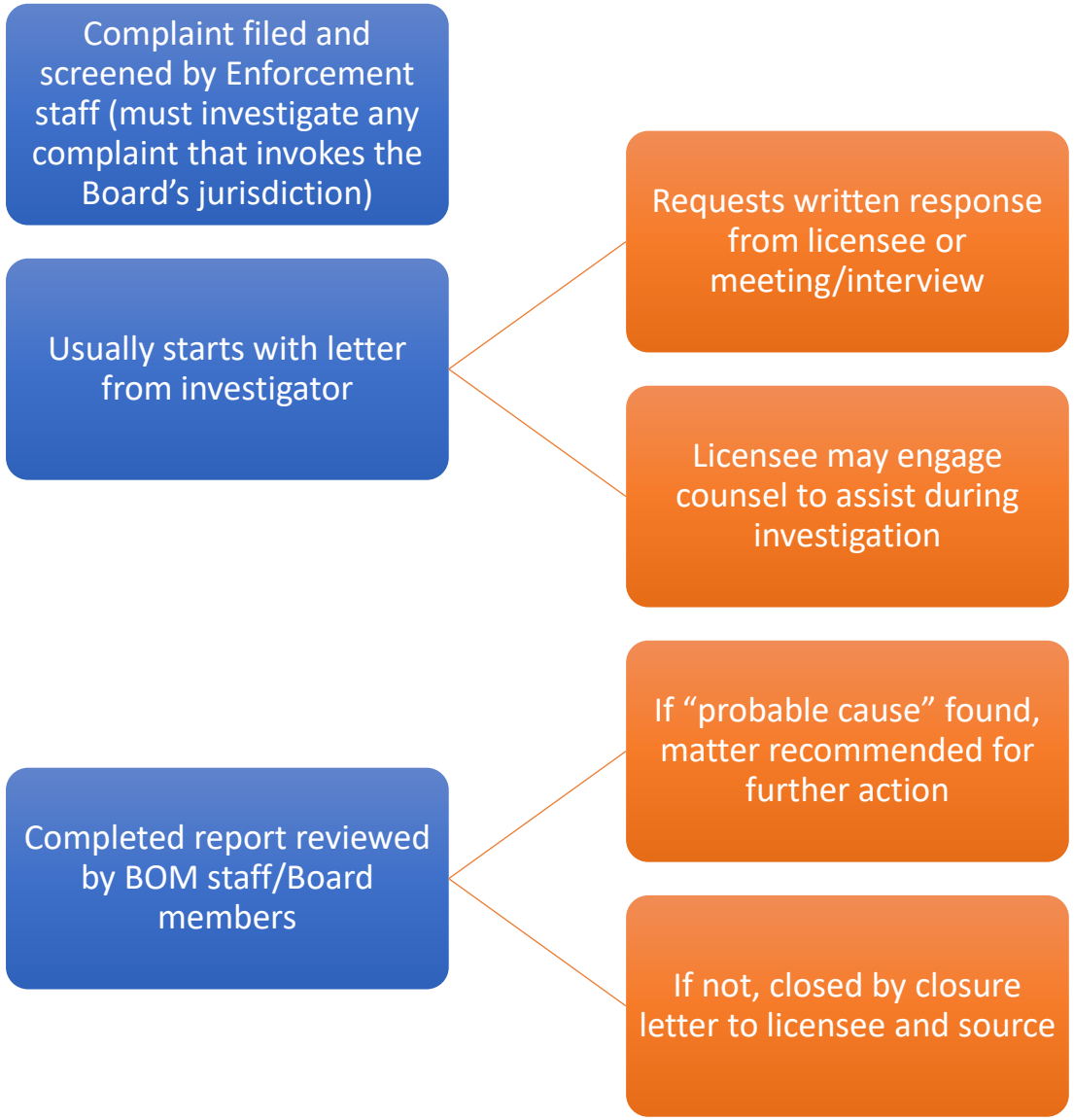
PRINCIPLES OF THE DISCIPLINARY PROCESS

- Confidentiality
- Protection of the public
- Due process for respondents
- Proportionate sanctions
- Strive to be fair to all parties

INVESTIGATIONS

- **Who Complains?**
  - The Public (e.g., patients, family members, anonymous, media)
  - Other licensees of the BOM (mandated reporters)
  - Employers
  - Healthcare institutions (e.g., hospital CEO = mandated reporter)
  - Medical malpractice insurance carriers

COMPLAINT PROCESS



ADVICE FOR RESPONDING TO COMPLAINTS

- Take the complaint seriously (even if you believe it to be frivolous)
- Fully cooperate w/the investigator (DHP/BOM is “health oversight agency” under HIPAA)
- You are responsible for ensuring a response and complete records are provided (not your office manager)
- Do NOT contact Board members to discuss your complaint
- Consult with an attorney (familiar with DHP/regulatory boards)

LAWS AND REGULATIONS TO KNOW

- Fraud or Dishonesty
- Substance abuse
- Negligence in practice – standard of care
- Mental or Physical Incapacity
- Aiding and Abetting Unlicensed Practice
- Ethical lapses – standards of professional conduct

LAWS AND REGULATIONS TO KNOW

- Felony convictions or misdemeanors of moral turpitude
- Any provision of the drug law
- Failure to timely sign a death certificate
- Opioid prescriptions submitted electronically
- Surprise billing
- Treating self and family
- Patient records

LAWS AND REGULATIONS TO KNOW

- Confidentiality
- Communication/Termination
- Subordinates and Disruptive Behavior
- Sexual Boundary Violations
- Reporting requirements
- Continuing Medical Education

LAWS AND REGULATIONS TO KNOW

- Office-Based Anesthesia
- Prescription Monitoring Program
- Health Practitioners' Monitoring Program
- Renew License every 2 years

Hearing Protocol

Virginia Board of Medicine

June 14, 2018

Panel Members at Hearings

- Purpose of disciplinary proceedings is to protect the public by regulating professional conduct and provide fair and impartial consideration of the matter before the Board
- Panel members should avoid actual conflicts and the appearance of impropriety—if you receive case material and think you have a conflict, call staff! (procedure for potential conflict at hearing)
- Strive to be fair and impartial—goal is fairness to *respondent* and *also to the public*

Open vs. Closed Sessions

- Board business takes place in open, public forums to foster public accessibility and confidence of the public in the integrity of the regulatory process
- Any meeting of three or more members of the Board at which the members discuss *anything* related to the Board should be considered an open meeting for FOIA purposes (includes group emails).
- Closed meetings: for the Board to deliberate or receive legal advice
- Disciplinary proceedings may also close to deliberate and to protect health information of a respondent

Formal Hearings – You are on the record!

A court reporter attends formal hearings

Your words are recorded

The transcript will be reviewed by the Circuit Court if the respondent appeals for evidence of violations of a respondent's constitutional rights, failure of the Board to observe required procedure, indications that the Board may not have had substantial evidence (Erin ex.)

Hearings (IFC or formal)

- Cannot deviate earlier from noticed start time
- Choose your questions carefully (avoid answering questions from R)
- Hearings can be emotional; avoid engaging on emotional level (try not to be swayed by tears or manipulative behavior)
- Avoid texting board members (e.g., Loudoun meeting; FOIA Council)
- Do not state you have more knowledge than others-- or less-- based on specialty or non-MD status. All board members are experts in the matters before the board. This has been clearly stated by CAV.
- Do not give practice advice—do not want to bind the Board (especially if you are wrong)

Hearings (IFC or formal)

- Questions should relate to facts of the case and the allegations contained in the Statement of Particulars
- Do not sermonize, do not inject personal, religious, or political beliefs
- Do not express your personal opinion (i.e.," Well, I think your record-keeping was fine.")
- Do not argue with other panel members during hearings, or make statements disparaging other members' statements or questions
- Do not argue with witnesses, respondents, or counsel for respondents – we understand it can be hard with some!

Hearings (IFC or formal)

PANEL CHAIR WILL RULE ON ISSUES RELATED TO RELEVANCE OR THE ADMISSION OF EVIDENCE (WITH BOARD COUNSEL GUIDANCE)

AVOID “ATTORNEY TESTIMONY”, THIS IS YOUR OPPORTUNITY TO HEAR FROM THE LICENSEE

DELIBERATION HAPPENS IN CLOSED SESSION

DO NOT ENGAGE, INFORM, INSTRUCT ONCE PROCEEDINGS ARE OVER (STAFF WILL HANDLE; E.G. FRIENDLY ATTORNEY AND PATIENT FAMILY IN AUDIENCE)

Procedural mysteries

Board counsel records and enters evidence

Evidence must be formally admitted even though Board members received evidence prior to hearing

Must initial and date evidence to provide record on appeal.

Procedural mysteries, cont.

Some cases appear old when they reach the formal hearing stage

Can be for any number of reasons (continuances prior to IFC or formal, length of investigation, etc.)

Staff and counsel will answer procedural questions in closed session – NOT open session!

What happens in closed session?

Decision on sanction

Craft order, including findings of fact (refer to helpful notes you made during proceeding)

Review conclusions of law alleged; determine what stays

What are grounds for an appeal?

- (1) Violation of a Constitutional right, power, or privilege;
- (2) Failure to comply with statutory authority;
- (3) Failure to observe required procedure where the failure did not result in harmless error; and
- (4) Substantial evidence did not support Board decision.

(Va. Code § 2.2-4027.)

Helping to ensure that the Board's decisions do not get overturned

- Follow staff guidelines, procedures, and scripts for hearings.
- Ask legal questions in *closed session*. Do not state specific legal questions for board counsel on the record. This raises privilege issues.
- Only the chair of a panel may rule on motions made at a hearing.
- Avoid stating opinions on the record (i.e., "That does not sound like a standard of care issue to me.")
- Work with your fellow panel members, board counsel, and staff to craft well thought out orders.
- Be aware that any respondent can appeal.

Thank you

The travel regulations require that "travelers must submit the Travel Expense Reimbursement Voucher within 30 days after completion of their trip". (CAPP Topic 20335, State Travel Regulations, p.7). Vouchers submitted after the 30-day deadline cannot be approved.

In order for the agency to be in compliance with the state travel regulations, please submit your request for today's meeting on or before

November 23, 2025