Meeting of the Virginia Board of Medicine

October 30, 2025
8:30 a.m.

Virginia Department of Health Professions

Board of Medicine
Thursday, October 30, 2025 @ 8:30 a.m.
Perimeter Center
9960 Mayland Drive, Suite 201
Board Room 2
Henrico, VA 23233

Call to Order

Emergency Egress Procedures i

Roll Call

Consideration of a Possible Administrative Proceeding under §54.1-2408.1

Approval of Minutes from June 26, 2025 1

Adoption of Agenda

Public Comment on Agenda Items 10

DHP Director's Report 37

Reports of Officers and Executive Director 38

- President ..... -----
- Vice-President ..... -----
- Secretary-Treasurer ..... -----
- Executive Director 39
  - Cash Balance ..... --
  - Summer Meetings ..... --

Committee and Advisory Board Reports 40

- List of Committee Appointments 41
- Executive Committee – August 1, 2025 42
- Legislative Committee – September 5, 2025 48
- Advisory on Acupuncture – October 22, 2025 53
- Advisory Board on Radiological Technology – October 22, 2025 57
- Advisory Board on Athletic Training – October 23, 2025 59
- Advisory Board on Physician Assistants – October 23, 2025 63
- Boards of Medicine and Nursing Workgroup - Psychotropic Medications to Children and Adolescents 67
- Revision of the Midwifery Formulary 71

Other Reports **80**

- Board Counsel ..... -----
- Podiatry Report ..... -----
- Chiropractic Report ..... -----
- Committee of the Joint Boards of Nursing and Medicine 81

New Business:

1. Regulatory chart..... 83
2. Readoption of electronic participation policy 88
3. Consideration of petition for rulemaking regarding chiropractic continuing education ...91
4. Consideration of specific requirement for nutrition continuing education for the 2028 – 2029 renewal cycle 131
5. Adoption of the revised midwifery formulary..... 133
6. Revision of Guidance Document 90-56 consistent with statutory changes 140
7. Consideration of biennial CE topic 2026-2027 143
8. Adoption of proposed regulatory language regarding provisional and restricted licensure for foreign physicians 149
9. Licensing Report..... 193
10. Discipline Report – Ms. Deschenes 194
11. Announcements/Reminders..... 208
12. 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

Board Room 2

Exit the room using one of the doors at the back of the room. (Point) Upon exiting the room, turn **RIGHT.** 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.

You may also exit the room using the side door (**Point**), turn **Right** out the door and make an immediate **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.

Agenda Item: Approval of Minutes of the June 26, 2025

Staff Note: Draft minutes that have been posted on Regulatory Townhall and the Board's website are presented. Review and revise if necessary.

Action: Review and approve with or without corrections.

VIRGINIA BOARD OF MEDICINE
FULL BOARD MINUTES

June 26, 2025 | Department of Health Professions | Henrico, VA 23233

CALL TO ORDER: Dr. Clements called the meeting to order at 8:35 a.m.

ROLL CALL: Ms. Brown called the roll; a quorum was established.

MEMBERS PRESENT:
John R. Clements, DPM – President & Chair
Peter J. Apel, MD – Vice-President
Leroy Brown Vaughan, Jr., MD – Secretary-Treasurer
Kamlesh Dave, MD
Hazem Elariny, MD
Deborah DeMoss Fonseca
William Hutchens, MD
Oliver Kim, JD, LLM
Elliott Lucas, MD
L. Blanton Marchese
Patrick McManus, MD
Michele Nedelka, MD
Pradeep Pradhan, MD
Jennifer Rathmann, DC
Mark Simcox, MD

MEMBERS ABSENT:
Krishna P. Madiraju, MD
Ken McDowell, DO

COUNSEL PRESENT: M. Brent Saunders, JD – Senior Assistant Attorney General

STAFF PRESENT:
William L. Harp, MD - Executive Director
Jennifer Deschenes, JD - Deputy Exec. Director for Discipline
Michael Sobowale, LLM - Deputy Exec. Director for Licensure
Barbara Matusiak, MD - Medical Review Coordinator
Erin Barrett, JD - Director of DHP Legislative and Regulatory Affairs
Matt Novak - DHP Policy and Economic Analyst
Deirdre Brown - Executive Assistant
Shelby Smith – Licensing Specialist

OTHERS PRESENT:
Brandi Kilmer – Refugee Physician Advocacy Coalition
Lily Cameron, MD - Refugee Physician Advocacy Coalition
Scott Castro – Medical Society of Virginia
Tamika Hines – Discipline and Compliance Case Manager
Kathleen LaMotte – Board Administrator

Roslyn Nickens – Licensing Supervisor
Sonya Armstead – Licensing Specialist
Erin Pollard – Licensing Specialist
Denise Christian – Licensing Specialist

EMERGENCY EGRESS INSTRUCTIONS

Dr. Clements provided the emergency egress instructions for Board Room 2.

SUMMARY SUSPENSION PRESENTATION

The Board received information from David Robinson, Assistant Attorney General, regarding Dr. Schuyler Matthew Whelan, License No. 0104557902, to determine whether his ability to practice chiropractic constituted a substantial danger to public health and safety. Mr. Robinson provided details of the case for the Board's consideration.

On a motion by Dr. Apel, and duly seconded by Dr. Nedelka, the Board determined that Dr. Schuyler Matthew Whelan's ability to practice constituted a substantial danger to public health and safety and voted to summarily suspend his license simultaneously with the institution of proceedings for a formal administrative hearing pursuant to Section 54.1-2408.1 of the Code of Virginia. The vote was unanimous, 15-0.

APPROVAL OF MINUTES OF OCTOBER 25, 2024

Mr. Kim moved to approve the minutes of October 25, 2024. The motion was properly seconded by Dr. Elariny and carried unanimously.

ADOPTION OF AGENDA

Mr. Marchese moved to approve the agenda as presented. The motion was properly seconded by Mr. Kim and carried unanimously.

PUBLIC COMMENT

Brandi Kilmer, representing the Refugee Physician Advocacy Coalition, expressed her appreciation to the Board for its work with HB995. She stated that the Refugee Physician Advocacy Coalition currently has 150 registered international physicians that it will be assisting in the licensing process once the provisional license becomes available.

HEALTHCARE WORKFORCE DATA CENTER PRESENTATION ON THE 2024 PHYSICIAN SURVEY

Yetty Shobo, PhD, Director of the Healthcare Workforce Data Center, provided the Board with an update on the physician workforce with data from the 2024 Physician Survey.

The presentation was for informational purposes only.

DHP DIRECTOR'S REPORT

On behalf of Arne Owens, Dr. Harp stated that DHP will be providing a day of orientation for all Board and Advisory Board members on October 3, 2025. Both veteran and new Board members are welcome to attend.

REPORTS OF OFFICERS AND EXECUTIVE DIRECTOR

PRESIDENT

Dr. Clements thanked the Board for allowing him to serve as the Board's President for the past two years.

No further report.

VICE-PRESIDENT

No report.

SECRETARY-TREASURER

No report.

EXECUTIVE DIRECTOR

Budget Numbers as of May 31,2025

Dr. Harp shared an update on the budget as of May 31, 2025, covering the first 11 months of FY2025. With 1 month remaining in the Board's fiscal year, Dr. Harp said that the Board is ahead on projected revenue with only 7% of licensing fees yet to be received. On the expenditures side, the Board has 10% of its funds left with 1 month to go, again a positive.

2026 Budget Derivation by July 1, 2025

Dr. Harp stated that the deputies and he will be finishing up the proposed budget for FY2026 to be submitted by July 1, 2025.

Licensing Section Reorganization - June 1, 2025

Dr. Harp shared that the licensing section was reorganized on June 1, 2025. The Board currently has over 96,000 licensees and averages over 11,000 new applications each year. To address

the volume and to meet expectations of shorter licensing times, Mr. Sobowale will cover the allied professions, and Ms. Opher will cover MDs, DOs, DPMs, DC's, Interns and Residents.

Board Administrator

Dr. Harp said that the Board has added a new position, a Board Administrator, who will work across all three sections of the Board: licensing, discipline and administration. He introduced Kathleen LaMotte who provided a brief bio for the Board members.

New PGY-4 Begins Rotation on July 3, 2025

Dr. Harp stated that through the years the Board of Medicine has supported VCU Psychiatry with an elective option for 4th year residents. The elective allows residents to learn more about the Board of Medicine and other divisions within DHP. He thanked everyone for mentoring them and noted that a resident will be starting next week.

Designation of Continuing Education for 2026-2027

Dr. Harp said that the Board is authorized to require up to 2 hours of Type 1 continuing education on a specific topic each biennium. It may also opt not to require a specific activity beyond what is required of a licensee's profession. Dr. Harp stated that licensees renewing in 2024-2025 have been required to complete a 1-hour CE activity on Human Trafficking. If the Board decides to select a new topic for the 2026-2027 renewal cycle, it will need to notify licensees of the requirement before January 1, 2026.

Upcoming Meetings

- July 9, 2025 – Psychologist Prescribing Work Group
  - Dr. Madiraju and Dr. Lucas will serve on this work group.
- August 12, 2025 – Therapeutic Interchange Work Group
  - Dr. Hutchens will serve on this work group.
- August 20, 2025 – Budget Item 285 – Best Practices for Psychotropic Medications in Children and Adolescents
  - Dr. Harp will serve in this effort.

COMMITTEE AND ADVISORY BOARD REPORTS

Ms. DeMoss Fonseca moved to accept all Committee and Advisory Board meeting minutes since January 10, 2025 en bloc. The motion was properly seconded by Dr. Lucas and carried unanimously.

OTHER REPORTS

Board Counsel – Brent Saunders, JD – Senior Assistant Attorney General

Mr. Saunders provided an update on 9 ongoing legal cases.

Additionally, Mr. Saunders introduced a new member of his team, Ms. Sara Blose.

Podiatry Report

No report.

Chiropractic Report

No report.

Committee of the Joint Boards of Nursing and Medicine

No report.

NEW BUSINESS

1. Current Regulatory Actions

   Mr. Novak presented the chart of regulatory actions as of June 16, 2025, stating that there is currently only one regulatory action in the Secretary's Office.

   This report was for informational purposes only and did not require any action.

2. Report from the 2025 Session of the General Assembly

   Ms. Barrett stated that there was no legislative report at this time. The Agency's legislative proposals for the 2026 Session are being prepared and will be filed in August. Ms. Barrett will provide an update at the October Full Board meeting.

3. Consideration of Exempt Changes to Licensed Certified Midwives – Practice Agreements

   Mr. Novak reviewed the proposed regulatory changes for Licensed Certified Midwives Practice Agreements. He stated that the Board of Nursing approved these changes at their May business meeting.

   MOTION: Mr. Marchese moved to amend 18VAC90-30 and VAC90-70 by exempt action. Dr. Nedelka seconded, and the motion passed unanimously.

4. Recommendation of Fast-Tracking Regulatory Changes – Occupational Therapy

   Ms. Barrett reviewed the recommended changes for reactivation and reinstatement of Occupational Therapists and Occupational Therapists Assistants. After review of the public comment, she added that these changes were approved by the Advisory Board of

Occupational Therapy. It also voted to recommend these changes to the Board as a fast-track action.

A Board member requested that "one of the following:" be added after "shall provide" in 18VAC85-80-80 subsection B.

MOTION: Mr. Marchese moved that the changes be fast-tracked as amended. Dr. Clements seconded, and the motion carried unanimously.

5. Repeal of Guidance Document 76-21.130

Mr. Novak pointed out that the Chapter 20 periodic review action became effective on February 27, 2025 which included the elimination of Mixing, Diluting, or Reconstituting regulations. He said that since MDR is no longer in Chapter 20, Guidance Document 76-21.1.30 is unnecessary.

MOTION: Dr. Clements moved to repeal Guidance Document 76-21.1.30. Mr. Marchese seconded, and the motion carried unanimously.

6. Consideration of Petition for Rulemaking – Athletic Training – Dry Needling

Ms. Barrett stated that there were 764 public comments on Town Hall on the petition to add dry needling to the current scope of practice for Athletic Trainers. 500 of the public comments were in favor of the change, and 250 were opposed.

MOTION: Dr. Apel moved to deny the petition for rulemaking since dry needling is not in the scope of practice for Athletic Trainers. Dr. Nedelka seconded, and the motion carried unanimously.

7. Licensing Report

Mr. Sobowale stated that the number of licensees is currently 96,724 plus an additional 23,336 APRN's jointly licensed with the Board of Nursing. He said the Board has received 11,359 applications so far this year; 10,314 have been issued. This gives the Board a 95% clearance rate. The average time to licensure is 35 days across all 20 professions.

Mr. Sobowale introduced the following new licensing specialists to the Board:

- Sonya Armstead
- Erin Pollard
- Denise Christian

8. Discipline Report

Ms. Deschenes provided a brief report on the status of open cases as of June 6, 2025, stating that there are a total of 805 cases across all stages. During the 3rd Quarter of FY2025, the Board received 502 cases and closed 516.

9. Report of the Nominating Committee

Dr. Rathmann reported that the Nominating Committee met this morning at 7:47 a.m. and developed the following slate of officers for the Board's consideration:

- Dr. Peter Apel – President
- Dr. Bo Vaughan – Vice President
- Dr. Ken McDowell – Secretary-Treasurer

MOTION: Ms. DeMoss Fonseca moved to approve the slate provided by the Nominating Committee. Dr. Lucas seconded, and the motion passed unanimously.

10. 2026 Meeting Calendar

Dr. Clements asked Board members who have conflicts with the listed dates to please notify staff.

MOTION: Dr. Apel moved to adopt the 2026 Meeting Calendar as presented. Mr. Marchese seconded, and the motion carried unanimously.

11. Recognition of Board Members with Expiring Terms

Dr. Clements announced that the following Board member terms would expire on June 30, 2025:

- Dr. Rathmann – completing 1st term
- Mr. Marchese – completing 1st term
- Dr. Pradhan – completing 1st term
- Mr. Kim – completing 1st term

He thanked them all for their dedication to the Board and the public. Each member received a gift of appreciation.

Dr. Pradhan stated that he has been practicing for over 30 years and that the Board has been a great learning experience. He thanked the Board for allowing him to serve and Dr. Harp for his leadership.

12. Consideration of Consent Order

Ms. Deschenes presented a Consent Order for Richard Kenneth Gaines, MD, an applicant for reinstatement.

MOTION: Mr. Marchese moved to accept the Consent Order. The motion was properly seconded by Dr. Clements and passed with a vote of 15-0.

ANNOUNCEMENTS

Dr. Clements announced that the next Full Board meeting will be held October 30, 2025, at 8:30 a.m. He then passed the gavel to Dr. Apel.

ADJOURNMENT

With no additional business, Dr. Apel adjourned the meeting at 10:35 a.m.

_____
William L. Harp, MD
Executive Director

Agenda Item: Public Comment on Agenda Items

From: Tahera Ahmadi <tahera.raha@gmail.com>
Sent: Sunday, October 19, 2025 7:05 PM
To: Harp, William L. (DHP) <William.Harp@dhp.virginia.gov>
Cc: Brandi Kilmer <brandikilmer@tsosrefugees.org>
Subject: Request for Consideration: Provisional License Pathway for Refugee Physicians in Virginia

Dear Members of the Virginia Board of Medicine,

My name is Dr. Tehera Ahmadhi, and I am a physician trained in Afghanistan. I came to the United States as a refugee in 2021 after the fall of my country. Today, I live in Virginia, which has become my home. I am writing to you with deep respect and hope that the new provisional license pathway will allow me, and others like me, to serve the people of this state as physicians.

I completed my medical degree in Afghanistan—a six-year program plus a full year of clinical rotations across all major specialties. I then worked in outpatient clinics where I cared for patients from both the city and surrounding rural areas. Many came to us in advanced stages of illness, and we often had to rely on clinical judgment without access to modern labs or imaging. This experience made me resourceful, decisive, and patient-centered. Here in the U.S., we have access to more advanced technology, which would serve to only amplify my experience, commitment, and care.

After coming to Virginia, I started preparing for U.S. licensing exams. I passed my USMLE Step 1 and Step 2, obtained my ECFMG certification, and am now preparing for Step 3. I have also shadowed physicians here and learned how the U.S. system works. I am confident that with supervised practice, I can adapt quickly and safely to medical practice in Virginia.

But as a refugee, the journey has not been easy. When I first arrived, I lived for months in military camps in Qatar, Germany, and Virginia. I had left Afghanistan with nothing but a few clothes and my computer. I lost my home, my belongings, and my community. In Virginia, I had no car, no resettlement support, and no financial stability. I suffered from PTSD and physical pain after escaping violence. It took time just to access healthcare, insurance, and basic necessities.

Even through all of this, I never gave up on my dream to practice medicine. I studied every day. I tutored and mentored other students to help pay my living expenses. I borrowed money from generous friends to help pay for my exams. I made personal sacrifices—I even postponed starting a family so that I could give my full energy to this goal. I was offered jobs outside medicine, including as a case manager and a program coordinator, but I turned them down because I wanted to stay focused on becoming a doctor again and devote all of my energy to studying so that I can be the best possible doctor.

That is why I am deeply concerned about the proposed rule limiting eligibility for the provisional license to those who are within four years of active practice. I last practiced in July 2021—just over four years ago now. If this rule remains, it would exclude me and many other refugee physicians

who are qualified, motivated, and ready to serve. This time gap beyond four years does not reflect a loss of skill or commitment; it reflects the reality of displacement. Refugees like me spend those years rebuilding our lives, navigating immigration, working toward exams, and adapting to a new country. We are resilient, we are tenacious, we are qualified, and we have persevered through extraordinary barriers just to stand where we are today. Not only do we bring our medical skills and experiences to the US system, but we also bring these skills which can not be taught.

I respectfully ask the Board to consider expanding or removing this four-year limit. The intent of the law was to help fill physician shortages and open doors for internationally trained doctors to contribute. A rigid time limit would close that door for the very people this law was meant to include. Competence can be ensured through supervised practice, as the legislation already provides. What we need is the opportunity to prove ourselves.

Today, as a permanent resident, I see the people of Virginia as my own people. I love this community and I want to give back—to be a relief to others, to ease their pain, and to serve with compassion. I have rebuilt my life here, and all I ask is the chance to serve the patients who need care. I want to practice medicine in Virginia because there is a real and urgent need for doctors here, especially in underserved areas. When I first arrived, I saw how difficult it was for many people to get timely care. When I finally got health insurance and went to a primary care doctor, she barely had time to speak with me before rushing to her next patient. There simply are not enough doctors, especially family medicine and primary care physicians. I know that so many people in Virginia are waiting for care—and I want to help meet that need.

Medicine has never been just a profession for me; it is who I am. Whether in Afghanistan or here in the U.S., I see every patient simply as a human being. Each one deserves care, compassion, and attention. When I know that I have the skills to help, and at the same time I see the U.S. healthcare system struggling with physician shortages, I feel a deep responsibility to serve. I cannot ignore that responsibility.

Thank you for your time and for considering this request. Your decision has the power to transform lives—both the lives of refugee doctors who wish to give back and the lives of the patients across Virginia who need care.

With respect and gratitude,
Dr. Tahera Ahmadi
Internationally Trained Physician from Afghanistan
Resident of Virginia

From: Sarah Kureshi <sk795@georgetown.edu>
Sent: Monday, October 20, 2025 11:02 PM
To: Harp, William L. (DHP) <William.Harp@dhp.virginia.gov>
Cc: Barrett, Erin (DHP) <erin.barrett@dhp.virginia.gov>; Brandi Kilmer <brandikilmer@tsosrefugees.org>
Subject: Public Comment on Proposed Provisional License Eligibility Criteria

Dear Dr. Harp and Members of the Board of Medicine,

I am writing as a Family Medicine physician, Professor, and Co-Founder of the Refugee Physicians Advocacy Coalition. I have extensive experience in medical education, having worked with medical students, residents, and fellows for many years and have also mentored numerous internationally trained physicians (ITPs). I urge you to oppose any proposed rule that would limit eligibility for Virginia's two-year Provisional License for Internationally Trained Physicians to only those who have been out of medical practice for four years or less.

Throughout my career, from residency through my current role, I have had the privilege of working alongside internationally trained physicians in both educational and clinical settings. The ITPs I have worked with are exceptional clinicians who consistently provide the highest quality of care. They embody a growth mindset and a genuine commitment to lifelong learning. Having practiced in other countries before coming to the United States, they bring diverse clinical perspectives and a deep appreciation for patient-centered, culturally responsive care. Most of the ITPs I have encountered are multilingual, which has allowed them to connect with patients in their native languages and provide care that is both more effective and more compassionate.

Their passion for medicine is unmistakable. After years of being unable to practice, they approach every opportunity to serve patients with gratitude, humility, and dedication. In my experience, they hold themselves to the highest professional standards and are, anecdotally, less prone to burnout because of their enduring sense of purpose. These are precisely the kinds of physicians our communities need, especially in areas where access to care remains limited.

As an educator, I can say with confidence that competence is best evaluated through structured, competency-based assessments and direct supervision, not through arbitrary time-based restrictions. There is no evidence that the number of years out of active practice predicts clinical readiness or quality of care. What ensures safety and excellence is robust oversight, certification, and ongoing evaluation.

The Unlocking.Virginia's.Physician.Workforce policy brief that my colleagues and I have prepared, which I have attached for your review, outlines this evidence clearly. It shows that rigid temporal thresholds are not supported by research and that supervised, competency-based pathways are both safer and more equitable. If a time restriction is

required, then adopting a flexible standard, such as allowing physicians who have practiced within the past 60 months of the last 12 years (like Minnesota has done), would maintain quality while meaningfully expanding access to care in underserved areas.

In addition, data indicate that limiting eligibility based on years since graduation or practice disproportionately affects women and individuals displaced by war or political instability, groups who already face structural barriers. This rule would therefore inadvertently exclude some of the most resilient and dedicated physicians in our state's workforce.

Thank you for your leadership and your commitment to ensuring both patient safety and equitable access to care across Virginia. I respectfully urge the Board to reject the proposed four-year limit and instead adopt an evidence-based, competency-driven approach that allows qualified international physicians to serve our communities under appropriate supervision.

Respectfully,

Sarah Kureshi, MD, MPH

Professor & Vice Chair for Education, Department of Family Medicine

Associate Medical Director of Health Equity, Medstar Health

Director, Patients, Populations & Policy Course

Co-Founder, Refugee Physicians Advocacy Coalition

Co-Chair, Center for Health Equity Advisory Committee

Georgetown University School of Medicine

Medstar Medical Group Family Medicine at Fort Lincoln

301-699-7700 (clinical office)

202-687-7857 (academic office)

sk795@georgetown.edu

Sarah Kureshi - Georgetown360 Profile

Pronouns: she / her

Schedule an appointment: calendly.com/sk795

Unlocking Virginia's Physician Workforce:

How International Medical Graduates and Refugee Physicians Offer Benefits to the Health Care System

Shikha Chandarana, PhD, MS[I]; Anna Alikhani, PhD, MPH, MSW[I]; Brandi Kilmer, MS Candidate[II]; Sarah Kureshi, MD, MPH[I,II]

I. Department of Family Medicine, Georgetown University School of Medicine
II. Refugee Physicians Advocacy (RPA) Coalition

Executive Summary

The Virginia Board of Medicine is implementing 2024 HB 995 via rulemaking to create provisional and restricted licenses for internationally trained physicians.[1,2] During public input and national policy discussions, some stakeholders (e.g., ABMS) have urged guardrails such as "no more than two years out of practice."[3] However, practice gaps are common and structurally driven—not evidence of incompetence. The U.S. already faces a projected physician shortfall by 2036, and Virginia has substantial access gaps (≈3.8M residents in neighborhoods with inadequate primary-care access).[4,5] Competency-based, supervised assessment pathways—as contemplated by HB 995 and national guidance—are safer and more equitable than blanket gap limits.[1,6]

Introduction

There is currently a shortage of physicians,[4] which can impair health care delivery and worsen health inequity for a variety of patient populations. A recent Association of American Medical Colleges report estimated that by 2036, there will be a shortage of up to 86,000 physicians nationwide.[4]

Currently, one in four practicing physicians in the U.S. medical workforce is an IMG (24.7% in 2023).[7] IMGs include refugee physicians who have fled their home countries and immigrated to the U.S. These physicians are highly trained and often multilingual, enhancing linguistically and culturally responsive care capacity in clinical settings.[8,9] International medical graduates are more likely to fill low-preference training and practice positions that are traditionally harder to staff, providing care to historically underserved populations, and helping increase the geographic practice of general and specialist physicians.[8,10–12]

One way to close the gap is to facilitate ethical, competency-based integration of IMGs into U.S. systems. Systematic reviews on "skills fade" find wide variability by task and prior expertise and do not support a universal time-based cutoff.[13–15] Rigid temporal thresholds (like a 2-year limit) are not evidence-based predictors of clinical readiness and in fact exclude qualified International Medical Graduates (IMGs), refugee physicians, and caregivers returning from career interruptions, without improving patient safety.[16,17]

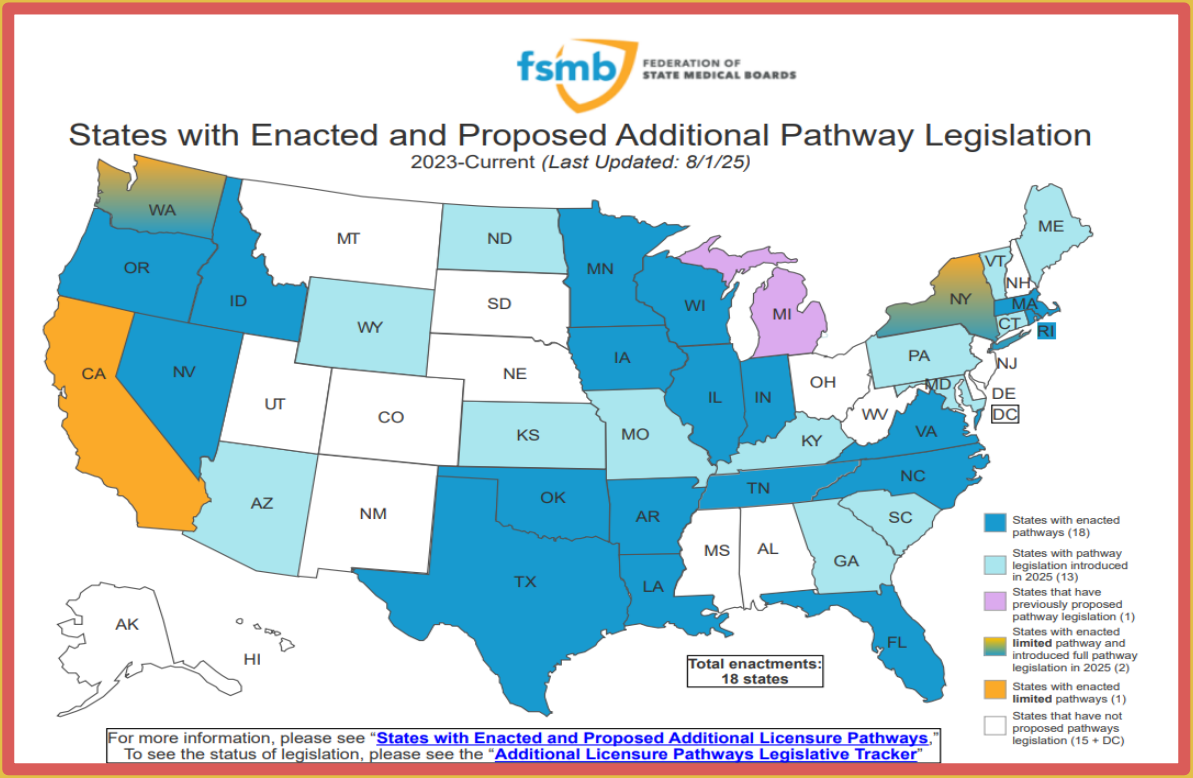
Virginia has a gap of nearly **800 physicians** and is projected to need over a **1,000 by 2035.**[9]

Around **44%** of Virginia neighborhoods lack adequate primary-care access, affecting **≈3.8 million residents.**[10]

Barriers to IMG Participation

There are several challenges that IMGs face when attempting to join the medical workforce. Evidence from recent reviews identified that IMGs face marginalization through structural exclusions, stereotypes and stigmatization.[16,17] In addition to the experiences of marginalization, challenges with complicated laws create unnecessary barriers to increasing medical access for all populations and decrease health equity. Visa and licensure rules can delay entry without clear safety benefit if not designed around supervised, competency-based assessment.

Virginia's primary-care access problem is geographically widespread; targeting supervised IMG pathways can help address shortages in high-need areas while maintaining safety through structured assessment. Rigid temporal thresholds (like a 2-year limit) are not supported by evidence; syntheses show **no** consensus on a universally "safe" gap length.[13–15] Competence depends on recentness, case mix, prior expertise, and targeted remediation, not an arbitrary calendar threshold, and is best assessed via supervised practice, direct observation, and outcomes review.[11]



Current Laws

Across the U.S., many states require 1-3 years of clinical training in residency or fellowship programs accredited by the Accreditation Council for Graduate Medical Education to obtain state medical licensure.[6,19] Since 2021, numerous states have enacted alternative licensure pathways for internationally trained physicians that do not require repeating full U.S. residency, typically with supervision and structured assessment.[6,20] In 2023, Tennessee passed a law that allows IMG licensed in an international country to obtain provisional licensure to practice without the completion of a U.S. based residency.[21] Florida's 2024 "Live Healthy" legislation likewise directs a new licensure path for certain foreign-trained physicians.[22] In 2024, Virginia House Bill 995 created a path for internationally trained doctors already in the U.S. to gain provisional licenses, work under supervision, and be assessed before being fully licensed.[1,2]

Recommendations:

- **Replace** strict temporal cutoffs with individualized, competency-based assessments
  - Why: Rigid time limits are not evidence-based predictors of clinical readiness and can unnecessarily exclude qualified IMGs, limiting workforce capacity and delaying patient care.
- **Adopt** a tiered, supervised provisional licensure pathway (enabled by HB 995)
  - Why: Clear competency-based supervision levels, approved settings, and progression milestones ensure patient safety while allowing IMGs to integrate efficiently into the workforce.
- **Standardize** re-entry assessment components
  - Why: Using simulation for key skills, targeted chart audits, and minimum case-exposure benchmarks focuses on actual competence rather than arbitrary calendar time, improving both safety and fairness.
- **Leverage** existing state models while preserving Virginia-specific safeguards
  - Why: Tennessee (2023) and Florida (2024) provide practical templates, but adding Virginia-specific supervision ratios, scope limits, and escalation criteria ensures local patient safety and regulatory alignment.
- **Align** the pathway with workforce planning
  - Why: Prioritizing specialties and areas with the greatest shortages (e.g., primary care, maternal health, behavioral health; rural/high-deprivation areas) directly addresses access gaps while maximizing impact of IMG integration.
- **Establish** equity and anti-bias guardrails
  - Why: Salary parity, anti-discrimination mechanisms, and protected onboarding time mitigate documented inequities affecting IMGs, supporting retention and fairness.
- **Collect** and publicly report core safety and quality metrics
  - Why: Tracking supervised encounters, remediation steps, patient-safety events, and competency milestones promotes transparency, continuous improvement, and accountability in provisional licensure.

Conclusion

Adopting a competency-based, supervised provisional licensure pathway, rather than blanket "time out of practice" cutoffs, will allow Virginia to safely expand physician capacity where need is the greatest, advance equity for internationally trained and refugee physicians, and maintain patient safety through structured assessment and oversight. Implementing HB 995 with clear guardrails, transparency, and placements in underserved high-need areas offers a practical, evidence-based route to close access gaps while maintaining professional standards. A hard "no more than two years out of practice" cutoff risks excluding qualified physicians during a crisis in the workforce.

References

1. Virginia Regulatory Town Hall. Licensure of foreign physicians through provisional and restricted licenses (Action page). 2025. Accessed August 25, 2025. https://townhall.virginia.gov/L/viewaction.cfm?actionid=6636
2. Virginia General Assembly. Medicine, Board of; Temporary Licensure of Physicians Licensed in a Foreign Country. Accessed August 25, 2025. https://legacylis.virginia.gov/cgi-bin/legp604.exe?241+sum+HB995
3. American Board of Medical Specialties. Licensing Pathways for Internationally Trained Physicians: National Standards for Specialty Medical Care (policy brief). 2025. https://www.abms.org/wp-content/uploads/2025/01/abms-policy-brief-licensing-pathways-internationally-trained-physicians-national-standards-specialty-medical-care20250214.pdf
4. Association of American Medical Colleges. New AAMC Report Shows Continuing Projected Physician Shortage. Accessed August 22, 2025. https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage
5. VCU News. Primary care shortage affects 44% of Virginia's neighborhoods and almost 3.8 million residents, new VCU study finds. Accessed August 25, 2025. https://news.vcu.edu/article/2025/07/primary-care-shortage-affects-44-of-virginias-neighbhorhoods-new-vcu-study-finds
6. Federation of State Medical Boards. States with Enacted and Proposed Additional Licensure Pathways (Key-Issue Chart; updated Aug 2025.
7. Association of American Medical Colleges. 2024 Key Findings and Definitions (Physician Workforce Data). "In 2023, 24.7% of active physicians were IMGs."
8. McElvaney OJ, McMahon GT. International Medical Graduates and the Physician Workforce. JAMA. 2024;332(6):490-496. doi:10.1001/jama.2024.7656
9. Pirzada A, Chaban Z, Rosenthal A. Afghan and Arab Refugee International Medical Graduate Brain Waste: A Scoping Review. Accessed August 25, 2025. https://www.mdpi.com/2076-0760/14/3/147
10. Hart LG, Skillman SM, Fordyce M, Thompson M, Hagopian A, Konrad TR. International medical graduate physicians in the United States: changes since 1981. Health Aff Proj Hope. 2007;26(4):1159-1169. doi:10.1377/hlthaff.26.4.1159
11. Morris MH, Barton M, Zane M, Hutson SP, Raman R, Heidel RE. A Nurse-Navigated, Postpartum Support Text Messaging Intervention: Satisfaction Among Primiparous Women. J Perinat Neonatal Nurs. 2021;35(4):330-339. doi:10.1097/JPN.0000000000000596
12. Refugee Physicians Advocacy Coalition. Their Story is Our Story. Accessed August 22, 2025. https://tsosrefugees.org/projects/refugee-physicians-advocacy-coalition
13. Oates J. Skills fade: a review of the evidence that clinical and professional skills fade during time out of practice. General Medical council.
14. Campbell DP, Duncan-Millar J, Torrens C, Pollock DA, Maxwell PM. Health and social care professionals return to practice.
15. Main PAE, Anderson S. Evidence for recency of practice standards for regulated health practitioners in Australia: a systematic review. Hum Resour Health. 2023;21(1):14. doi:10.1186/s12960-023-00794-9
16. Healey SJR, Fakes K, Nair BR. Inequitable treatment as perceived by international medical graduates (IMGs): a scoping review. BMJ Open. 2023;13(7):e071992. doi:10.1136/bmjopen-2023-071992
17. Nwankwo EP, Onyejesi DC, Onyia OE. A review of support for International Medical Graduates (IMGs): a scoping review. BMC Med Educ. 2025;25(1):924. doi:10.1186/s12909-025-07389-z
18. Waiver of the Exchange Visitor Two-Year Home-Country Physical Presence Requirement. Accessed August 25, 2025. https://travel.state.gov/content/travel/en/us-visas/study/exchange/waiver-of-the-exchange-visitor.html
19. USCIS. Memorandum: Determining H-1B Cap Exemptions under AC21 (AFM Ch. 31.3). Published online 2000. https://www.uscis.gov/sites/default/files/document/memos/ac21c060606.pdf USCIS
20. Asaad M, Erekat K, Rajesh A. An In-Depth Analysis of the State Laws That License International Medical Graduates Without American Residency Training. J Surg Res. 2025;306:524-532. doi:10.1016/j.jss.2024.12.029
21. Ramesh T, Horvitz-Lennon M, Yu H. Opening the Door Wider to International Medical Graduates — The Significance of a New Tennessee Law. N Engl J Med. 2023;389(21):1925-1928. doi:10.1056/NEJMp2310001
22. Forida Senate. Health Care ("Live Healthy" Initiative) — Bill Summary. Accessed August 25, 2025. https://www.flsenate.gov/Committees/billsummaries/2024/html/3515

Morton, Colanthia D. (DHP)

From: Brandi Kilmer <brandikilmer@tsosrefugees.org>
Sent: Monday, October 20, 2025 11:35 PM
To: Harp, William L. (DHP)
Cc: Barrett, Erin (DHP); Morton, Colanthia D. (DHP)
Subject: Public Comment on Proposed 4-year out of practice rule

Dear Dr. Harp and Members of the Board of Medicine,

The Refugee Physicians Advocacy (RPA) Coalition actively supported the passage of Virginia HB995, creating an alternative licensure pathway for Internationally Trained Physicians (ITPs). Since its passage, we have worked with ITPs—each with at least five years of prior medical practice—to help them qualify for Virginia's Provisional License.

As of today, approximately 45 ITPs in our network are eligible and at various stages of completing the USMLE Step 1 and Step 2 CK requirements. However, the proposed rule restricting eligibility to physicians who have been out of practice for less than four years would disqualify every one of these candidates—as well as many others outside our network—who could otherwise help fill critical gaps in Virginia's healthcare system. Given that the Provisional License is expected to become active in 2027, a four year out-of-practice rule would exclude any qualified physicians who were displaced from countries like Afghanistan in 2021 or Ukraine in 2022—and any others before them—who have been investing time, energy, and financial resources to prepare for this Provisional Licensure pathway.

We fully recognize and share the Legislative Committee's commitment to patient safety and high-quality care. We would emphasize, however, that such protections are already inherent through the requirements of:

1. Two full years of structured supervision after passing Step 1 & Step 2 CK of the USMLE exams, and

2. Quarterly competency evaluations conducted by a team of at least four supervising physicians.

Both of these provisions provide multiple checkpoints and safeguards for quality assurance throughout the Provisional License period.

Beyond that, the proposed four-year out-of-practice limit risks placing Virginia at a competitive disadvantage. Other states with a similar Provisional License pathway—such as Minnesota—have adopted more inclusive standards, allowing eligibility for physicians with 60 months (5 years) of practice within the past 12 years while relying on employers to perform robust vetting and oversight.

Many ITPs in our network have expressed a willingness to relocate to Virginia's underserved communities, but if this four-year rule becomes final, RPA will need to begin referring these candidates outside the Commonwealth.

Therefore, if the Board will be imposing a time out-of-practice rule, we urge you to adopt a 60-month (5 years) within 12-year standard, which:

- Incorporates HB995's statutory intent,
- Maintains strong professional and patient safety standards, and
- Expands Virginia's capacity to address its growing healthcare workforce shortage.

This approach honors both the spirit of HB995 and the needs of Virginia's patients—balancing safety, equity, and access to care. Expanding the rule to 60 months within 12 years acknowledges the real-world financial, familial, and logistical barriers that may delay otherwise qualified physicians from re-entering practice, while preserving patient safety and strengthening Virginia's healthcare system.

Respectfully,

Brandi Kilmer
Co-Founder & Senior Director, Refugee Physicians Advocacy (RPA) Coalition
Follow RPA on LinkedIn

RPA is a coalition of nonprofits led by Georgetown University School of Medicine, NOVA Friends of Refugees, medical partners, and Their Story is Our Story with technical support from World Education Services. We assist international physicians in the Virginia region to continue their careers through mentorship, streamlined upskilling, legislative and regulatory change, and grants.

Brandi Kilmer
Community Programs Coordinator, Washington D.C.

949-614-3004
www.tsosrefugees.org

Morton, Colanthia D. (DHP)

From: CoCo.Morton@dhp.virginia.gov
Subject: FW: Public comment re: HB995 4 year rule

From: Saulters, Kacie
Sent: Monday, October 20, 2025 7:33 PM
To: Harp, William L. (DHP) <william.harp@dhp.virginia.gov>
Cc: erin.barrett@dhp.virginia.edu; Brandi Kilmer <brandikilmer@tsosrefugees.org>
Subject: Public comment re: HB995 4 year rule

To Dr. Harp and the Virginia Board of Medicine –

My name is Kacie Saulters, and I serve as the Internal Medicine Residency Program Director at the University of Maryland Capital Region Health. I have held this position since July 2022, and prior to that served for six years as Core Faculty and Assistant Program Director at MedStar Georgetown University Hospital. During my time in the MedStar system, I also served as System Director of Global Health Education, building and sustaining international partnerships and facilitating exchange of learners across diverse medical education settings. Through these roles, I have gained a deep understanding of both international and U.S.-based graduate medical education. These experiences inform my perspective on policies affecting the integration of internationally trained physicians.

I am writing to provide input regarding the proposed Year of Graduation (YOG) cutoff for provisional medical licensure. Based on my experience directing a residency program that trains predominantly internationally educated physicians, I believe that such a cutoff is not supported by evidence and may inadvertently limit Virginia's physician workforce.

Each year, the United States graduates approximately 28,000 physicians, while there are over 40,000 first-year residency positions available. Even with many programs recruiting internationally trained physicians (ITPs) to fill these positions, the nation still faces a projected shortfall of 87,000 primary care physicians by 2037. With many qualified ITPs already living in Virginia, creating additional barriers to licensure risks worsening these workforce gaps and limiting access to care for our communities.

At Capital Region Health, our Internal Medicine Residency Program is proud of its long-standing ACGME accreditation and its diverse, highly capable trainees—more than 95% of whom are internationally trained. We prioritize candidates with ties to our region and do not apply a YOG cutoff. While some programs restrict eligibility to those who graduated within five years, this practice is arbitrary and unsupported by evidence. Limited data show only a minimal decline in standardized in-training exam scores with increased age, and no correlation with poorer patient outcomes or board pass rates. In our experience, internationally trained physicians often achieve higher overall exam performance, and we have successfully trained residents who matriculated anywhere from one month to eighteen years after medical school graduation.

Our internal data also show that physicians further removed from graduation are more often women or individuals displaced by trauma or political instability—groups for whom arbitrary cutoffs disproportionately create barriers. While I wish there were a single predictive marker of clinical success, I have yet to find one—and certainly not the Year of Graduation.

I fully support the Board's commitment to ensuring competence and patient safety and recognize the value of exploring alternative pathways to licensure. However, a YOG cutoff does not meaningfully advance that goal. Competence is best demonstrated through rigorous assessment and supervised clinical evaluation, not by time since graduation.

Thank you for the opportunity to share these perspectives. I would be happy to collaborate or provide additional data as the Board continues to develop thoughtful and evidence-based approaches to licensing internationally trained physicians.

Sincerely,
Kacie J. Saulters, MD, FACP
Program Director, Internal Medicine Residency
University of Maryland Capital Region Health

Morton, Colanthia D. (DHP)

From: CoCo.Morton@dhp.virginia.gov
Subject: FW: Public Comments Regarding the Four-Year Limit for International Physicians

From: faizi laila
Sent: Tuesday, October 21, 2025 9:42 AM
To: Harp, William L. (DHP) <William.Harp@dhp.virginia.gov>
Cc: Brandi Kilmer <brandikilmer@tsosrefugees.org>
Subject: Public Comments Regarding the Four-Year Limit for International Physicians

Dear Dr. William Harp,

Good morning, and thank you for the opportunity to speak.

My name is Dr. Laila Faizi Sohail, and I am a medical doctor trained in Turkey, with five years of experience as an emergency room physician. I have treated thousands of patients—sometimes more than 200 in a single day. I managed both critical and noncritical cases, and I learned to make fast, sound clinical decisions under intense pressure. My training and my experience prepared me to serve people with skill, care, and compassion.

I came to Virginia during the COVID-19 pandemic. This was the first state I lived in, and it has become my home. My husband and child are here, and I have built a community and a social network. I currently work as a laboratory analyst, and I volunteer in medical and community settings whenever I can. But what truly brings me joy is patient care. I became a doctor because, when I was a little girl, my grandmother was very sick with cancer. Everyone thought she would die, but after she was treated, she lived many more years with us. From that moment, I knew I wanted to help others the way her doctors helped her.

I want to practice medicine in Virginia because there is a clear need for more doctors—especially in primary care and emergency medicine—and because this is my home. I have the skills, the education, and the motivation to serve this community.

When I came to the United States, however, I had to start my life from zero. I came alone during COVID, pregnant and without support. I had to find housing, pay bills, and learn to navigate a new country and language. For a time, I drove for Uber and cooked for neighbors just to make ends meet. Later, I worked

at Pfizer as an associate medical director, analyzing cases and studying side effects of medications, and now I work as a lab analyst. These jobs have helped me stay close to medicine, but they are not what I was trained for. My goal has always been to return to patient care.

I have faced the same licensing process as U.S. graduates—studying for the USMLE exams, step by step. These exams require eight to ten hours of study each day for many months, and it is only recently, after stabilizing my life and family, that I've been able to focus fully on them.

That is why the proposed four-year limit for physicians to be eligible for a provisional license would be devastating. It would exclude me, even though I am qualified, experienced, and ready to serve. For people like me—especially women who are caregivers—those first years in a new country are focused on basic survival. We are rebuilding our lives, caring for our families, sometimes learning a new language, and working to support ourselves.

My husband was still in Afghanistan, and I was raising a newborn alone during COVID, while also adjusting to a new system, a new language, and a new culture. My brother, who is also a doctor, passed all his exams within five years because he had no family responsibilities. I am proud of him—but I want you to understand that this difference does not make me less competent. It only shows how the same path takes longer when you are caring for others while also rebuilding your life.

For refugee and immigrant women, the four-year limit is not realistic. It punishes those who have already overcome some of the greatest obstacles—war, displacement, financial hardship, and family responsibilities. It takes time to reach stability, to regain confidence, and to prepare for exams.

Virginia's legislature passed this law to bring more doctors into the workforce and to help address physician shortages. The four-year rule would do the opposite. It would block capable, experienced doctors—many of us women—from even having a chance.

I am not asking for shortcuts or exceptions. I am asking for a fair opportunity. The law already provides safeguards through supervised practice. Let us demonstrate our competence. Let us give back to the communities that have become our home.

I want to serve the people of Virginia. I want to bring my skills, my multilingual abilities—I speak five languages—and my compassion to patients who need care. Please expand the rule beyond four years, so that dedicated physicians like me can contribute to the health of this Commonwealth.

Thank you for listening and for considering my request.

Sincerely,

Dr. Laila Faizi Sohail

October 21, 2025

Dear Dr. Harp and Members of the Board of Medicine,

I am writing as a fourth-year medical student at Georgetown University School of Medicine (GUSOM) and lead author of a recently completed qualitative research study examining barriers to medical re-licensure among Internationally Trained Physicians (ITPs). I support the Provisional License Pathway for ITPs as a smart strategy to strengthen Virginia's healthcare workforce. However, the proposed 12-month direct supervision requirement is overly burdensome and makes the program impractical for most hospitals and clinics.

Over the last four years, I have conducted in-depth interviews with ITPs in the DMV area as the principal investigator of an IRB approved study at GUSOM. This work revealed critical insights about both the barriers these physicians face and the remarkable clinical strengths they bring to the American healthcare systems. While logistical challenges dominate their re-licensure journey, ITPs demonstrate extraordinary clinical competence, resilience, and dedication to patient care. Many practiced in crisis settings where they developed broad, advanced skillsets out of necessity. As one participant described, "Whatever [patients] needed, it would be provided…at that time, I didn't just do trauma surgery…I worked in neurosurgery, thoracic surgery, abdominal surgery, orthopedic surgery, and surgical urology." This breadth of hands-on experience, often in resource-limited settings requiring clinical acumen over technological dependence, creates physicians with refined diagnostic and treatment capabilities.

Another participant noted a critical difference in clinical practice: "Here [in the U.S.], 90% of the analysis done by the diagnostic equipment, but in Afghanistan, more than 60% of the diagnosis done by doctors through the symptoms and signs alone." This reliance on clinical examination skills and diagnostic reasoning represents a valuable complement to technology-dependent American medicine, particularly in rural and underserved settings where advanced diagnostic equipment may be limited or where the human element of medicine remains paramount. Furthermore, our research identified that most frequently coded themes across interviews which included "Passion for Helping Others," "Experience in Patient Care," and "Compassion and Empathy." These are not abstract qualities. They represent the foundation of excellent clinical practice that makes ITPs effective healers.

Additionally, as a Georgetown medical student currently in my fourth year of training, I have had the privilege of working alongside and learning from numerous ITPs during my clinical rotations. Many of my residents were ITPs, and I consistently observed their exceptional competence both at treating patients and teaching medical students. The

ITPs with whom I worked were attending physicians at teaching hospitals or lecturers at medical schools in their home countries before coming to the U.S. Thus, they bring not only years of independent clinical practice but also pedagogical experience and a depth of medical knowledge that was often well beyond the scope of their domestically trained intern colleagues.

The proposed rule restricting eligibility to physicians who have been out of practice for less than four years would disqualify all 45 of the ITP candidates in the RPAC network, including many of our study participants, who could otherwise help fill critical gaps in the VA healthcare system. The ITPs with whom I have trained and conducted research have successfully practiced medicine for years and are willing to undergo additional U.S. examinations and supervised practice to demonstrate their competence. They should not be excluded based solely on the brief time elapsed since last practice. Many ITPs must rebuild their lives from scratch, often supporting extended families while working entry-level jobs. One physician captured this reality saying, "It took me at least three years to understand what I had to do to practice here. And as soon as I knew that, we quickly came to realize that I don't have the resources to do it."

I support the Provisional License Pathway for Internationally Trained Physicians (ITPs) as a smart strategy to strengthen Virginia's healthcare workforce. However, the proposed rule to restrict eligibility to four years out of practice risks sidelining talented physicians who face extraordinary financial, family, and time constraints who could otherwise be part of the solution to our growing healthcare access crisis. Further, the present recency requirement will leave Virginia at a competitive disadvantage with other states who are adopting longer periods including Minnesota which only requires 60 months in the previous 12 years and places a higher screening role with the hiring entities. Adopting a more inclusive standard—sixty months (5 years) within the last twelve years—strikes the right balance between meeting HB995's statutory requirements, maintaining high professional standards, and addressing Virginia's health workforce gaps.

To succeed, this program must be both safe and sustainable. I urge the Board to adopt a supervision standard that reflects operational realities and supports Virginia's urgent need for qualified physicians. This approach honors both the spirit of HB995 and the needs of Virginia's patients—balancing safety, equity, and access to care. The refugee physicians in our study demonstrated not only clinical excellence but also an unwavering commitment to serving others, often in the most challenging circumstances. As Dr. Begonia reflected on working in crisis conditions: "We faced death every second, every minute, every hour of the day, and we continued to go to the university and continued our education…hoping we would not miss the lecture. In this way, we finished medical school."

Respectfully,

Amanda Wibben

MD Candidate, Georgetown University SOM '26
MTS, Harvard Divinity School '22
BA, College of the Holy Cross '19
Lead Author, "Voices of Refugee Physicians: A Qualitative Analysis of Barriers to Medical Re-licensure in the United States"

Morton, Colanthia D. (DHP)

From: CoCo.Morton@dhp.virginia.gov
Subject: FW: Provisional License for ITPs - time out of practice
Attachments: Upwardly Global_VA Board of Medicine Letter_TimeOutof Practice.pdf

---

From: Bethany Atkins <bethanya@upwardlyglobal.org>
Sent: Tuesday, October 21, 2025 5:20 PM
To: Harp, William L. (DHP) <William.Harp@dhp.virginia.gov>
Cc: Barrett, Erin (DHP) <erin.barrett@dhp.virginia.gov>; brandikilmer@tsosrefugees.org
Subject: Provisional License for ITPs - time out of practice

Dear Dr. Harp and Members of the Board of Medicine,

Please find attached a letter on behalf of Upwardly Global regarding the proposed time-out-of-practice rule for ITPs on behalf of Upwardly Global. Upwardly Global has 25 years of experience working with Internationally Trained Physicians (ITPs) in all states, including the DMV region. We provide coaching support in professional pathways, including re-licensing informational support. Upwardly Global supports the Provisional License Pathway for Internationally Trained Physicians (ITPs) as a smart strategy to strengthen Virginia's healthcare workforce.

However, regarding Virginia's two-year Provisional License for Internationally Trained Physicians (ITPs). I urge you to oppose any proposed rule that would limit eligibility to only those with no more than four years out of medical practice. We are concerned that the proposed recency rule of no more than 4 years out of practice rule will create a significant barrier for talented physicians who face extraordinary financial, family, and time constraints, who could otherwise be part of the solution to our growing healthcare access crisis, including the more than 30 + ECFMG-certified professionals in our program this year.

Further, the present recency requirement will leave Virginia at a competitive disadvantage with other states that are adopting longer periods, including Minnesota, which only requires 60 months in the previous 12 years and places a higher screening role with the hiring entities. Adopting a more inclusive standard—**sixty months (5 years) within the last twelve years**—strikes the right balance between meeting HB995's statutory requirements, maintaining high professional standards, and addressing Virginia's health workforce gaps.

This adjustment would responsibly expand the pool of qualified international physicians able to serve Virginia's patients under supervision—especially in areas facing persistent provider shortages. It would do so without compromising patient safety, as provisional licensees must still practice under oversight and meet rigorous examination, certification, and evaluation standards.

Thank you for your leadership and your commitment to the people of Virginia. I urge you to vote **against** narrowing the eligibility criteria and to **support** language that broadens the provisional licensure pathway for international physicians.

Best,

Bethany

Bethany Atkins, (she/her)
Program Director I Upwardly Global
bethanya@upwardlyglobal.org

Upwardly Global

A resource for skilled immigrants.
An opportunity for America.

Dear Dr. Harp and Members of the Board of Medicine,

I am writing on behalf of Upwardly Global. Upwardly Global has 25 years of experience working with Internationally Trained Physicians (ITPs) in all states, including the DMV region. We provide coaching support in professional pathways, including re-licensing informational support. Upwardly Global supports the Provisional License Pathway for Internationally Trained Physicians (ITPs) as a smart strategy to strengthen Virginia's healthcare workforce.

However, regarding Virginia's two-year Provisional License for Internationally Trained Physicians (ITPs). I urge you to oppose any proposed rule that would limit eligibility to only those with no more than four years out of medical practice. We are concerned that the proposed recency rule of no more than 4 years out of practice rule will create a significant barrier for talented physicians who face extraordinary financial, family, and time constraints, who could otherwise be part of the solution to our growing healthcare access crisis, including the more than 30 + ECFMG-certified professionals in our program this year.

Further, the present recency requirement will leave Virginia at a competitive disadvantage with other states that are adopting longer periods, including Minnesota, which only requires 60 months in the previous 12 years and places a higher screening role with the hiring entities. Adopting a more inclusive standard—**sixty months (5 years) within the last twelve years**—strikes the right balance between meeting HB995's statutory requirements, maintaining high professional standards, and addressing Virginia's health workforce gaps.

This adjustment would responsibly expand the pool of qualified international physicians able to serve Virginia's patients under supervision—especially in areas facing persistent provider shortages. It would do so without compromising patient safety, as provisional licensees must still practice under oversight and meet rigorous examination, certification, and evaluation standards.

Thank you for your leadership and your commitment to the people of Virginia. I urge you to vote **against** narrowing the eligibility criteria and to **support** language that broadens the provisional licensure pathway for international physicians.

Sincerely,

Avigail Ziv
Chief Programs Officer
Upwardly Global
avigail@upwardlyglobal.org

Upwardly Global
www.upwardlyglobal.org

New York
505 8th Avenue, Suite 1704
New York, NY 10018
T: 212.219.8828

Morton, Colanthia D. (DHP)

From: CoCo.Morton@dhp.virginia.gov
Subject: FW: Public Comment Submission for October 30 Board Meeting – HB 995 Draft Rule
Attachments: WES Comment to the VA MedBoard_Oct_FINAL.docx

From: Fatima Mahmoud Ramadan Sanz <fsanz@wes.org>
Sent: Tuesday, October 21, 2025 9:00 PM
To: Harp, William L. (DHP) <William.Harp@dhp.virginia.gov>
Cc: Mike Zimmer <mzimmer@wes.org>; Brandi Kilmer <brandikilmer@tsosrefugees.org>; Barrett, Erin (DHP) <erin.barrett@dhp.virginia.gov>
Subject: Public Comment Submission for October 30 Board Meeting – HB 995 Draft Rule

Dear Dr. Harp,

Attached please find a public comment submitted on behalf of my colleague, Mike Zimmer, Senior Policy Consultant at World Education Services (WES), regarding the draft rules implementing HB 995.

Thank you for your time and for your continued leadership in shaping policies that improve access to quality care for all Virginians.

Best,

Fatima Sanz
Sr US Policy Manager
World Education Services

E: fsanz@wes.org | wes.org/gtb

To: Dr. Harp, Executive Director, and Members of the Virginia Board of Medicine
Subject: Comments on Draft Rules for Temporary Licensure of Physicians Licensed in a Foreign Country

Dear Dr. Harp and Members of the Virginia Board of Medicine,

Thank you for the opportunity to comment on the draft rules implementing Virginia's new licensure pathway for physicians licensed in a foreign country, as established by HB 995. I appreciate the Board's thoughtful work in translating the legislative intent into regulatory language and commend your commitment to expanding access to qualified internationally trained physicians (ITPs) in the Commonwealth.

My name is Michael Zimmer, and I serve as a Senior Policy Consultant at World Education Services (WES), a non-profit social enterprise that supports the educational, economic, and social inclusion of immigrants, refugees, and international students. Through partnerships with community organizations, institutions, and policymakers, WES helps internationally trained professionals contribute their skills and expertise to the U.S. workforce — strengthening communities and expanding access to good work.

WES was proud to support Delegate Kathy Tran and Virginia stakeholders in the development of HB 995. I believe the draft rules represent a significant step forward in operationalizing the legislation. However, I respectfully offer the following recommendations to ensure the rules fully reflect the law's intent and maximize the pathway's effectiveness.

1. Recency of Practice Requirement

The current draft requires applicants to have practiced medicine within a limited number of recent years. While ensuring recent clinical experience is important, overly restrictive timeframes may inadvertently exclude qualified candidates — particularly those who have experienced displacement, immigration-related delays, or other barriers to practice.

I recommend expanding the allowable timeframe to include applicants who have practiced for **at least 60 months within the past 12 years**. This approach maintains a high standard of prior experience while accommodating the realities faced by many internationally trained physicians.

Additionally, I encourage the Board to consider a **discretionary provision** that allows applicants to qualify through **equivalent combinations of postgraduate training and active medical practice**. For example, applicants with fewer years of recent practice but more extensive postgraduate training — or vice versa — may still demonstrate the competencies necessary for safe and effective care. This flexibility would better reflect the diverse backgrounds of internationally trained physicians and support Virginia's workforce needs.

2. Assessment and Evaluation Requirements

While HB 995 does not explicitly reference supervision, I understand that the draft rules may include a provision requiring **12 months of direct supervision** for provisional licensees. I appreciate the Board's commitment to ensuring patient safety and professional accountability through structured assessment and evaluation.

However, I am concerned that a blanket 12-month direct supervision requirement may be **overly burdensome** and impractical for many hospitals and clinics, particularly those in underserved areas. To ensure the success and sustainability of this pathway, I recommend a **phased, competency-based model** that allows for flexibility in how supervision is implemented.

Specifically, I recommend establishing a minimum level of oversight equivalent to first-year residency programs, where **indirect supervision** is permitted once competency is demonstrated. In line with existing Virginia regulatory language, **indirect supervision** should be defined as:

"The supervising physician is not physically present at the site but is immediately available by electronic or telephonic means and is able to provide direct supervision when necessary."

This approach allows for an initial period of more intensive direct observation and assessment, followed by a transition to needs-based supervision as the provisional licensee's competencies are established. It maintains patient safety while providing institutions with the **flexibility to tailor their assessment and evaluation programs** to their operational realities and the needs of their clinical teams.

3. Proof of Good Standing Requirement

I understand that the draft rules may require applicants to provide **proof of good standing in their country of licensure**. While this is a reasonable expectation in many cases, it may present significant barriers for some internationally trained physicians — particularly refugees.

I recommend revising the language to allow applicants to demonstrate **proof of good standing during their most recent year of active practice**, rather than requiring current licensure status. This adjustment would account for situations where a physician's license may have expired due to relocation, conflict, or other circumstances unrelated to professional conduct or competency.

This change would preserve the Board's ability to assess professional qualifications while ensuring that otherwise qualified physicians are not excluded due to administrative or geopolitical barriers beyond their control.

4. Definition of Eligible Medical Care Facilities

I am concerned that the draft rules may impose a narrower definition of "medical care facility" than what is intended in HB 995. Specifically, the draft limits eligibility to facilities defined under § 32.1-3 of the Code of Virginia, which may exclude community health centers, outpatient clinics, and other non-hospital entities capable of providing robust assessment and evaluation programs.

HB 995 uses broader language, requiring only that the applicant be employed by a "medical care facility that provides an assessment and evaluation program." We recommend that the Board ensure the final rules **do not create additional restrictions beyond the text of the statute** and instead allow **any licensed healthcare facility** that meets the programmatic requirements to participate. The intent of HB 995 is to create a pathway that enables internationally trained physicians to help address provider shortages across the state and improve access to health care for all Virginians. To fulfill that goal, it is essential that **all types of medical care facilities as defined by the statute** be able to benefit from and participate in this pathway.

I thank the Board for its leadership in advancing this important initiative. With thoughtful adjustments to the draft rules — particularly around recency of practice and structure of assessment and evaluation programs — Virginia can set a national example in responsibly integrating internationally trained physicians into its healthcare workforce. These changes will help ensure the pathway is not only safe, but also **feasible and responsive to the operational realities** of healthcare institutions across the Commonwealth. I look forward to continued collaboration and stand ready to support the Board's efforts to make this pathway a success.

Sincerely,
Michael Zimmer
Senior Policy Consultant
World Education Services (WES)

Agenda Item: Consideration of biennial CE topic 2026-2027

Staff Note: The General Assembly gave the Board the authority to designate a CE topic each biennium as a requirement for renewal. The Board can choose to exercise this authority or not. If it chooses to exercise the authority, it could designate any topic for any group of licensees. The requirement is that those subject to the required CE must be notified prior to January 1st of the upcoming biennium. Included in your packet is the enabling law and a brief outline of a PowerPoint CE activity developed by the Virginia Department of Health on completing death certificates.

Action: Discussion as to whether to exercise the authority for the coming biennium and if so to select a topic.

Agenda Item: **DHP Agency Director's Report**

Staff Note: All items for information only

Action: None.

Agenda Item: **Report of Officers**

Staff Note:

- President
- Vice-President
- Secretary-Treasurer
- Executive Director

Action: Informational presentation. No action required.

Agenda Item: **Executive Director's Report**

Staff Note: All items for information only.

Action: None.

Agenda Item: **Committee and Advisory Board Reports**

Staff Note: Please note Committee assignments and minutes of meetings.

Action: Motion to accept minutes as reports to the Board.

VIRGINIA BOARD OF MEDICINE

Committee Appointments

FY2025

EXECUTIVE COMMITTEE (8)
Randy Clements, DPM – President, Chair
Peter Apel, MD – Vice-President
Leroy Vaughan, Jr., MD – Secretary-Treasurer
Deborah DeMoss Fonseca
William Hutchens, MD
Oliver Kim
L. Blanton Marchese
Jennifer Rathmann, DC

LEGISLATIVE COMMITTEE (7)
Peter Apel, MD – Vice-President, Chair
Randy Clements, DPM – President
Leroy Vaughan, Jr., MD – Secretary-Treasurer
Krishna Madiraju, MD
Patrick McManus, MD
Pradeep Pradhan, MD
Jennifer Rathmann, DC

CREDENTIALS COMMITTEE (9)
William Hutchens, MD – Chair
Kamlesh Dave, MD
Hazem Elariny, MD
Elliott Lucas, MD
Krishna Madiraju, MD
Ken McDowell, DO
Patrick McManus, MD
Michele Nedelka, MD
Mark Simcox, MD

FINANCE COMMITTEE
J. Randy Clements, DPM – President
Peter Apel, MD – Vice-President
Leroy Vaughan, Jr., MD – Secretary-Treasurer

BOARD BRIEFS COMMITTEE
William L. Harp, M.D., Ex Officio

CHIROPRACTIC COMMITTEE
Jennifer Rathmann, DC

BOARD OF HEALTH PROFESSIONS
Krishna Madiraju, MD

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
Randy Clements, DPM – President
Blanton Marchese
Leroy Vaughan, Jr, MD **– Secretary-Treasurer**

VIRGINIA BOARD OF MEDICINE

EXECUTIVE COMMITTEE MINUTES

Friday, August 1, 2025 Department of Health Professions Henrico, VA

CALL TO ORDER: Dr. Apel called the Executive Committee to order at 8:33 a.m.

ROLL CALL: Ms. Brown called the roll; a quorum was established.

MEMBERS PRESENT:
Peter Apel, MD – President
John R. Clements, DPM
Deborah DeMoss Fonseca
L. Blanton Marchese
Kenneth McDowell, DO – Secretary-Treasurer
Jennifer Rathmann, DC

MEMBERS ABSENT:
William Hutchens, MD
Leroy Vaughan, Jr., MD – Vice President

STAFF PRESENT:
William L. Harp, MD - Executive Director
Jennifer Deschenes, JD - Deputy Exec. Director for Discipline
Michael Sobowale, LLM - Deputy Exec. Director for Licensure
Colanthia Morton Opher - Deputy Exec. Director for Medical Licensing and Administration
Barbara Matusiak, MD - Medical Review Coordinator
Arnie Owens - DHP Director
Erin Barrett - Director for DHP Legislative and Regulatory Affairs
Matt Novak – DHP Policy and Economic Analyst
Deirdre Brown - Executive Assistant

OTHERS PRESENT:
Tamika Hines – Board of Medicine Case Manager
Roslyn Nickens – Board of Medicine Licensing Supervisor
David Brown, DC – Immediate Past DHP Director
Colleen Grady-Koerner – Medical Society of Virginia

EMERGENCY EGRESS INSTRUCTIONS

Dr. Apel provided the emergency egress instructions.

APPROVAL OF MINUTES FROM APRIL 4, 2025

Dr. Clements moved to approve the meeting minutes from April 4, 2025, as presented. The motion was seconded by Ms. DeMoss Fonseca and carried unanimously.

ADOPTION OF AGENDA

Ms. DeMoss Fonseca moved to adopt the agenda as presented. The motion was seconded by Dr. Clements and carried unanimously.

PUBLIC COMMENT

There was no public comment.

DHP DIRECTOR'S REPORT

Mr. Owens, DHP Director, shared that the final cases for 2025 have been wrapped up and is now working on proposed legislation along with the biennial budget for 2026-2027 for consideration by the 2026 General Assembly.

Mr. Owens stated that DHP is currently focusing on providing support to all boards with Human Resources, Procurement, and IT. The goal is to operate efficiently and to cut costs. He stated that he appreciates the work the Board of Medicine is doing to provide a healthy workforce.

PRESIDENT'S REPORT

There was no President's report.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp gave a brief review of the proposed FY2026 budget. He pointed out that the budget has two sections, direct and allocated expenditures. The allocated expenditures are costs shared with other boards for APD, Enforcement and other departmental services. Direct expenditures are those specifically for Board operations, such as per diem payments for Board members, staff salaries, furniture, etc. Dr. Harp informed the Board that many of the advisory boards did not meet last year, so those costs were not reflected in FY2025. A significant amount of the $399,000 surplus from FY2025 will most likely be spent on 33 potential advisory board meetings in FY2026.

Dr. Harp reviewed two new policies:

- DHP Policy 76-10.24 Conflict of interest policy acknowledgment for board members.
    - It is the duty of all Board members to notify the Executive Director (or designee) of any conflicts of interest between you and the subject of any investigation or disciplinary action. Such notification must occur as soon as you are aware of the conflict.
    - Dr. Harp stated that all Board members should have received an email from staff requesting the acknowledgement form.
    -
- § DHP Policy 76-10.25 Prior convictions not to abridge rights.
    - Dr. Harp stated that the Board cannot deny a license solely based on a criminal conviction, per SB826.

- Ms. Barrett stated that the Board can deny a license if the conviction is related to the occupation or profession.

NEW BUSINESS

1. Regulatory Actions as of July 17, 2025

Mr. Novak reviewed the Current Regulatory Actions as of July 17, 2025, stating that there have been no changes since July 17th.

This report was for informational purposes only and did not require any action.

2. Consideration of Notice of Intended Regulatory Action to License Anesthesiology Assistants

Ms. Barrett stated that the Board will need to convene a Regulatory Advisory Panel to develop the regulations for Anesthesiology Assistants.

One concern voiced by a member was that the legislation did not define the scope of practice in the Code.

It was recommended to obtain information from West Virginia and the District of Columbia, as both jurisdictions currently regulate this profession and have not had significant public safety concerns.

MOTION: Mr. Marchese moved to issue a Notice of Intended Regulatory Action to license Anesthesiology Assistants. The motion was seconded by Dr. McDowell and carried unanimously.

3. Consideration of Proposed Action for Reduction of Requirements for Consultation and Collaboration

Mr. Novak reviewed the new language that included a slight reduction of requirements for consultation and collaboration.

MOTION: Dr. McDowell moved to adopt proposed stage regulations for the reduction of requirements for consultation and collaboration. The motion was seconded by Mr. Marchese. A roll call vote was taken and with a vote of 3-3 the motion did not pass.

Ms. Barrett asked the Board if they would like to withdraw the action. None replied.

BREAK: Dr. Apel called for a break at 9:03 a.m. and the meeting resumed at 9:13 a.m.

Dr. Apel opened the floor to the Board for comment:

- Dr. Apel expressed his opposition to the motion, arguing that the previous language was stronger, while the new language was too vague and could potentially be

misused. Dr. Clements, Dr. Rathmann, and Ms. DeMoss Fonseca agreed.

- Dr. McDowell stated that the current language sets up a barrier to care, and the proposed changes should not impact practice. Dr. Rathmann and Mr. Marchese agreed.

After the suggestion to add years of experience to the proposed language to make the revised language more acceptable, the following motion was made:

MOTION: Mr. Marchese motioned to return the proposed action for the Reduction of Requirements to the Physician Assistant Advisory Board for review of the Committee's concerns. The Executive Committee will revisit the Advisory Board's input at their next meeting in December. The motion was seconded by Dr. Rathmann and carried unanimously.

4. Consideration of Proposed Action for Removal of Patient Care Team Physician or Podiatrist from Prescriptions

Mr. Novak reviewed the proposed removals requested by the Physician Assistant advisory board.

MOTION: Mr. Marchese moved to adopt proposed stage regulations for removal of patient care team physician or podiatrist from prescriptions. The motion was seconded by Dr. McDowell and carried unanimously.

5. Consideration of Petition for Rulemaking – Buprenorphine Prescriptions

Ms. Barrett reviewed the Petition for Rulemaking from Dr. Lauren H. Grawert on behalf of the Virginia Society of Addiction Medicine (VASAM). The petitioner requested for 18VAC85-21-150 be amended by removing the requirement for documentation of prescribed doses exceeding 24 mg of buprenorphine per day. Additionally, the petitioner requested for 18VAC85-21-160 to remove the restriction on prescribing buprenorphine for addiction to patients under the age of 16, unless approved by the FDA.

Board members reviewed the petition and concluded that the current regulations protected patients, and the use of buprenorphine in patients under the age of 16 is not currently approved by the FDA.

MOTION: Mr. Marchese moved to deny the petition based on the lack of justification to remove the requirement for documentation of higher doses and on prescribing buprenorphine to patients under the age of 16. The motion was seconded by Dr. McDowell and carried unanimously.

6. Consideration of Exempt Endorsement Regulatory Action for Behavior Analysts

Mr. Novak reviewed the General Assembly's and the Governor's requirement for all professions at the Board of Medicine to develop licensure by endorsement pathways.

MOTION: Mr. Marchese moved to amend 18VAC85-150 by exempt action with a correction in 18VAC85-150-50(3) of "on" to "in". The motion was seconded by Dr. Rathmann and carried unanimously.

7. Consideration of Exempt Endorsement Regulatory Action for Genetic Counselors

Mr. Novak reviewed the draft changes to 18VAC85-170 as recommended by the Advisory Board for Genetic Counseling.

MOTION: Mr. Marchese to amend 18VAC85-170 by exempt action. The motion was seconded by Dr. Rathmann and carried unanimously.

8. Consideration of Exempt Endorsement Regulatory Action for Occupational Therapists

Mr. Novak reviewed the draft changes to 18VAC85-80 as recommended by the Advisory Board on Occupational Therapists. He suggested removing the strikethrough from 18VAC85-80-35(4).

MOTION: Mr. Marchese moved to amend 18VAC85-80 by exempt action with amendment to include 18VAC85-80-35(4). The motion was seconded by Dr. Mc Dowell and carried unanimously.

9. Consideration of Exempt Endorsement Regulatory Action for Polysomnographic Technology

Mr. Novak reviewed the draft changes to 18VAC85-140 as presented to the Advisory Board on Polysomnographic Technologists. He suggested removing the strike through 18VAC85-140-50 (4) and adding a number (5) with the language from 18VAC85-140-60(B) and add "and current NPDB".

MOTION: Mr. Marchese moved to amend 18VAC85-140 by exempt action with amendment to include 18VAC85-140-50(4) and add requirement from 18VAC85-140-60(B) as 18VAC85-140-50(5) with adding a current NPDB. The motion was seconded by Dr. Mc Dowell and carried unanimously.

ANNOUNCEMENTS

Dr. Apel informed the Board of the updated guideline for travel reimbursement. Effective immediately, Board members need to submit their request for reimbursement within 30 days for approval. After 30 days, no exceptions will be granted.

The next meeting of the Executive Committee will be December 5, 2025, at 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 10:01 a.m.

_____
William L. Harp, MD
Executive Director

--- DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE

LEGISLATIVE COMMITTEE MINUTES

Friday, September 5, 2025 Department of Health Professions Henrico, VA

CALL TO ORDER: Dr. Vaughan called the meeting of the Legislative Committee to order at 8:36 a.m.

ROLL CALL: Ms. Brown called the roll; a quorum was established.

MEMBERS PRESENT:
Leroy Vaughan, Jr., MD - Vice-President & Chair
J. Randy Clements, DPM - Past President
Krishna Madiraju, MD
Patrick McManus, MD
Jennifer Rathmann, DC
Michele Nedelka, MD

MEMBERS ABSENT: Peter Apel, MD - President

STAFF PRESENT:
William L. Harp, MD - Executive Director
Jennifer Deschenes, JD - Deputy Director, Discipline
Colanthia Morton Opher - Deputy Director, Doctors' Licensing and Administration
Michael Sobowale, LLM - Deputy Director, Allied Health Professions' Licensing
Arne Owens – DHP Director
Erin Barrett, JD – Director of DHP Legislative and Regulatory Affairs
Matt Novak - DHP Policy and Economic Analyst
Deirdre Brown - Executive Assistant

COUNCIL PRESENT: W. Brent Saunders, JD - Senior Assistant Attorney General

OTHERS PRESENT:
Tamika Hines - Discipline Case Manager
Brandi Kilmer – Refugee Physicians Advocacy Coalition
Scott Castro – Medical Society of Virginia
Ben Traynham – Hancock, Daniel & Johnson, PC

EMERGENCY EGRESS INSTRUCTIONS

Dr. Vaughan provided the emergency egress instructions for Board Room 4.

APPROVAL OF MINUTES OF May 9, 2025

Dr. Rathmann moved to approve the meeting minutes of May 9, 2025. The motion was seconded by Dr. McManus and carried unanimously.

ADOPTION OF AGENDA

Dr. Nedelka moved to approve the agenda as presented. The motion was seconded by Dr. Rathmann and carried unanimously.

PUBLIC COMMENT

Brandi Kilmer, representing the Refugee Physician Advocacy Coalition, expressed her appreciation to the Board for its work with HB995. Ms. Kilmer asked the Committee to consider removing “no more than two years out of practice”, stating that this requirement would exclude qualified physicians who may have been displaced due to conflict in their country.

DHP AGENCY DIRECTOR’S REPORT

Arne Owens, DHP Director, shared that DHP is tracking activities in Washington, DC to include new guidelines for administering COVID vaccines, Medicaid, PMP Federal funding, and the November 2026 elections.

Internally, Mr. Owens stated that DHP’s biennial budget will indicate that it is striving for greater efficiency. He said DHP is developing several legislative proposals for the 2026 General Assembly.

NEW BUSINESS

1. Ongoing Discussion of Proposed Regulatory Language Pursuant to HB995 (2024)

Dr. Vaughan shared with the Board that the Federation of State Medical Boards (FSMB) released a Guidance Document from the Advisory Commission on Additional Licensing Models in August 2025. The document provides recommendations regarding optional licensure pathways for internationally trained physicians (ITPs). Dr. Vaughan reviewed several points from the Commission’s report to assist the Committee with the review of the draft regulations.

Ms. Barrett stated that the Committee’s draft will go to the October full Board for review and further revision. After proposed regulations are adopted, they will be posted for 60 days to allow public comment.

18VAC85-20-10. Definitions.

Ms. Barrett reviewed options for defining direct supervision and indirect supervision. She presented the following as the definition for “Direct Supervision.”

- **"Direct supervision"** means the supervising physician is physically present and immediately available to the supervised individual and the patient.

MOTION: Dr. Vaughan moved the definition of direct supervision as presented. The motion was adopted by a unanimous show of hands.

Ms. Barrett then presented the first option for defining Indirect Supervision.

- **"Indirect supervision"** means the supervising physician is immediately available and is physically within the hospital or other site of patient care and is immediately available to provide direct supervision.

MOTION: Dr. Vaughan moved the first option for defining indirect supervision. The vote was 3 yeas and 3 nays. The definition was not adopted.

Ms. Barrett presented a second possible definition for indirect supervision.

- **"Indirect supervision"** means the supervising physician is immediately available but is not physically present within the hospital or other site of patient care but is immediately available by electronic or telephonic means and is available to provide direct supervision.

MOTION: Dr. Vaughan moved this definition for indirect supervision. The vote was 3 yeas and 3 nays. The definition was not adopted.

Ms. Barrett said that the discussion of the Committee on this matter will be presented to the full Board in October.

18VAC85-20-20. Required fees.

Ms. Barrett reviewed the application fee for a provisional license, stating that the fees match the current Medicine license fees.

18VAC85-20-211. Provisional licensure of foreign physicians.

Ms. Barrett suggested language to be added to 85-20-211A along with adding a new 85-20-211B, which would change the current 85-20-211B and 85-20-211C to 85-20-211C and 85-20-211D.

Dr. Harp suggested rephrasing 85-20-211A to the following:

- A physician <u>that has practiced in a foreign country for at least 5 years</u> after medical training may apply for a provisional license as a physician.

All agreed to the revision, and Mr. Saunders suggested that the Board remove 85-20-211D. Ms. Barrett agreed and struck 85-20-211D.

18VAC85-20-212. Requirements for maintenance of provisional licensure for foreign physicians.

Ms. Barrett reviewed 85-20-212A, asking the Board if they would like to revise the gap for full-time practice from 2 years.

MOTION: Dr. Vaughan moved to revise 85-20-212A from "two years" to "four years." The motion was adopted with 4 yeas and 2 nays.

18VAC85-20-213. ~~Requirements for medical~~ Medical care facilities providing evaluation programs for foreign physicians.

Ms. Barrett reviewed the updates of 85-20-213 with the Board.

Dr. Harp said that the language in 85-20-213F and 85-20-213G.2 should match for "clinical competency committee" or "clinical competence committee". Dr. Vaughan suggested that the phrase for both sections be "clinical competency committee." All Board members agreed.

18VAC85-20-214. Supervision of provisionally licensed foreign physicians.

Ms. Barrett reviewed the updates of 85-20-214 with the Board.

18VAC85-20-215. Restricted licensure of foreign physicians.

Ms. Barrett reviewed the updates of 85-20-215 with the Board.

18VAC85-20-216. Patient notification of status of physician holding a provisional license ~~or restricted license.~~

Ms. Barrett reviewed the updates of 85-20-216 with the Board.

MOTION: Dr. Vaughan moved to send the revised draft language to the full Board held in October. The motion was seconded by Dr. Madiraju and carried unanimously.

Guidance Regarding Foreign Physicians Obtaining Provisional Licenses

Ms. Barrett reviewed the Guidance Document and asked the Board for a suggested number of years for proof of active practice. All Board members agreed on proof of 5 years of active practice.

In the list of organizations other than the World Health Organization (WHO), Mr. Sobowale suggested removing the Liaison Committee on Medical Education (LCME) because it only recognizes US medical schools, not international schools, and therefore is not applicable to ITP's. Dr. Harp suggested adding Educational Commission for Foreign Medical Graduates (ECFMG).

CONSIDERATION OF CONSENT ORDER

Ms. Deschenes presented a Consent Order regarding an applicant for reinstatement.

MOTION: Dr. Clements moved to accept the Consent Order. The motion was properly seconded by Dr. Nedelka and passed with a vote of 6-0.

ANNOUNCEMENTS

None.

NEXT MEETING

January 9, 2026.

ADJOURNMENT

With no other business to conduct, the meeting adjourned at 10:29 a.m.

_____

William L. Harp, MD
Executive Director

<< DRAFT >>

ADVISORY BOARD ON ACUPUNCTURE
Minutes
October 22, 2025

The Advisory Board on Acupuncture met on Wednesday, October 22, 2025, at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Elizabeth Fuqua, L.Ac.
Haley Parker, L.Ac.
Luke Robinson, DO
Yong Kyun Shin. L.Ac.

MEMBERS ABSENT: None

STAFF PRESENT:
William L. Harp, M.D., Executive Director
Michael Sobowale, LLM, Deputy Executive Director - Licensure
Jennifer Deschenes, Deputy Executive Director – Discipline
Colanthia M. Opher, Deputy Executive Director – Medical Licensure and Administration
Kathleen LaMotte, Board Administrator
Erin Barrett, Director of Legislative and Regulatory Affairs
Roslyn Nickens, Licensing Supervisor
Erin Pollard, Licensing Specialist
Denise Christian, Licensing Specialist

GUESTS PRESENT: None

Call to Order

Dr. Harp called the meeting to order @ 10:00 a.m.

Emergency Egress Procedures

Kathleen LaMotte announced the emergency egress instructions.

Roll Call

Ms. LaMotte called the roll; a quorum was declared.

Introduction of Members

Dr. Harp asked everyone present in the room to introduce themselves.

Approval of Minutes

Dr. Parker moved to approve the minutes from the June 5, 2024, meeting. Dr. Robinson seconded. The motion passed unanimously.

Adoption of Agenda

Dr. Robinson motioned to adopt the agenda as presented. The motion was seconded by Dr. Parker. The motion passed unanimously.

Public Comment on Agenda Items

None received

New Business

1. **Recommendation of draft amendments for licensure by endorsement**
   Erin Barrett presented a draft regulatory change for licensure by endorsement to create a separate path to licensure in Virginia when people are licensed in other states. This was in response to 2025 legislation directing the Department of Health Professions (DHP) to create more pathways to licensure. This will allow a slightly easier process for these applicants to enter Virginia. This Advisory Board's recommendation will be sent to the full Board of Medicine to consider adoption of an exempt regulatory action to amend the regulations.

   Erin Barrett also raised a question regarding the requirement for evidence of completion of the Clean Needle Technique (CNT) course, as administered by the Council of Colleges of Acupuncture and Herbal Medicine (CCAHM). While this is currently required for initial licensure, staff sought the Advisory Board's input on whether it should also be required for licensure by endorsement.

   Board members noted that while the CNT course is a standard requirement in most states, it is necessary for public protection. There was no opposition to keeping the CNT requirement, and it was not considered overly burdensome.

   Next Steps:
   The proposed amendments will be presented to the Executive Committee in December. Due to the shortened regulatory review process, implementation is anticipated by the middle of 2026.

   Dr. Parker moved to recommend the proposed changes to the full Board. Dr. Robinson seconded. The motion passed unanimously.

2. **Reference to National Association for Foreign Student Affairs (NAFSA) for**

submission of transcripts in the instructions for applications that applies to graduates of non-ACOM approved programs – Michael Sobowale

Michael Sobowale addressed the current application instructions for graduates of non-ACOM-approved programs, which reference both the National Association for Foreign Student Affairs (NAFSA) and the National Association of Credential Evaluation Services (NACES) for foreign credential evaluation. Upon review, it was determined that NAFSA functions primarily as an advocacy organization and does not perform credential evaluations.

Most applicants currently use credential evaluation services approved by the National Board of Education. Additionally, a review of the May 2003 meeting minutes confirmed that NAFSA was not among the credential evaluation bodies approved by the Board at that time. To avoid confusion for applicants, Board staff recommended removing NAFSA from the application instructions.

Dr. Harp noted that the Board operates under laws, regulations, guidance documents, and office policies, and believed that this change could be made with the Advisory Board's approval. Erin Barrett agreed.

Motion:
Dr. Parker moved to remove NAFSA from the application instructions. Dr. Robinson seconded. The motion carried unanimously.

3. **Election of Officers**

The Advisory Board held elections for the positions of Chair and Vice Chair.

Motions:
Chair: Ms. Fuqua moved to elect Dr. Robinson as Chair. Dr. Parker seconded. The motion passed unanimously.
Vice Chair: Ms. Fuqua moved to elect Dr. Parker as Vice Chair. Dr. Robinson seconded. The motion also passed unanimously.

4. **Approval of 2026 Meeting Calendar**

Acupuncture meetings are scheduled for February 4, May 13 and September 30, 2026. Dr. Robinson moved to approve the calendar. Dr. Parker seconded. The motion passed unanimously

Motion:
Dr. Robinson moved to adopt the meeting calendar. Dr. Parker seconded. The motion passed unanimously.

5. **Orientation to the Board**

Dr. Harp shared a presentation to welcome new Advisory Board members to their role and serve as a refresher for members that have served on the Board for a while. Dr. Harp reviewed the structure of the Department of Health Professions and how the Board of Medicine receives oversight from the Commonwealth. Jennifer Deschenes covered hearing protocol expected of Advisory Board members.

Licensing Report

Erin Pollard provided the following licensing statistics for licensed acupuncturists:

Total number of Licensed Acupuncturists: 656. Since January 1, 2025, 39 have been licensed, 43 including reinstatements. The average processing time for applications is 31 days. There is a 100% clearance rate.

Announcements

Members were reminded to submit their travel expense reimbursement vouchers within 30 days of the meeting.

Next Scheduled Meeting

The next scheduled meeting will be Wednesday, February 4, 2026, at 10:00 a.m.

Adjournment

Dr. Robinson adjourned the meeting at 11:30 a.m.

_____

William L. Harp, MD, Executive Director

<< DRAFT >>

ADVISORY BOARD ON RADIOLOGICAL TECHNOLOGY
Minutes
October 22, 2025

The Advisory Board on Radiological Technology met on Wednesday, October 22, 2025, at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Sandra J. Catchings, DDS
Uma Prasad, MD, Vice-Chair

MEMBERS ABSENT: Cheryl Cunningham, RT
David L. Roberts, RT
Angela Dunn, RT

STAFF PRESENT: William L. Harp, M.D., Executive Director
Michael Sobowale, LLM, Deputy Executive Director - Licensure
Jennifer Deschenes, Deputy Executive Director – Discipline
Colanthia M. Opher, Deputy Executive Director – Medical Licensure and Administration
Kathleen LaMotte, Board Administrator
Erin Barrett, Director of Legislative and Regulatory Affairs
Roslyn Nickens, Licensing Supervisor
Denise Christian, Licensing Specialist

GUESTS PRESENT: None

Call to Order

Dr. Prasad called the meeting to order @ 1:17 p.m.

Emergency Egress Procedures

Kathleen LaMotte announced the emergency egress instructions.

Roll Call

Ms. LaMotte called the roll; a quorum was not declared.

Announcements

Members present were reminded to submit their travel expense reimbursement vouchers within 30 days of the meeting.

Next Scheduled Meeting

The next scheduled meeting is Wednesday, February 4, 2026, at 1:00 p.m. Dr. Prasad is not available.

Adjournment

Dr. Prasad adjourned the meeting at 1:23 p.m.

_____

William L. Harp, MD, Executive Director

<< DRAFT >>

ADVISORY BOARD ON ATHLETIC TRAINING
Minutes
October 23, 2025

The Advisory Board on Athletic Training met on Thursday, October 23, 2025, at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: David Pawlowski, AT, Chair
Chris Casola
William S. Powers, AT

MEMBERS ABSENT: Larry D'Shawn Wright (citizen)
Virginia Wells, MD

STAFF PRESENT: William L. Harp, M.D., Executive Director
Michael Sobowale, LLM, Deputy Executive Director - Licensure
Jennifer Deschenes, Deputy Executive Director – Discipline
Colanthia M. Opher, Deputy Executive Director – Medical Licensure and Administration
Kathleen LaMotte, Board Administrator
Erin Barrett, Director of Legislative and Regulatory Affairs
Roslyn Nickens, Licensing Supervisor
Sonya Armstead, Licensing Specialist

GUESTS PRESENT: Debra Rodman - VATA

Call to Order

David Pawlowski called the meeting to order @ 10:02 a.m.

Emergency Egress Procedures

Kathleen LaMotte announced the emergency egress instructions.

Roll Call

Ms. LaMotte called the roll; a quorum was declared.

Introduction of Members

Mr. Pawlowski asked everyone present in the room to introduce themselves.

Approval of Minutes

Mr. Powers moved to approve the minutes from the June 12, 2025, meeting. Mr. Casola seconded. The motion passed unanimously.

Adoption of Agenda

Michael Sobolwale proposed a minor revision to the agenda, suggesting the removal of the "Orientation to the Board" presentation. Instead, he will email the presentation to Board members as a refresher, noting that most have previously received the information.

Mr. Powers moved to adopt the amended agenda. Mr. Casola seconded the motion. The motion carried unanimously.

Public Comment on Agenda Items

None received

New Business

1. **Recommendation of draft amendments for licensure by endorsement**
   Erin Barrett presented draft regulatory changes aimed at establishing a separate pathway for licensure by endorsement in Virginia. This new pathway would streamline the process for individuals already licensed in other states, making it slightly easier for them to obtain licensure in Virginia. The Board's recommendation will be forwarded to the Executive Committee for consideration of an exempt regulatory action to amend the current regulations.

   Ms. Barrett also explained that the General Assembly determines whether Virginia may enter licensure compacts. The simplest compacts, such as those for nursing and massage therapy, allow for multi-state licensure. Most other compacts, including those for physical therapy, counseling, occupational therapy, and physician assistants, operate under a "compact privilege" model. While this model is designed to expedite licensure, it still requires an FBI criminal background check and can take 4–5 years to fully implement due to the regulatory process.

   There was discussion regarding the use of NATABOC, which has since split into two separate entities. A statutory change may be necessary to update the language in the regulations accordingly.

   The Board expressed support for the proposed changes, recognizing the benefit of helping qualified professionals become licensed more efficiently. Board staff noted that the time required to issue a license largely depends on how promptly applicants submit the necessary documentation.

Mr. Powers moved to adopt the proposed changes for recommendation to the full Board. Mr. Casola seconded the motion. The motion passed unanimously.

2. **Election of Officers**

   Mr. Powers moved to retain Mr. Pawlowski as Chair. Mr. Casola seconded the motion. The motion passed unanimously.

   Mr. Pawlowski then moved to nominate Mr. Powers as Vice Chair. Mr. Casola seconded the motion. The motion also passed unanimously.

3. **Athletic Trainer Interstate Compact**
   Mr. Pawlowski reported on his recent attendance at the National Center for Interstate Compacts (NCIC) conference in Omaha, where licensure portability was a key topic of discussion. He outlined the potential benefits and drawbacks of joining an interstate compact for athletic trainers. Topics included:

   Fees: The Board of Medicine may need to absorb certain costs, such as access to the compact database and state participation fees. However, the applicant's fee may be comparable to the current endorsement fee.

   Eligibility: Licensure by endorsement would remain open to applicants from all states, while compact licensure would only apply to those from participating states.

   Dr. Harp raised a point about the Servicemembers Civil Relief Act (SCRA), which already facilitates expedited licensure for military members and their families.

4. **Approval of 2026 Meeting Calendar**
   Mr. Powers moved to approve the 2026 meeting calendar. Mr. Casola seconded the motion. The motion passed unanimously.

   Licensing Report

   Sonya Armstead provided the following licensing statistics for Athletic Trainers:
   - Total number of licensed Athletic Trainers: 1,787
   - New licenses issued since January 1, 2025: 188
   - Average processing time: 23 days
   - Clearance rate: 109%

Announcements

Members were reminded to submit their travel expense reimbursement vouchers within 30 days of the meeting.

Next Scheduled Meeting

The next scheduled meeting is Thursday, February 5, 2026, at 10:00 a.m.

Adjournment

Mr. Pawlowski adjourned the meeting at 11:05 a.m.

_____

William L. Harp, MD, Executive Director

<< DRAFT >>

ADVISORY BOARD ON PHYSICIAN ASSISTANTS
Minutes
October 23, 2025

The Advisory Board on Physician Assistants met on Thursday, October 23, 2025, at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Justin Hepner, PA-C, Chair
Tracey Dunn - citizen
Erin Myers, PA-C
Lucy Treene, PA-C
Brian Hanrahan, MD *

** Dr. Hanrahan joined at 1:09*

MEMBERS ABSENT: None

STAFF PRESENT: Michael Sobowale, LLM, Deputy Executive Director - Licensure
Jennifer Deschenes, Deputy Executive Director – Discipline
Colanthia M. Opher, Deputy Executive Director – Medical Licensure and Administration
Kathleen LaMotte, Board Administrator
Matthew Novak, DHP Policy and Economic Analyst
Roslyn Nickens, Licensing Supervisor
Jamie Culp, Licensing Specialist
Erin Pollard, Licensing Specialist

GUESTS PRESENT: Jonathan Williams - VAPA

Call to Order

Justin Hepner called the meeting to order @ 1:00 p.m.

Emergency Egress Procedures

Kathleen LaMotte announced the emergency egress instructions.

Roll Call

Ms. LaMotte called the roll; a quorum was declared.

Introduction of Members

Mr. Hepner asked everyone present in the room to introduce themselves.

Approval of Minutes

Two scrivener's errors were noted and corrected on the previous minutes. Ms. Dunn moved to approve the minutes as amended from the June 12, 2025, meeting. Ms. Treene seconded. The motion passed unanimously.

Adoption of Agenda

Staff requested a change to the agenda. An orientation to the Board of Medicine (BOM) had been planned; however, this presentation was delivered to most members of the Advisory Board last year. Staff proposed sending the presentation out as a refresher for those who previously viewed it and as an introduction for new members. Ms. Dunn motioned to adopt the agenda as amended. The motion was seconded by Ms. Meyers. The motion passed unanimously.

Public Comment on Agenda Items

None received

New Business

1. **Regulatory Update**
   Since publication, the proposal to remove the requirement for including the name of the patient care team physician or podiatrist on prescriptions issued by physician assistants has progressed from the Department of Planning and Budget to the Secretary's Office for further review.

   Regarding the broader revisions to 18VAC85-50, which govern the practice of physician assistants, the Board of Medicine's Executive Committee has scheduled further discussion for its December 5, 2025, meeting.

2. **Recommendation of draft amendments for licensure by endorsement**
   Mr. Novak reviewed a draft regulatory change for licensure by endorsement to create a separate path to licensure in Virginia when people are licensed in other states. This will allow a slightly easier process for these applicants to enter Virginia. This board's recommendation will be sent to the executive committee in December to consider adoption of an exempt regulatory action to amend the regulations.

   Ms. Dunn moved to approve the licensure by endorsement proposal. Ms. Meyers seconded. The motion passed unanimously.

3. **Report on PA education and scope of practice nationally – Matthew Novak**

Mr. Novak presented the study required by HB2489, which was submitted by the Virginia Department of Health Professions. A copy of the report was provided to the Advisory Board. The study offers a national overview of physician assistant education and scope of practice, including:

- A review of PA education and training requirements across the U.S., which are largely consistent and include a master's level education, national certification, and extensive clinical rotations.
- A survey of scope of practice models, noting that Virginia uses a collaborative practice model, while other states vary between supervisory, collaborative, or fully autonomous models.
- An analysis of potential costs and benefits to patients if PA autonomy were expanded in Virginia.

No formal recommendations were made in the report; it was presented as an informational item for the Board's awareness

4. **Compact update – Justin Hepner, PA-C, Chair**
   Mr. Hepner provided an update on the Physician Assistant (PA) Licensure Compact. As of this report, 19 states have officially joined the compact, with additional states having legislation pending1. The compact facilitates multistate practice for PAs, allowing them to obtain a compact privilege to practice in other member states without needing separate licenses.

   The inaugural meeting of the Compact Commission was held in September 2024, and the annual meeting now includes delegates from all member states. At the inaugural meeting, Mr. Hepner was appointed to the Executive Committee.

   Mr. Hepner reported that the compact is progressing well and remains on track for full implementation.

5. **Election of Officers**

   Ms. Treene nominated Mr. Hepner to serve as Chair. Ms. Treene seconded the nomination.
   Ms. Treene nominated Ms. Meyers to serve as Vice Chair, and Dr. Hanrahan seconded the nomination.
   Both motions passed unanimously.

6. **Approval of 2026 Meeting Calendar**

   Mr. Hepner moved to approve the 2026 meeting calendar. Ms. Dunn seconded the motion. The motion passed unanimously.

Licensing Report

Mr. Culp provided the following licensing statistics for Physician Assistants:

- **Total licenses issued this year**: 7,269
- **New licenses issued**: 741
- **Total reinstatements**: 20
- **Total by reciprocity**: 97
    - From Maryland: 60
    - From D.C.: 15
    - From both MD and D.C.: 22
- **Average processing time**: 31 days
- **Clearance rate**: 104%

Announcements

Members were reminded to submit their travel reimbursement voucher within 30 days

Next Scheduled Meeting

The next scheduled meeting is Thursday, February 5, 2026, at 1:00 p.m.

Adjournment

Mr. Hepner adjourned the meeting at 1:30 p.m.

_____

William L. Harp, MD, Executive Director

Meeting of the of Medicine and Nursing

Workgroup on Prescribing Psychotropic Medications to Children and Adolescents
Minutes

Wednesday, August 20, 2025
Perimeter Center, 9960 Mayland Drive, Suite 201, Board Room 1, Henrico, VA 23233

Call to Order and Roll Call

Dr. William Harp called the meeting to order at 10:00 a.m.

Attendees:

- Neil Sonenklar, MD - Associate Professor of Psychiatry, VCU School of Medicine
- Tess Searls - Psychiatric APRN
- Laney Kortas - Parent

DHP Staff Present:

- William Harp, MD - Executive Director, Board of Medicine
- Claire Morris, RN, LNHA - Executive Director, Board of Nursing
- Kathleen LaMotte - Board Administrator, Board of Medicine
- Jennifer Deschenes, JD - Deputy Executive Director for Discipline, Board of Medicine
- Erin Barrett, JD - Director for DHP Legislative and Regulatory Affairs
- Michael Sobowale, LLM - Deputy Executive Director for Licensure, Board of Medicine

---

Emergency Egress Procedures

Dr. Harp reviewed the emergency egress procedures for the Perimeter Center.

Introduction of Workgroup Members

Dr. Harp welcomed and thanked members for their participation. Each member introduced themselves and their roles.

Adoption of Agenda

A motion to adopt the agenda was made by Dr. Sonenklar, seconded by Ms. Searls, and passed unanimously by voice vote.

Public Comment on Agenda Items

No public comments were received.

New Business

Charge of the Workgroup – Dr. William Harp

- The workgroup was convened in response to the General Assembly's (GA) budget language directing the Department of Health Professions (DHP) to study best practices for prescribing, monitoring, communication by and availability of the provider in the treatment of children and adolescents on behavioral health medications.
- Erin Barrett clarified that while DHP is funded by licensing fees and not directly impacted by the state budget, the language mandates a report to the GA.
- Concerns were raised about the feasibility of requiring 24/7 provider availability, especially for small or rural practices.

Discussion of AACAP Article

- Dr. Sonenklar shared the AACAP article *"Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents."*
- The group discussed the relevance of the article's 13 principles, particularly Principle 6, which addresses medication monitoring and follow-up.
- Members agreed that many of the principles are already reflected in existing Board of Medicine regulations.

Concerns and Observations

- Members questioned whether this study would lead to enforceable standards on after-hours availability, and it was noted that GA studies may often lead to legislative proposals.
- Concerns raised included that increased regulation could discourage providers of all specialties from prescribing psychotropic medications to minors.

- The parent representative shared that her experience with provider communication has been positive, with timely responses via email.

Regulatory Context

- The group acknowledged the Board's current regulations require that treatment plans be communicated to patients/authorized representatives and provide for reasonable practitioner availability.
- Consumer complaints about provider unavailability are rare and often deemed non-emergent.
- Members discussed the distinction between untimely medication refill requests and serious medication side effects.

Recommendations

- The workgroup recommends no new regulations at this time.
- A reminder of existing best practices should be included in the Board Briefs Newsletter.
- The report to the GA will affirm that:
    - Current regulations address the concerns in Budget Item 285.
    - The small number of complaints does not support regulatory change.
    - Best practices should apply to all medications, not just psychotropics.

Next Steps

- Staff will draft the report to the GA, due by **December 1, 2025**.
- The report will include:
    - Summary of discussions.
    - Reference to existing regulations.
    - Recommendation to disseminate best practices via communication, not regulation.

Adjournment

The meeting adjourned at 11:40 a.m.

Revision of the Midwifery Formulary
Virginia Board of Medicine
Monday, August 25, 2025, 10:00 a.m.
9960 Mayland Drive, Suite 200, Board Room 4
Henrico, VA 23233

Call to Order

Blanton Marchese called the meeting to order at 10:00 a.m.

Roll Call

Members Present:

- Blanton Marchese – Chair & Past President of the Virginia Board of Medicine
- Rebecca Banks, LM - Chair of the Advisory Board on Midwifery
- Story Jones, LM *(arrived at 10:15 a.m.)* - Member of the Advisory Board on Midwifery
- Jordan Hylton, DO - Associate Professor of OB-GYN at VCU School of Medicine
- Kim Pekin, LM – Virginia Midwives Alliance
- Jennifer Green, LM – Member of the Advisory Board on Midwifery
- Ildiko Baugus, LM – Member of the Advisory Board on Midwifery
- Christian Chisolm, MD – Professor of Fetal-Maternal Medicine at the University of Virginia School of Medicine

Staff Present:

- William L. Harp, MD – Executive Director, Board of Medicine
- Kathleen LaMotte – Board Administrator, Board of Medicine
- Jennifer Deschenes, JD – Deputy Executive Director for Discipline
- Erin Barrett, JD – Director, DHP Legislative and Regulatory Affairs
- Michael Sobowale, LLM – Deputy Executive Director for Licensure

Emergency Egress Instructions:
Mr. Marchese reviewed the emergency egress procedures.

Approval of Minutes – July 20, 2023

Correction noted: Dr. Hylton's credentials should read "DO" not "MD."
Motion: Dr. Chisolm moved to approve the minutes as amended.
Second: Jennifer Green
Motion passed.

Adoption of Agenda

The agenda was adopted without changes.

Public Comment on Agenda Items

No public comment was received.

New Business

Code of Virginia § 54.1-2957.9 – Practice of Midwifery

Mr. Marchese provided background on the Board's statutory authority and the alignment that the formulary follows with the North American Registry of Midwives Job Analysis. The formulary was originally written in 2023 and is being revisited for updating.

Review of Current Midwifery Formulary

- The current formulary has been well-received by midwives.
- National medication shortages have impacted access, particularly for non-hospital providers.
- The Board reviewed proposed revisions and additions (see Appendix A).

2024 NARM Job Analysis

- Kim Pekin discussed the NARM process and its relevance to certification and formulary updates.
- Emphasis was placed on the needs of rural midwives and the importance of emergency medications.

- A webinar is being developed to provide clinical updates on medication use, storage, informed consent, and AIM bundles.
- Erin Barrett noted that to make the webinar training mandatory would require regulatory changes.

Discussion of Specific Medications and Protocols

General Updates

- The statement on medication storage was revised to emphasize administration according to best practices.
- A new recommendation was added for licensed midwives to discuss available medications with each patient.

New Medications Added

- Tranexamic Acid (TXA) – for postpartum hemorrhage; both IV and oral dosing included.
- Carboprost (Prostaglandin F2 alpha) – for postpartum hemorrhage; IM administration.
- Terbutaline – to temporarily reduce uterine contractions during emergency transport.
- Sterile Water – for intradermal injections for labor pain relief.
- Dicloxacillin, Clindamycin, Cephalexin (Keflex) – for treatment of mastitis.
- Magnesium Sulfate – for seizure prevention; both IM and IV routes included with guidance on calcium gluconate as an antidote.
- Nitrous Oxide – for analgesia; self-administered per manufacturer guidelines.
- Zofran (Ondansetron) – anti-nausea; sublingual and IV options listed.
- Meyer's Cocktail – IV vitamin therapy for nausea and nutrient replenishment.
- Phenergan (Promethazine) – anti-nausea; suppository form.
- Iron Infusions – for anemia; to be administered per best practices.
- Vaccinations – including Tdap, MMR, HBV, HBIG, influenza, and COVID; per FDA-approved guidelines.

- Opioid Reversal Agent (e.g., Naloxone) – for suspected opioid overdose; intranasal administration.

Neonatal Section Updates

- Vitamin K1 – now includes both IM and oral options.
- Clarified dosing and administration for neonatal oxygen and epinephrine.

Next Steps

- The revised formulary will be presented to the full Board of Medicine on **October 30, 2025**.
- Public comment will be accepted at that meeting.

Announcements

- Members were reminded to submit per diem and travel vouchers for reimbursement.

Adjournment

The meeting adjourned at **11:45 a.m.**

~~Adopted: August 4, 2023~~
Revised: October 30, 2025

Virginia Board of Medicine
Formulary and Best Practices
Midwifery Administration of Drugs

Medication listed in this document should be stored as directed by the manufacturer and administered according to best practices. ~~should not be administered to any person after the expiration date listed.~~

The Board recommends that a licensed midwife discuss with each patient the medications that the midwife may provide.

	Drug	Indication	Dose/Route of Administration	Duration of Treatment
Maternal	Rh(D) immune globulin (Rhig) (RhoGAM/WinRho/Rhophylac)	Prevention of isoimmunization	300 mcg IM	After SAB, third trimester, and within 72 hours postpartum.
	Lidocaine HCl (1% or 2%)	Local anesthetic for suturing	Maximum 50 mL (1%) Maximum 15 mL (2%) Administered percutaneously	Completion of repair
	Medical Oxygen	Maternal hemorrhage or fetal distress	4-15 L/min by mask or bag/mask as needed to keep SpO2>93% or for fetal distress	Until maternal/fetal stabilization is achieved or transfer to the hospital is complete.
	Oxytocin (Pitocin)	Postpartum uterine atony	10 units IM per dose, 20-40 units in 500-1000 mL IV NS or LR	PRN during immediate postpartum care
	Misoprostol (Cyotec)	Postpartum hemorrhage	Prevention • Buccal or sublingual 200-400 mcg single dose immediately after delivery • Oral: 600 mcg single dose after delivery Treatment • Oral or rectal 600 to 1000 mcg single dose	PRN during immediate postpartum care

			• Sublingual 800 mcg single dose	
	Methylergonovine Maleate (Methergine)	Postpartum hemorrhage	0.2 mg IM or PO	Single dose IM or every six hours PO, may repeat 3 times. Contraindicated in hypertension and Raynaud's Disease.
	Tranexamic acid (TXA)	Postpartum hemorrhage	1 gram via IV 1300 mg orally	10 minutes
	Prostaglandin F2 alpha (carboprost)	Postpartum hemorrhage	250 mcg IM	Q 15-90 minutes (max 2 mg); avoid in asthma
	Terbutaline	Decrease or stop uterine contractions	0.25 mg subcutaneous	Once. If no significant decrease in contractions within 15-30 minutes, second dose of 0.25 mg may be administered.
	IV Fluids: ➢ Normal Saline (0.9%) ➢ Ringers Lactate ➢ Ringers Lactate with 5% Dextrose	Dehydration, exhaustion, volume replacement	1000 mL or 500 mL bolus as needed for dehydration, maternal exhaustion, inability to tolerate PO hydration and/or food, postpartum hemorrhage	Antepartum, intrapartum, and postpartum, as indicated.
	Sterile water	For intradermal injections for pain relief	1 mL sterile water per injection site; 4 injection sites using a 1 mL tuberculin syringe	May be repeated during labor
	Penicillin G (Pfizerpen) (Recommended)	GBS prophylaxis	5 million units IV in>=100 mL LR, NS, or D5LR initial dose, then 2.5 million units IV in>=100 mL LR, NS, or D5LR every 4 hours until birth	Throughout labor until birth of baby
	Ampicillin Sodium (Alternative)	GBS prophylaxis	2 grams IV in>=100 mL NS or D5LR initial dose, then 1 gram	Until birth of baby

			IV in NS >=100 mL every 4 hours until birth	
	Cefazolin Sodium (Ancef) (Alternative if allergic to PCN, high risk for anaphylaxis, and GBS is susceptible)	GBS prophylaxis	2 grams initial dose IV in>=100 mL LR, NS, or D5LR, then 1 gram IV in>=100 mL LR, NS, or D5LR every 8 hours	Until birth of baby
	Clindamycin Phosphate (Cleocin) (Alternative if allergic to PCN, high risk for anaphylaxis, and GBS is susceptible)	GBS prophylaxis	900 mg IV in>=100 mL LR, NS, or D5LR every 8 hours	Until birth of baby
	Dicloxacillin (Recommended)	Treatment of mastitis	500 QID	7 – 10 days
	Clindamycin (Alternative)	Treatment of mastitis	300 mg QID	7 – 10 days
	Cephalexin/Keflex (Alternative)	Treatment of mastitis	500 mg QID	7 – 10 days
	Epinephrine HCl 1:1000	Allergic reaction	0.3 mL IM	Every 20 minutes or until emergency medical services arrive. Administer the first dose then immediately request emergency services.
	Magnesium sulfate	Prevention of maternal seizures pending transport	10 grams IM, 5 grams in each buttock (preferred) 4 grams IV (alternative) If choosing IV, must have calcium gluconate available for IV administration at 1 gram over 5 – 10 minutes.	Once Over 30 minutes

	Nitrous oxide	Analgesic	Self-administered by patient per manufacturer of delivery system's guidelines	Per manufacturer of delivery system's guidelines
	Zofran/ondansetron (preferred during labor)	Anti-nausea	Sublingual 4 mg Sublingual 8 mg IV 4 mg	Every 4 hours Every 8 hours Once
	Meyer's cocktail (IV fluids including IV thiamine and IV multivitamin)	Anti-nausea	IV over 20-60 minutes; IV therapy provided slowly	Once
	Phenergan	Anti-nausea	12.5 mg or 25 mg suppository	Once
	Iron infusions	Anemia	Pursuant to best practices	Pursuant to best practices
	Vaccination against infectious diseases (including, but not limited to, Tdap, MMR, HBV, HBIG, influenza, and COVID)	Prevention against infectious diseases	Per FDA-approved manufacturer recommendations	Per manufacturer directions
	Opioid reversal agent	Suspected opioid overdose: unresponsive patient (not following commands but has a pulse) AND hypoventilating (respiratory rate of 8 or below and/or presence of gasping or agonal respirations) OR apneic	4mg/0.1mL nasal spray single spray intranasally into one nostril. If no response after initial treatment, give additional dose in opposite nostril.	Additional doses may be administered every 2-3 minutes until emergency medical services arrives.

Neonate	Drug	Indication	Dose/Route of Administration	Duration of Treatment
	Vitamin K1 (Phytonadione/Phylloquinone)	Prevention of vitamin K deficiency bleeding	1 mg IM Oral	Once, soon after birth

		(hemorrhagic disease of the newborn)		According to manufacturer directions
	Erythromycin ophthalmic ointment (0.5%)	Prevention of ophthalmia neonatorum	1 cm strip ophthalmic administration inside each eyelid	Once, soon after birth
	Medical Oxygen	Neonatal resuscitation	2-8 L/min mask, bag and mask, and/or laryngeal mask airway as needed to keep SpO2 within NRP guidelines	Until neonatal stabilization is achieved or transfer to the hospital is complete
	Epinephrine HCl 1:10,000	Neonatal resuscitation	0.01 mg/kg umbilical vein catheter or intraosseous injection (0.1 ml/kg of 1:10,000 concentration)	Every 20 minutes or until emergency medical services arrive. Administer the first dose then immediately request emergency services.

Agenda Item: **Other Reports**

- Board Counsel*
- Podiatry Report*
- Chiropractic Report*
- Committee of the Joint Boards of Nursing and Medicine

Staff Note: *Reports will be given orally at the meeting

Action: These reports are for information only. No action needed unless requested by presenter.

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
POSSIBLE SUMMARY SUSPENSION TELEPHONE CONFERENCE CALL
SEPTEMBER 25, 2025

A possible summary suspension telephone conference call of the Committee of the Joint Boards of Nursing and Medicine was held September 25, 2025, at 4:30 P.M.

The Committee Members participating the call were:
Helen Parke, DNP, FNP-BC - **Chair**; Board of Nursing Member
Delia Acuna, FNP-C; Board of Nursing Member
Shelly Smith, PhD, DNP, ANP-BC; Board of Nursing Member
Randy Clements, DPM; Board of Medicine Member
Blanton Marchese, Citizen Member; Board of Medicine Member
Bo Vaughan, Jr., MD; Board of Medicine Member

Others participating in the meeting were:
Sara Blose, Senior Assistant Attorney General, Board Counsel
David Kazzie, Deputy Director, APD
Amy Weiss, Adjudication Specialist, APD
Claire Morris, RN, LNHA; Executive Director
Randall Mangrum, DNP, RN; Deputy Executive Director for Advanced Practice
Christina Bargdill, BSN, MHS, RN; Deputy Executive Director
Cheryl Giles, Administrative Support Specialist

The meeting was called to order by Dr. Parke. With 6 members of the Committee of the Joint Boards of Nursing and Medicine, a quorum was established.

Amy Weiss, Adjudication Specialist, presented evidence that the continued practice of **Amy Elizabeth Kubler, APRN (0024-175068)** as an advanced practice registered nurse may present a substantial danger to the health and safety of the public.

CLOSED MEETING: Ms. Acuna moved that the Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to 2.2-3711(A)(27) of the *Code of Virginia* at 4:38 P.M. for the purpose of deliberation to reach a decision in the matter of Ms. Kubler. Additionally, Ms. Acuna moved that Ms. Morris, Dr. Mangrum, Ms. Bargdill, Ms. Giles, and Ms. Blose attend the closed meeting because their presence in the closed meeting is deemed necessary, and their presence will aid the Committee in its deliberations. The motion was seconded by Mr. Marchese and carried unanimously.

Ms. Weiss and Mr. Kazzie left the meeting at 4:38 P.M.

RECONVENTION: The Committee reconvened in open session at 4:55 P.M

Ms. Weiss and Mr. Kazzie re-joined the meeting at 4:55 P.M

Committee of the Joint Boards of Nursing and Medicine
Telephone Conference Call
September 25, 2025

Ms. Acuna moved that the Committee of the Joint Boards of Nursing and Medicine certify that it heard, discussed, or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded by Dr. Clements and carried unanimously.

Mr. Marchese moved to summarily suspend the license of **Amy Elizabeth Kubler** to practice as an advanced practice registered nurse and to offer a consent order for indefinite suspension of her license in lieu of a formal hearing. The motion was seconded by Dr. Vaughn and carried unanimously.

The meeting was adjourned at 4:57 P.M.

_____

Randall Mangrum, DNP, RN
Deputy Executive Director for Advanced Practice

Agenda Item: **Current Regulatory Actions**

Staff Note: Ms. Barrett or Mr. Novak will speak to the Board of Medicine actions underway.

Action: If any action is required, guidance will be provided.

Board of Medicine
Regulatory Actions
As of October 14, 2025

In the Governor's Office

None.

In the Secretary's Office

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC85-50	NOIRA	Implementation of the PA Compact	4/14/2025	176 days	Regulatory amendments necessary for entry into the PA Compact
18VAC85-20	Fast-Track	Removal of requirement to provide documentation of continuing competency for reactivation of a license	10/29/2024	53 days	This will make only attestation required, similar to renewal of licenses
18VAC85-50	NOIRA	Implementation of the PA Compact	4/14/2025	176 days	Facilitates entry into the PA Compact
18VAC85-50	Fast-Track	Creation of reinstatement process for physician assistants with lapsed licenses	10/29/2024	53 days	Missing process for PAs
18VAC85-80	Fast-Track	Expansion of options for reinstatement of lapsed occupational therapy or occupational therapy assistant license	7/1/2025	7 days	Amends reinstatement and reactivation regulations to allow quicker return to practice

18VAC85-180	NOIRA	Licensure of Anesthesiologist Assistants	8/18/2025	47 days	Begins the process to license Anesthesiologist Assistants as required by legislation

At DPB or OAG

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC85-20	Fast-Track	Clean up of continuing education requirement references following regulatory reduction	4/8/2025	OAG; 189 days	Removes references to CE requirements that were removed in a previous regulatory action
18VAC85-40	Proposed	Implementation of 2022 Periodic Review for Chapter 40	4/8/2025	OAG; 189 days	Implements changes following 2022 periodic review. Fast-track received an objection from a legislator pursuant to Va. Code § 2.2-4012.1., which converted the fast-track into a NOIRA. This action will now undergo the full regulatory process.

Recently effective/awaiting publication

VAC	Stage	Subject Matter	Submitted for publication	Effective Date	Notes
18VAC85-20	NOIRA	Licensure of foreign physicians through	3/24/25	4/23/2025	Proposed stage to be voted on at October meeting

		provisional and restricted licenses			
18VAC85-50	NOIRA	Amendment to requirements for patient care team physician or podiatrist consultation and collaboration	3/10/2025	4/9/2025	This action will be before the executive committee in December
18VAC85-50	Fast-Track	Implementation of Periodic Review for Chapter 50	6/2/2025	7/17/2025	Implements changes following 2022 periodic review
18VAC85-110	Fast-track	Implementation of 2022 Periodic Review for Chapter 110	5/19/2025	7/3/2025	Implements changes following 2022 periodic review
18VAC85-130	Fast-track	Implementation of 2022 Periodic Review for Chapter 130	5/19/2025	7/3/2025	Implements changes following 2022 periodic review
18VAC85-150	Fast-track	Implementation of 2022 Periodic Review for Chapter 150	5/19/2025	7/3/2025	Implements changes following 2022 periodic review
18VAC85-170	Fast-track	Implementation of 2022 Periodic Review for Chapter 170	5/19/2025	7/3/2025	Implements changes following 2022 periodic review
18VAC85-130	Fast-Track	General disclosure requirement amendment consistent with statutory changes	7/28/2025	9/11/2025	Updates requirements for midwife disclosures consistent with 2023 legislative changes
18VAC85-80	Final/Exempt	Licensure by endorsement for occupational therapy	11/3/2025	12/3/2025	Creates a licensure by endorsement pathway as required by 2025 legislation
18VAC85-140	Final/Exempt	Licensure by endorsement for polysomnographic technologists	11/3/2025	12/3/2025	Creates a licensure by endorsement pathway as

					required by 2025 legislation
18VAC85-150	Final/Exempt	Licensure by endorsement for behavior analysts	11/3/2025	12/3/2025	Creates a licensure by endorsement pathway as required by 2025 legislation
18VAC85-1700	Final/Exempt	Licensure by endorsement for genetic counselors	11/3/2025	12/3/2025	Creates a licensure by endorsement pathway as required by 2025 legislation

Agenda Item: Readoption of electronic meeting policy

Included in your agenda package:

- Electronic participation policy.

Staff notes: Virginia Code § 2.2-3708.3(D) requires public bodies to adopt electronic participation policies. The attached policy is consistent with the law and is applied across DHP.

Action needed:

- Motion to readopt the electronic participation policy.

Virginia Department of Health Professions

Meetings Held with Electronic Participation

Purpose:

To establish a written policy for allowing electronic participation of board or committee members for meetings of the health regulatory boards of the Department of Health Professions or their committees.

Policy:

Electronic participation by members of the health regulatory boards of the Department of Health Professions or their committees shall be in accordance with the procedures outlined in this policy.

Authority:

This policy for conducting a meeting with electronic participation shall be in accordance with Virginia Code § 2.2-3708.3.

Procedures:

1. One or more members of the Board or a committee may participate electronically if, on or before the day of a meeting, the member notifies the chair and the executive director that he/she is unable to attend the meeting due to:

    a. a temporary or permanent disability or other medical condition that prevents the member's physical attendance;

    b. a medical condition of a member of the member's family requires the member to provide care that prevents the member's physical attendance;

    c. the member's principal residence is more than 60 miles from the meeting location identified in the required notice for such meeting; or

    d. the member is unable to attend the meeting due to a personal matter and identifies with specificity the nature of the personal matter.

    No member, however, may use remote participation due to personal matters more than two meetings per calendar year or 25% of the meetings held per calendar year rounded up to the next whole number, whichever is greater.

2. Participation by a member through electronic communication means must be approved by the board chair or president. The reason for the member's electronic participation shall

be stated in the minutes in accordance with Virginia Code § 2.2-3708.3(A)(4). If a member's participation from a remote location is disapproved because it would violate this policy, it must be recorded in the minutes with specificity.

3. The board or committee holding the meeting shall record in its minutes the remote location from which the member participated; the remote location, however, does not need to be open to the public and may be identified by a general description.

Agenda Item: Consideration of petition for rulemaking

Included in your agenda package:

- Petition for rulemaking form filed by petitioner;
- Additional documentation provided by petitioner;
- Comments received via Town Hall regarding the petition; and
- 18VAC85-20-235.

Staff notes: Following the close of the comment period, the petitioner contacted the policy office with a clarification of his petition. The petitioner specifically requested that the Board withdraw the publication and petition. The Virginia Administrative Process Act provides no mechanism to take that step. The policy department will discuss the Board's options in response to the petition given the petitioner's request.

Action needed:

- Motion to either:
    - Accept the petition and initiate rulemaking; or
    - Deny the petition, clearly stating the reason why.

COMMONWEALTH OF VIRGINIA
Board of Medicine

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4600 (Tel)
(804) 527-4426 (Fax)
Coco.Morton@dhp.virginia.gov

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,)		
Joseph M. Foley DC		
Street Address	**Area Code and Telephone Number**	
708 S. Colorado St	540-798-3819	
City	**State**	**Zip Code**
Salem	VA	24153
Email Address (optional)	**Fax (optional)**	
bonesdc@aol.com		

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

18VAC85-20-235. Continued competency requirements for renewal of an active license. A. In order to renew an active license biennially, a practitioner shall attest to completion of at least30 hours of continuing learning activities within the two years immediately preceding renewal. The hours shall be in Type 1 activities or courses offered by an accredited sponsor or organization sanctioned by the profession.1. Type 1 hours in chiropractic shall be clinical hours that are approved by a college or university accredited by the Council on Chiropractic Education or any other organization approved by the board

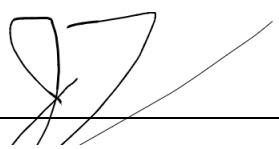
2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

Remove the requirement that Doctors of Chiropractic continuing education(CE)Type 1 hours be"clinical" in content. In addition, require 24, of the required 30 bi-annual CE hours to be in person, face-to-face and 6 can be gained through other learning platforms.

The purpose and rational for the chage- see attached.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is <u>other</u> legal authority for promulgation of a regulation, please provide that Code reference.

54..1-2400 Code of Virginia

Signature: 

Date: 7/25/2025

What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

18VAC85-20-235. Continued competency requirements for renewal of an active license.

A. In order to renew an active license biennially, a practitioner shall attest to completion of at least
30 hours of continuing learning activities within the two years immediately preceding renewal. The
hours shall be in Type 1 activities or courses offered by an accredited sponsor or organization sanctioned by the profession.

1. Type 1 hours in chiropractic shall be clinical hours that are approved by a college or university accredited by the Council on Chiropractic Education or any other organization approved by the board.

Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

Remove the requirement that Doctors of Chiropractic continuing education (CE) Type 1 hours be “clinical” in content. In addition, require 24, of the required 30 bi-annual CE hours to be in person, face-to-face and 6 can be gained through other learning platforms.

The chiropractic profession is the only profession under the Board of Medicine with this requirement that CE be "clinical". There are many important topics for the doctor of chiropractic to keep updated to that are not clinical in nature, such as HIPAA, No Surprises Act, Ethics and Boundaries, Human Trafficking etc.

The chiropractic profession practices largely as individual practitioners in standalone offices. This leads to isolation of the doctors as they may not interact with any of their peers in practice. By interacting with their peers while getting CE, isolated practitioners learn beyond the meeting agenda, on a broad range of topics, such as questionable billing practices, behaviors that bring chiropractors before the Board, or practical implementation for HIPAA. Just as important, their colleagues may notice signs of impairment and direct them to seek help. Finally, the chiropractic profession is a hands on profession, and effective learning for many key topics in chiropractic assessment and treatment is best achieved in-person.

Export to PDF Export to Excel

Agency **Department of Health Professions**

Board **Board of Medicine**

Chapter

Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic [18 VAC 85 - 20]

93 comments

All good comments for this forum Show Only Flagged

Back to List of Comments

Commenter: Daniel A. Shaye, D.C. 8/25/25 6:48 am

proposed changes to continuing education requirements for D.C.'s

Members of the Board:

My colleague, Joe Foley, D.C., has petitioned the Board of Medicine to amend the continuing education (CEU) requirements for Doctors of Chiropractic (D.C.). I am writing in support of eliminating the “clinical” CEU requirement but strongly **oppose** the proposed new in-person requirement for the required hours.

If the Board’s intent is to simplify requirements per Governor Northam’s directive while fulfilling its responsibility to protect public safety, removing the “clinical” requirement could benefit both the profession and the public by encouraging chiropractors to stay up to date on HIPAA, OSHA, the No Surprises Act, Medicare regulations, and other administrative obligations critical to compliant, safe practice. There is no public benefit in losing access to a competent provider simply because they fell behind on the complex web of non-clinical regulations. This portion of the proposal, I support.

In contrast, imposing a new in-person CEU requirement seems inconsistent with approaches taken by other regulated professions. For example:

- **Massage therapists**, despite recent public concern over boundary violations, are not required by the Virginia Board of Nursing to complete in-person CEUs.
- **Realtors ®** are permitted to complete all continuing education online—despite operating in fields with significant ethical and legal responsibilities.
- **Medical doctors** in Virginia, similarly, are not bound to in-person CEU formats.

Why, then, single out Doctors of Chiropractic?

Moreover, does in-person learning demonstrably reduce unethical or illegal behavior in health care practitioners? If such a belief exists, is it backed by evidence?

If there were data showing that D.C.s have significantly higher rates of ethical lapses or substance abuse compared to other professionals, one might consider whether in-person CEUs could help. However, I am not aware of such evidence. In fact, challenges related to substance abuse and boundary violations are shared across many health professions. Targeting D.C.s with additional regulatory burdens seems to solve a problem that has not been shown to exist.

Finally, I urge the Board to consider the issue of **provider burnout**, a major threat to public health. A recent study published in *Mayo Clinic Proceedings* involving 7,643 participants concluded:

"Occupational distress in physicians remains markedly elevated relative to the US workforce. Meaningful, evidence-informed intervention is needed from government, payers, and health care organizations to address these issues."

Requiring in-person CEUs only adds to this burden. Providers should be able to choose the format—online or in-person—that best suits their learning style, schedules, and educational needs. Trusting professionals to make those decisions is both practical and respectful.

In conclusion: Though (if regulations so permit) I personally may choose in-person learning settings for some or all of my requirements, retaining the option for fully online continuing education supports provider well-being and, by extension, patient care. Thank you for your thoughtful consideration and for your service to the public.

Sincerely,

~Daniel A. Shaye, D.C.

Williamsburg, VA
CommentID: **237030**

Commenter: Elizabeth Murphree, DC. Fairfax Chiropractic

8/25/25 7:35 am

Dr. Foley's Open Letter re: Continuing Education Ideas

I oppose this suggestion. I agree with Daniel Shaye's previous comment 100%. To add face to face seminars is less time with my Friday evening & Saturday patients for the last 28 years. It hurts my income as well as being a disservice to my very role as a Doctor of Chiropractic.

OPPOSE.

Thank you,

Elizabeth K. Murphree DC

CommentID: **237031**

Commenter: Ainsley Hendon Flynn, DC

8/25/25 8:40 am

Re: Proposed Changes

I am writing in strong support of the petition to amend 18VAC85-20-235 to remove the clinical continuing education hour requirement and to require that 24 of the 30 annual chiropractic CEU hours be completed in person, face-to-face.

Chiropractic is a profession rooted in hands-on, patient-centered care, and our continuing education should reflect that. In-person education fosters true professional growth through live demonstration, peer-to-peer dialogue, and real-time feedback—experiences that cannot be replicated online. These face-to-face interactions strengthen our clinical skills, keep us connected to the latest best practices, and reinforce the sense of community that sustains our profession.

Equally important, removing the "clinical" requirement gives chiropractors greater flexibility to pursue the education most relevant to their practice. Every chiropractor serves patients in unique ways—whether through technique, integrative approaches, nutrition, or other supportive

disciplines. By eliminating the restrictive “clinical” designation, the Board will empower doctors of chiropractic to select continuing education that is meaningful to their patient populations while still maintaining high standards of professional excellence. This flexibility allows our field to stay innovative, responsive, and aligned with patient needs rather than being limited by arbitrary categories.

This amendment not only protects patients by strengthening practitioner competence, but also supports the growth and vitality of the chiropractic profession in Virginia. I urge the Board to adopt these changes so we may continue to advance in a way that is both patient-focused and professionally adaptive.

Respectfully submitted,
Ainsley Hendon Flynn, DC
CommentID: **237032**

Commenter: Michael A Pasternack DC

8/25/25 10:05 am

Proposed Changes to CE Requirements

I approve the proposed action to remove the clinical component of the CE requirements.

I am opposed to adding a face to face requirement for CE

Respectfully

Michael A Pasternack, DC

3038 Valley Ave

Winchester, VA 22601

Phone 1-540-545-7891

Email fixspinedoc@aol.com

CommentID: **237033**

Commenter: Martin Skopp; Skopp Chiro, Sports & Health

8/25/25 2:05 pm

Remove clinical in wording

It is important that doctors of chiropractic be able to get relevant continuing education requirements that are other than treatment related. There are many subjects that pertain to chiropractors that re not clinical: risk management, patient recordkeeping, HIPPA requirements, medicare requirements, cultural competency, etc. Therefore, I agree with this petition and ask that the word "clinical" be removed from statute.

However, I strongly oppose the “in-person/live” recommendation in this petition. There are many great programs that are online. Why limit chiropractors to 6 hrs. online out of 30 hrs. (only 20%) as acceptable CEUs? Seems arbitrary and punitive for those that prefer online training. Also, the added cost of travel and accommodations on licensees seems unnecessarily burdensome. Some in-person/live requirement might be good. I suggest 10 hours out of 30 hours required to be live and allow 20 hours out of 30 to be online or other method.

CommentID: **237034**

Commenter: Dr. Allison Schwartz

8/25/25 2:07 pm

Comments on 18VAC85-20-235

Dear Members of the Board,

I support removing the requirement that Doctors of Chiropractic obtain a specific number of clinical continuing education hours. This change allows us, like our fellow primary care colleagues, to choose education most relevant to our practices and patients.

However, I oppose the requirement that 24 of the 30 hours be obtained face-to-face. Such a high number restricts access to diverse topics, increases time and cost burdens, and is inconsistent with the continuing education standards of other Virginia medical professionals. Online education provides flexibility and equal quality, and our requirements should remain consistent with our primary care peers.

Thank you for your consideration.

Blessings and Health,

Dr. Allison Schwartz
Doctor of Chiropractic and License in Virginia since 2011.

CommentID: **237035**

Commenter: MINESH PATEL

8/25/25 2:53 pm

Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic [18

I am writing to express my support for the proposed changes. The word "clinical" excludes HIPAA, Human Trafficking, etc. from fulfilling the CEU credits.

As for face-to-face time, I am in support of this change with one caveat, if a member due to a documented illness inhibiting travel is unable to accomplish this requirement is allowed to meet the CEU requirements through on-line classes.

Thank you,

Minesh Patel

CommentID: **237036**

Commenter: Jennifer Walker

8/25/25 4:28 pm

Proposed Changes to CE

Our CE requirements, governed by the Virginia Board of Medicine, should remain consistent across professions, excluding topics like Substance Use Disorder and anesthesia, which do not

apply to our scope of practice.

I respectfully oppose the proposed change requiring any in-person continuing education (CE) for our profession. The assumption that provider isolation leads to potential issues—and that mandatory live CE courses would resolve this—is unfounded. In-person CE does not guarantee increased engagement, learning, or support, and for many, it creates a significant burden in terms of time, cost, and travel.

Many of us already practice in collaborative environments or actively participate in professional groups that provide robust peer support and ongoing dialogue—often exceeding the benefit of traditional live CE events.

I urge the Board to maintain flexibility in CE formats and avoid imposing unnecessary restrictions that do not demonstrably improve practitioner competency or patient outcomes.

CommentID: **237038**

Commenter: Mark Smith, DC

8/25/25 6:02 pm

Proposed statute changes regarding chiropractic continuing education

After reading the UVCA online share, some of the comments, the law, and the intent of the suggested changes, I would support the removal of the clinical requirement, but leave the 30 hour CEU's alone. We do not need to be mandated to attend in person and the current law does not prevent any one from getting their CEU's in person if they so choose. It is an individual choice and it should remain one and I am grateful that the current statute supports that.

CommentID: **237039**

Commenter: Brad VanDyke DC

8/25/25 7:19 pm

Strongly oppose the CE changes

I've practiced in rural Southwest Virginia for 33 years and rely on online CE due to long travel times and high expenses. Unlike those in larger cities, this was essential for me. Back when CE was only available by weekend seminars, I would have to travel 4 hours to Charlotte, NC because that was the closest. Occasionally, I could travel only 3 hours to Roanoke. Therefore, I strongly oppose the proposed changes.

CommentID: **237040**

Commenter: Tiffany Grace Adams, Tuck Clinic

8/25/25 8:47 pm

No change to CEU's for chiropractors

I am writing to strongly oppose any changes to CEU requirements for chiropractors. Requiring in-person attendance for any portion of our CEU's puts an unnecessary strain on both finances as well as time for many people. It causes a particularly difficult burden for those of us who are parents and would have to find childcare for a weekend away. There are no regulations prohibiting chiropractors from attending in-person seminars if that is what they wish.

The online platform allows us to get high quality and affordable CEU's with the much needed flexibility and decreased time out of the office. Please consider not changing the online format for our CEU's. Thank you.

CommentID: **237041**

Commenter: BRM - Tuck Clinic

8/26/25 9:53 am

No changes to CE's

I strongly oppose the changes proposed for chiropractic CEs. As a full time working mom, I don't have the time or resources to go away for a weekend or more. Online CE's are convenient, cost efficient, and high quality; and it offers flexibility and decrease time out of office.

Therefore, I am strongly against the new proposed changes.

Thank you.

CommentID: **237043**

Commenter: Lincoln German

8/26/25 11:21 am

Proposed Changes to Chiropractic CEUs

I support changing the CEU to allow non-clinical educational hours. As others have stated, there are many topics that are critical for the practicing chiropractor to remain up to date other than strictly clinical subjects.

I do not support requiring in-person hours. There are plenty of online programs from accredited chiropractic colleges and others that are excellent and allow practicing chiropractors the opportunity to get top-notch education in topics that they deem relevant to their practice. There is no evidence that requiring in-person CEUs will make the public safer or make a better chiropractor.

CommentID: **237044**

Commenter: Craig Bromley, DC

8/26/25 11:26 am

Proposed CE Changes

As a licensed chiropractor practicing in VA I am opposed to changes that limit completing C.E. requirements online. The online platform allows for ease of access to collaborative efforts of the highest quality and most relevant knowledge created by colleges and associations across the nation and internationally. To limit and not further encourage online learning creates a barrier to knowledge dissemination.

CommentID: **237045**

Commenter: Samantha Coleman DC

8/26/25 12:11 pm

Support for Amending 18VAC85-20-235 Chiropractic CEU Requirements

I strongly endorse the petition to revise 18VAC85-20-235 by eliminating the "clinical" requirement to continuing education requirement. I am also in support on mandating at least 15 of the 30 annual chiropractic CEU hours to be in person.

CommentID: **237047**

Commenter: Douglas Gold DC

8/26/25 12:26 pm

CE Proposed Changes opinion

I'm writing to share my interest in removing the "clinical" requirement for the 30 hours of CE and my disinterest in requiring "in person" continuing education mandates. I practiced in Florida when they required many in person CE's back in 2006 to 2010. Many chiropractors signed friends in or out and or spent their time on phones or laptops and didnt pay attention to the lectures and complained about being forced to spend extra time and money at mandated CE's. You cannot force people to participate just because you're in person. In person education is not necessary for the majority of CE's in our profession. Many people have different styles of learning and cannot pay attention to a full day or long weekend of classes. Online gives you flexibility to stop and start a class on your own time.

I'm for choice. We all did the necessary education "in person" hours required by our accredited Colleges and passed National Board Examinations just like medical doctors. I'd like the flexibility to choose online or in person education; not be forced to do one over the other. Florida no longer requires in person and part of reason is mandates don't work well. Just my opinion. I enjoy doing the occasional in person technique/hands on seminars but don't require us to do so.

CommentID: **237048**

Commenter: Thomas Genovese, DC

8/26/25 1:27 pm

Strongly Oppose Changes to CEU Requirements

I STRONGLY OPPOSE any requirement that would require CEUs to be done in person. If the Board were to make this change then it should be equitable and apply to all healthcare professionals in Virginia, not just DCs.

I do approve of the proposed action to remove the clinical component of the CEU requirement.

CommentID: **237049**

Commenter: Jennifer Sims DC

8/27/25 10:08 am

Oppose CEU changes

I fully support the importance of ongoing education and believe the opportunities to pursue courses which enhance and support our practices are essential. I also agree with the recommendation to remove the word "clinical" from the statute, and I recognize the value of including an ethics requirement.

However, I strongly oppose the proposed requirement that CEUS's be obatined "in person/live." Each doctor has a unique practice and personal circumstances, including family repsonsibilites, that make flexibility in continuing education critical. Dicataing the format of CEU's must be earned unecessarily limits access, reduces automony, and fails to recognize the diverse need of practioners.

Thanks for your consideration,

Jennifer L. Sims DC

CommentID: **237052**

Commenter: Anonymous

8/27/25 10:43 am

Chiropractic CEU/CME requirement

I think that the current set up specific to chiropractic CEU/CME requirements works very well the way it is.

CommentID: **237053**

Commenter: Jason Stugart, Belmont Chiropractic

8/27/25 10:43 am

No

I would cast my vote against this motion. I would like CE rules to remain the same.

CommentID: **237054**

Commenter: Gravity Spine & Wellness

8/27/25 10:50 am

NOT RIGHT...

Who's is going to manage the practice when going out to do seminars? Some of them are just way too expensive. Have to find a plane ticket and hotel for few CE hours? I have a business and two kids just like many doctors. It is way too difficult to perform all this. Again the live seminars are very market based...meaning they want your money and want you to continue to pay for next seminars. Learn nothing much.

CommentID: **237055**

Commenter: Kevin McDade

8/27/25 10:50 am

Do away with CE - it's a hindrance

Everyone knows CE is a formality. Just charge us the fee to renew the license. Let us pursue other things we want to learn, but no doctor out there is only remaining competent due to a CE requirement. Practice makes us better and adding tons of CE hours in no way protects the public whether its online or face to face. That said, if CE must be there, forcing it to be face to face only takes away from doctors' hours they could be helping people as it typically requires office closures. Online allows us to do it in small chunks on evenings with no practice disruption

CommentID: **237056**

Commenter: Robert B Berube

8/27/25 10:58 am

Opposition to Proposed Changes to Virginia Chiropractic CE Regulations

I am writing to express my strong opposition to the proposed changes to 18VAC85-20-235, which would remove the requirement for clinical continuing education hours for doctors of chiropractic and mandate that 24 of the 30 annual hours be in-person.

I believe these changes would be detrimental to patient care and professional development. Online continuing education provides an invaluable opportunity for chiropractors to access a broader range of high-quality, specialized courses from experts across the globe. This accessibility is especially critical for those practicing in rural areas or those with limited travel availability. Limiting

online learning would not only restrict our educational options but also increase the financial and time burdens associated with travel, lodging, and in-person course fees.

Furthermore, removing the clinical hours requirement would dilute the focus on direct patient-centered skills. Clinical education ensures that we remain current with the latest advancements in diagnostic techniques, treatment protocols, and patient management. These skills are essential for providing safe, effective, and evidence-based care.

The current regulations strike a necessary balance between various learning formats, promoting both theoretical knowledge and practical clinical application. I urge the Board to maintain the existing requirements, which support flexible, accessible, and comprehensive continuing education for all doctors of chiropractic in Virginia.

CommentID: **237057**

Commenter: Scott Shaw

8/27/25 11:01 am

no to in person CE requirements

Requiring in person CE requirements will limit the options Doctor of Chiropractic have when choosing CE classes. In such cases many DC's will have to attend classes that do not offer subject matter that is of importance to them. Online classes offer a much larger subject matter. In addition, having to attend seminars can be expensive and time consuming due to travel. In such cases it is often necessary to close our offices on a Friday and or Monday to allow for such travel.

CommentID: **237058**

Commenter: Anonymous

8/27/25 11:02 am

Disagreement on the petition for chiropractic CEU changes

Dear Members of the Virginia Board of Medicine,

I am writing to respectfully oppose the recent petition proposing a requirement that chiropractors complete 24 of their 30 continuing education (CE) hours through in-person attendance.

While I fully support maintaining rigorous CE standards for chiropractors, I believe this specific change would impose unnecessary burdens on practitioners without meaningfully improving patient care or professional competency.

I oppose this petition for the following reasons:

1. Accessibility and Flexibility Online CE provides flexibility for practitioners with busy clinical schedules, family obligations, or geographic limitations. Restricting the majority of hours to in-person formats reduces equitable access to education.
2. Quality of Education Online CE programs have advanced significantly, offering evidence-based content, interactive modules, case studies, and real-time virtual engagement. The educational quality is not inherently diminished compared to in-person sessions.
3. Cost Burden Requiring in-person attendance adds significant financial burden, including travel, lodging, and time away from practice. These added costs may disproportionately

affect smaller practices or rural chiropractors.

4. Consistency with Other Professions Many healthcare professions in Virginia and nationwide recognize the validity of online CE. Singling out chiropractors with restrictive requirements creates inconsistency and unfair disadvantage.
5. Public Health Considerations The COVID-19 pandemic highlighted the importance and effectiveness of online learning platforms. Continuing to allow all 30 hours to be completed online or in person respects this lesson and keeps the profession adaptive and resilient.

For these reasons, I urge the Board to reject the petition and continue allowing chiropractors to fulfill CE requirements either online or in person, with professional discretion to choose the most effective and accessible format.

Thank you for considering my perspective and for your continued dedication to ensuring high standards in chiropractic care within the Commonwealth of Virginia.

Doctor of chiropractic for 18+ years
CommentID: **237059**

Commenter: Dr. Christina Lowenthal

8/27/25 11:32 am

Limiting online CE's

I disagree with the submitted request to change the way a chiropractor retains their CE's. It should be up to the practitioner on how they obtain their them as long as they are completing the required number and type.

CommentID: **237062**

Commenter: Dr. J Howard

8/27/25 12:08 pm

Not in favor of rule change in regards to the way chiropractors obtained their continuous education

As a practicing Chiropractor in Northern virginia. I am not in agreement with the change to make 24 of our 30 education credits be in person only I believe this limits the chiropractor’s ability to decide how they receive their continued education. It should be the practitioners choice on how they obtain their CE’s. Please allow the chiropractor to make the choice if they want to obtain the continue education credits in person or virtually or a combination of both.

If a concern is ethics and boundaries issues when it comes to chiropractors, then make those hours be in person.

CommentID: **237063**

Commenter: Marco Accordo, Accordo Chiropractic

8/27/25 12:38 pm

Awesome Idea

I totally support this change and think it's a great move for the profession.

CommentID: **237064**

Commenter: Anonymous

8/27/25 2:06 pm

Strongly Oppose CE changes

As a practicing Doctor of Chiropractic in Virginia, I strongly oppose changing the continuing education requirements. If Doctors wants to complete their hours face-to face than that option currently exists. However, I find online continuing education very practical, applicable and appropriate to satisfy the current requirements.

CommentID: **237065**

Commenter: Ryan E. Hollingshead (Pro Adjuster Chiropractic)

8/27/25 2:38 pm

The proposed amendment to 18VAC85-20-235.

As a Chiropractor, and a busy one at that, I personally cannot afford to take off long weekends on a regular basis to attend in-person CE hours. Having the ability to complete my hours online is absolutely essential for my practice. Limiting online CE hours would also hurt the companies that provide these crucial services to doctors like myself. Most of the time the in-person CE courses are out of state, as the Commonwealth of Virginia has very few opportunities for in-person Chiropractic CE's. There are no Colleges for Chiropractic here, so I am then burdened with not only paying for the courses themself, but travel and hotel expenses as well. I understand that some Chiropractors want more collaboration between the many offices across the state, but this is not a viable option for myself and many others. Financially it is actually more detrimental to us, not only from the travel aspect, but because of the time we have to take off to attend them. Closing our offices to travel to these events then becomes a day of lost pay from not seeing our patients, and also effects their treatment plans.

Thank you for your time and consideration.

Respectfully,

Dr. Ryan E. Hollingshead

CommentID: **237066**

Commenter: Anna Bender

8/27/25 2:51 pm

Oppose proposed changes

I like the current requirements as it is flexible for all chiropractors needs. There are a lot of great online programs that I have taken in the past including radiology, ethics and recently the human trafficking training that have all been very informative and educational.

By limiting to in person only as counting towards the 30 hours, that seems very restrictive. Is this the trend in other states?

I REALLY enjoy in person continuing education and that is definitely MY preference, but there was a time when I had a baby and was not able to travel as much or get to in person conferences as much as I would have preferred. These special considerations need to be addressed and, as another commenter stated, if a person has an illness, it may be difficult for them to acquire all of their continuing education in a year. I also think about the administrative energy it would take to keep up with these exceptions.

CommentID: **237067**

Commenter: Robert McAleese

8/27/25 2:56 pm

Oppose amending 18VAC85-20-235

I do not support amending 18VAC85-20-235 to (1) remove the requirement that doctors of chiropractic obtain clinical continuing education hours and (2) require 24 of the 30 annual hours be in person, face-to-face.

Rationale: This will add undue financial burden on doctors for unnecessary travel, airfare, lodging, rental cars. The majority of medical professionals already complete their continuing education on line.

CommentID: **237068**

Commenter: Katherine Brus, DC

8/27/25 4:02 pm

Changes to CEU reqs in VA

After reviewing the proposed changes to CEU requirements in VA, I support the removal of the clinical requirement.

I do not support mandating all CEUs be acquired in person. This puts an undue burden on the practitioner with regards to expense needs to travel (hotels, car, etc). It is also limiting the knowledge that can be acquired to serve our patient bases. Not every topic is covered in person and in a location/timeframe that would suit. Being able to take online courses opens up many more opportunities to learn about topics that actually serve our patient bases instead of just completing a requirement.

CommentID: **237069**

Commenter: Donald Bresnahan

8/27/25 4:09 pm

Continuing Ed

I do Not want to change the Continuing education requirements to 24 hours face to face.

CommentID: **237070**

Commenter: Anonymous

8/27/25 4:19 pm

CE Requiremetns

As a practicing chiropractor, I see the value in CEUs to help ensure that we are keeping up to date on the most relevant data and practices for our profession and craft. Most of us are doing this,

however, without gaining CEU data just because we need to ensure we are up to date for insurances, billing and coding compliance, and ethically, it's the right and best thing to do.

With that being said, the proposed amendment to make 24/30 CEUs "in-person" is not something that I support. As a provider who spends much of their time outside of practice traveling to conferences to disseminate her own research and policy work, other state's CEUs do not always qualify for Virginia specifically. The requirement for making the CEUs "in-person" fails to articulate if these requirements need to be within the state boundaries, which I believe is the primary goal of many of my colleagues who are petitioning for this support. Keeping the CEUs in-person likely means chiropractors in the state will be more willing to attend the state-chiropractic organization's events, which leaves the organization to gain financially from this requirement. As a member of the state association, it's important to acknowledge this to avoid biases. Other in-person conferences that are outside of the state of Virginia will likely require additional administrative work to submit for such approval for CEU requirements with this new change, and instead will prioritize the state-ran conferences for proximity bias rather than what is the best quality or most-relevant for chiropractors within the state.

We also are in a moment where CEUs are quite accessible online. If this proposal were placed in the 1990s or early 2000s, when it was difficulty to obtain CEUs online or there was greater question of quality, this proposal may be more appropriate. However, without clear data indicating if online or in-person educational experiences provide greater value than the other, it cannot be said if it is better to have CEUs on line or in person. Instead, it's more logical to allow for physicians to have the choice to exercise their professional judgement on what courses will help them best in clinical practice, and improve on their own skills with the CEUs that best suit their needs, in the educational format that works best for them.

Compared to other states, I encourage you to look further at the following link which provides details by state of CEU requirements: https://fclb.org/chiropractic-licensing-boards.php https://chiropracticfuture.org/resources/road-to-practice/

All in all, I oppose the "in-person" recommendation for 24/30 hours.
CommentID: **237071**

Commenter: Susan Sweeten

8/27/25 9:18 pm

In person CEU erequirements

I am retired from active office practice and see patients for 10 hours or less every week. It would be a hardship if I have to attend CEUs in person. Please consider retirees or part time practitioners be excused from mandatory in person attendance. Thank you

Susan M Sweeten,DC

smsdc89@gmail.com

CommentID: **237072**

Commenter: Eric C. Scott, Scott Chiropractic

8/28/25 11:25 am

Do NOT force in-person CE for Chiropractic

In this ever-increasing, expense-riddled world, forcing travel, hotel fees and time away from the business to do in-person CE hours is terrible idea. We currently meet the VA Board of Medicine requirements via online hours, which saves considerable time and money. Not all of us have multiple offices employing multiple doctors. I **am** my practice, so time away detracts from patient care, not to mention practice income.

Thank you,

Dr. Eric C. Scott

CommentID: **237075**

Commenter: Anonymous

8/28/25 12:20 pm

Petition for Rulemaking

The current continuing education requirements for Chiropractors are sufficient. By mandating that they be in person adds a financial burden on those doctors who have to travel enough of a distance that would require them to close their office, buy a plane ticket, have rental car expenses, pay for a hotel and meals, etc., all without gaining any additional knowledge or skill.

The economic ramifications of this change could be detrimental to a small practice. A third of chiropractors are women and the average age of a chiropractor puts half of those in what is referred to as "the sandwich generation." They are working/running a practice, taking care of children and their elderly parents. There is always an option to attend in person, however, making it mandatory is a burden not all can bear.

I strongly oppose this change. If my name and email were not made public, I would have included that. There should be an option to leave contact information without allowing my personal information to be made pubic. Thank you.

CommentID: **237076**

Commenter: Anonymous

8/28/25 12:30 pm

Who is Dr. Foley?

Who is Joseph Foley, DC? Does he sit on board of any type, or is he a chiropractor that thought things should be changed?

CommentID: **237077**

Commenter: Christopher Ubert, Creekside Chiropractic

8/29/25 4:19 pm

This is a terrible and baseless idea.

The author of this petition does not provide any data to support any of his suppositions that this new requirement will benefit isolated practioners, the profession, or that even identifies isolated practicioners as more "at risk." He even states that this is just his "belief."

In this ever increasingly automated world the training and continuing education content one has access to remotely is vast and of high quality. Many of us practice very differently and so the many choices of courses online can help one to focus and continue to build on established skillsets or be exposed to other new keen interests.

In-person continuing education is very limited. There just aren't that many that come to the state of Virginia or even nearby states and the topics/content can be irrelevant to individual practices or the

same old class coming round one more time. This form of CE is incredibly expensive, both in time and money. Time away from our families and our patients. This is also wasteful from an ecological perspective. Why involve planes, trains, and automobile travel, all of which aren't without personal risk and environmental emissions. The presenter pays huge fees to the hotel to use the space for the class, the cost of which is passed onto the docs who are already paying $200 plus per night for a hotel room. A doc from hours away often has to arrive early and cover an extra night's expense and then food expense as you are trapped for few days eating and paying for restaurant meals.

No disrespect to Dr. Joe, I am certain his sentiment is toward better connectedness of the chiropractic community, but this concept is fraught with inefficiencies and is taking a giant leap backwards as the world of tech keeps advancing our abilities to conquer the minutia of daily life remotely and with less expense. With all of the ways to connect and form community online it has actually never been more difficult to be isolated.

Please vote no and keep us firmly rooted in the 21st Century.

Christopher Ubert, D.C.
CommentID: **237078**

Commenter: Anonymous

8/29/25 5:58 pm

Opposed

As many other chiropractors have eloquently stated: in-person CEs create extreme financial duress. Most chiropractors are still hundreds of thousands of dollars in debt from our chiropractic school education and in-person CEs are exorbitantly priced including the cost to travel, pay for accommodation, etc. It is vastly preferrable to have a greater variety of CE classes and subjects to pick from online and to be able to complete our classes when we have availability.

I have a son with profound disabilities. It is all I can do to work full-time, complete CE requirements, and take care of him. There is not nursing assistance or childcare available for in-person CE classes, so I would be forced to terminate my license due to this arbitrary idea.

CommentID: **237079**

Commenter: Tarek Sayed Elganainy

9/1/25 12:34 am

Oppose removing virtual CEC option, agree with removing requirement for only clinical type CEC

Dead Board members;

I oppose the removal (or adding restriction) of the ability to obtain CEC virtually. All others professions allow it and it serves a huge benefit of decreasing travel, fatigue, delays, cost, time away from office, and time away from family.

I am also not aware of the problems sited as the reason for the suggestion. I asked for data and received none. I am also not sure that the remedy is to "punish" or force the whole profession to attend in person seminars. I am not sure if that solves the problems mentioned. Perhaps a more focused approach to address the people who commit ethical violations is more appropriate.

I support the removal of restriction that the 30 hours of CEC have to be clinical. This will allow more people to attend practice management, ethical, or liability CECs.

Thank you for your time

Tarek Elganainy, DC, DACNB

CommentID: **237080**

Commenter: Anonymous

9/2/25 12:05 pm

CEUs

Dear Board of Medicine Members,

I am writing you all today in order to show support to having the clinical stripped from the CEU clause. We have other non-clinical (non-hands on training) that we need to support our clinics and make sure that our patients are getting the best quality care possible, i.e. ethics, sex trafficking, etc.. Ideally, I wouldn't mind making us have slightly more CEU's to accommodate the other phases of practice.

I am also writing to oppose the in person CEU requirement. I do not believe that there should be one as we are and have been trying to be equal to the other Practitioners of Medicine in this state for a long time. Why add something that will make us further from that.

CommentID: **237082**

Commenter: Anonymous

9/3/25 3:19 pm

Opposed

Changing the hours to largely in person hinders the ability for some providers to seek quality courses due to cost for travel on top of courses. Having virtual options has opened the availability to obtain hours while maintaining a better work/life balance as well as lowering cost to provider without sacrificing education

CommentID: **237083**

Commenter: Dr. Chris Perron

9/8/25 9:11 am

CE Credit Changes for Doctors of Chiropractic

In reviewing Dr. Foley's proposal as well as the changes at the state level already reducing the CE hours in half and getting rid of Type 2 hours I am submitting comment for the BOM to consider as they determine what is best.

I strongly urge the removal to the term "clinical" that is place only on the hours of the Chiropractic profession at this time to make it in line with our peers of other degree specialities. This is an unnecessary burden placed on one group, even if unintended at the time the regulation was created.

I recognize that the BOM has been tasked with reducing the burden on providers but I do agree with there being an in-person requirement for part of the hours required. I do not agree with the rationale submitted by Dr. Foley that mental health is a primary reason or even much of a reason although I understand his point. This applies to a small fraction of practitioners for which the rest should not be burdened.

However, chiropractic is a very unique profession in that at its core it is a hands on practice. The public deserves providers to be at the top of their game for the most effective treatment as well as public safety. Chiropractic adjustments cannot be reviewed or improved in the solo office, as most

chiropractors are, or online. There is a "touch" and an art to a chiropractic adjustment. This needs to be reviewed and improved in person with peers and educators. Having no in person needed would allow a practitioner stop learning at the moment of graduation for school. To think their skills will have peaked at this point is clearly not ideal. To also think that an individual practitioner will figure it out with their own patient experiences is also short sighted. It assumes that the practitioner already knows what they are doing at and there is no need for review or advancement. I have served as an instructor for over 20 years and I can report that in person is necessary, for the sake of the patients we serve.

I believe that the BOM's primary role is to protect the public and in this light I propose that a requirement of 15 hours per two year be required to be in person. This allows the doctor to meet this requirement in just one day per year. One day per year is not a significant burden, in my opinion, and if it is then those would the doctors whom I suggest could benefit the most, and more so the patients they serve.

Being a licensed doctor is a privilege and carries with it a responsibility. I do not believe that this regulation should be to the convenience of the doctor at the potential risk to the patients. And if the counter argument is that doctors will just be responsible enough to do this on their own anyway, I view my proposal as no burden at all.

I see this as protecting patient care versus doctor convenience.

Thank you for your time and effort!
CommentID: **237086**

Commenter: Dr Robert Pinto

9/8/25 1:44 pm

In favor of in-person; opposed to clinical

I believe that, Chiropractic, as a profession that uses a hands on approach to patient care, it is imperative that we keep a component of in-person learning. Online Continuing Education cannot approach the efficacy of learning new skills and perfecting current skills. Chiropractic techniques are tactile and motor skill dependent which is difficult to master in a remote learning enviornment.

I feel that being surrounded by other practioners fosters discussion, exchange of clinical insights, and collaberation. Exposure to different practice styles broadens perspective.

Over my career I have done both in person and remote learning and feel that the focused time that one gets from in person and the lack of distractions from being at home or in the office leads to stronger retention. It has been shown that the kinesthetic component of in person learning activates different memory pathways compared to passive learning.

I have read the arguments against the in person requirement and nearly all are focused on the hardship on the practitioner but I believe the continuing education requirement is and should be for the betterment of the patient interaction and further the safety of clinical interventions which, from my perspective, are far superior with an in person requirement.

Lastly I feel strongly that the Clinical requirment should be dropped as there are many avenues that are for the improvement of the patient interaction that are notspecifically "clinical".

Regards,

Robert M. Pinto, DC

CommentID: **237088**

Commenter: BZ

9/8/25 2:46 pm

Proposed CE changes

I fully support decreasing the required CE hours to 30 every 2 years and taking 'Clinical' out of the requirement for the 30 type1 hours of Chiropractic CE. I believe this would limit our expansion of being a fully rounded healthcare provider to the general public and our peers.

I fully oppose forcing Chiropractors to obtain any CE's in-person only. I think there are good reasons to do in-person CE's, but that should be up to the individual to decide what's best for them. Forcing in-person CE's takes our freedoms away, and I believe our profession is better than that. It additionally is very burdensome on the practitioner, their families, and financially.

Thank you for the opportunity to comment on these issues.

CommentID: **237089**

Commenter: Joe Cantu

9/9/25 11:12 am

Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic [18

I believe that the CEU requirements proposed by the BOM and as well as the use of the term "clinical" in the subject of those hours should be equal across all professions that the BOM regulates and should not be different for Chiropractors compared to our allopathic colleagues. Although chiropractic is a unique type of healthcare, the public should rest assured that our professional requirement are on par with other physicians in the commonwealth. Furthermore, if CEU's are allowed to be obtained partially or fully online for other healthcare professionals, the regulation should be the same for chiropractors. In person or virtual choice should be left up to each individual practitioner.

In conclusion, I feel the CEU hours of 30 hours every cycle renewal is acceptable. I am opposed to changing that 24 of the 30 hours be mandated to be in-person, specifically if you are a chiropractor. No matter how well intentioned this suggestion is, it does not mean that the majority are in favor of this. Not to mention that this change does not cut, eliminate or downsize regulatory and legislative burdens.

Furthermore, I am for changing the term "clinical" hours being required for chiropractor's, if that is not a requirement for other healthcare professionals regulated by the BOM. The type of CEU allowed may not be clinical, but nonetheless relevant to the safety, health and well-being of the community and should not be discouraged by the BOM.

CommentID: **237091**

Commenter: Carly Swift

9/9/25 1:56 pm

In person hours

In reviewing Dr. Foley’s proposal, along with the recent state-level changes that already cut CE hours in half and removed Type 2 hours, I want to share my perspective for the BOM’s consideration.

First, I support the reduction of overall hours, but I strongly believe chiropractors should be required to maintain some hands-on CE. Chiropractic is, at its core, a hands-on profession. Patients deserve providers who are continually sharpening their skills for both effectiveness and safety.

I urge the Board to remove the word “clinical” as it applies only to chiropractic CE at this time. Singling out our profession in this way, when our healthcare peers are not held to the same

language, creates an unnecessary burden. I understand the BOM is tasked with reducing burdens on providers, and I support that mission.

Here's the reality: chiropractic adjustments can't be refined alone in an office or through a computer screen. There is a touch, an art, and a nuance that requires live feedback and peer-to-peer interaction. Without in-person training, many doctors would essentially stop developing the day they graduate. That's not only shortsighted, it's risky.

That's why I propose requiring **15 in-person CE hours every two years**. This can be completed in just one day per year. One day is not an undue burden, and if it feels like one, those are likely the doctors who need it the most and more importantly, so do their patients.

Being a licensed chiropractor is a privilege that carries responsibility. Regulations shouldn't bend toward maximum convenience for doctors if it risks patient safety. Protecting the public is the BOM's primary role, and I believe this balanced approach honors that mission.

Thank you for your time and for considering this perspective.
CommentID: **237092**

Commenter: Anonymous

9/9/25 2:57 pm

Potential Rule Change

This proposed change is unfair an unreasonable. It would close practices more and take us away from patient care which is the most important. This is not expected of any other types of doctors and I feel this is predatory and unfair.

CommentID: **237094**

Commenter: Christine M. Stewart, DC

9/10/25 9:15 am

OPPOSE IN-PERSON CEU

I strongly oppose in-person CE requirements for chiropractors. Providers should be able to choose the format that suits their learning styles whether online or in-person. There is no evidence to suggest that in-person CE hours improve the public health and safety of our patients.

Also, this is not required of any other medical professional, including surgeons.

I do approve of the proposed action to remove the clinical component of the CEU requirement.

CommentID: **237098**

Commenter: Kimberly Chernichky, D.C.

9/10/25 9:25 am

Strongly Opposed

My understanding is that the proposed amendment to our CEU requirements are to prevent isolation, as well as maintain high standards to keep our providers out of trouble, as was stated in the email we received a few weeks ago from Dr. Foley.

Bad providers exist in every profession. This remains true, regardless of the setting they practice in, opportunities for connection, as well as their requirements for CEUs. As noble as the intention is, modifying CEU requirements simply will not weed out bad chiropractors.

Respectfully, connection and fighting isolation is not the purpose of a CEU. A CEU is intended to expand upon our knowledge and skill base to promote clinical excellence. Connection should be encouraged through local gatherings by profession-specific and locality-specific groups (for example the UVCA).

As many of the other commenters have stated, a requirement for in-person CEU credits will only prove to be restrictive for many in practice. In my personal experience, there are not adequate in-person CEU opportunities within reasonable distance within my specialty (pediatric and prenatal). This would require me to travel, which means significantly more time and money, as well as time away from my family. In a two-chiropractor household, with young children and no family to help care for them when we are away for continuing education, this would be absolutely debilitating. Potentially even career-ending.

The current set up of CEU requirements allows my husband and I to grow in our field while continuing to serve our community as well as our family. Please do not take this away from families who are trying to grow, serve in their community, and not burn out in the process.
CommentID: **237099**

Commenter: Mark Smith, DC

9/10/25 10:18 am

No need for in person ceu's

We do not need to be mandated to attend in person and the current law does not prevent anyone from getting their CEU's in person if they so choose. It is an individual choice, and it should remain one and I am grateful that the current statute supports that. There is no obvious problem that I am aware of that would be helped by mandating in person CEUs. Every chiropractor has different interests, and we all pursue them unhindered and that is how it should remain.

CommentID: **237100**

Commenter: Anonymous

9/10/25 10:44 am

No to in person hours for chiro

I am opposed to this as a chiro practicing in Va since 2009.

CommentID: **237101**

Commenter: Jason kennedy

9/10/25 10:45 am

Proposed changes to Chiro CEU

Opposed to in person mandate

CommentID: **237102**

Commenter: Sara Miller, D.C.

9/10/25 10:47 am

Opposed to requirement of in person CEUs

I am opposed to changing CE requirements for chiropractors to force in person attendance for CE. First of all, no other VA Board of Medicine licensed professional group has this requirement and Doctors of Chiropractic (D.C.s) should be afforded the same level of respect and autonomy as to whether we obtain CE in person or online. Second, Governor Northam's initiative to cut, eliminate, and downsize the Board's regulatory and legislative burdens would be undermined by changing

D.C.'s requirements to in person CE. Third, requiring in person CE, can be detrimental to patient care when a D.C. has to close the office to travel and/or attend in person seminars. Finally, if in person attendance had been a requirement in 2020-2021, during a global pandemic, public safety could have been affected by forcing D.C.s to travel and interact with large groups of people, then return to close contact with staff and patients.

I am, however, in favor of removing the "clinical" content requirement for D.C.s CE. This is a positive and long overdue step. Removing this restriction aligns our profession with others, promoting parity and fairness. No other VA Board of Medicine licensed professional group has this "clinical" requirement for CE.

Thank you for your consideration.

CommentID: **237103**

Commenter: Stephanie Blackton, DC

9/10/25 11:28 am

Online classes are more conducive to learning and retention for most subjects.

Thank you for your time. I was surprised to see that Dr. Foley made no mention of why he feels that in person CEU's should be a new requirement, unique to the chiropractic profession. To expand my understanding, I've been reading comments from other doctors both for and against this change and appreciate the discussion.

Dr. Mark Shaye made an excellent case for continuing to allow online hours as an option. I agreed with everything he said. For those that want to take in-person classes, that should remain an option.

Before online learning was a possibility I earned my all my CEU's in person. And while there is merit to some in-person classes, especially technique classes, they have their limitations too.

Glitches in AV equipment, delayed flights / tired presenters, distracted colleagues, vendors competing for my interest, and the stress of travel affecting my ability to be at my best, fully present in the class.

In my experience, I have found I am actually able to learn better in online classes. I have chosen when to take the class. I choose a time when I feel rested and ready to learn. I can pause, rewind, take better notes and use my internet search functions to expand my understanding at my own pace. I can repeat the entire lecture. And I retain more.

Additionally I can choose from a wide catalog of courses that meet my needs, as opposed to what might be available at a particular weekend event just to meet my required hours. I have access to experts from all over the country who have created a polished presentation. I am getting them at their best.

Most recently I took an excellent online class on osteoporosis at a time when I needed access to that information. Because I came to the class with questions, I was even more engaged in hearing the answers. I was able to take screenshots of the slides I was most interested in and I can refer back to, again and again. And I can easily share this information with patients.

I don't think it's remotely fair to say that meeting in-person is a better option and should be required. In my experience, online classes are far more conducive to learning and retention than in-person classes for almost all subjects. And for those exceptions, that warrant an in-person experience, that will still be an option.

I am opposed to mandating that any in-person hours be required leaving the choice up to the doctor based on the subject of interest.

Thank you for your service to the health profession.

Sincerely,

Stephanie Blackton, DC
CommentID: **237104**

Commenter: Dr Christopher Bruno

9/10/25 11:36 am

CE Changes

I would like to say that I approve the Virginia Board of Medicines adoption for the new CE rules and requirements. I find it much easier to find an online seminar that interests me and my clinical interests as well. There are so many that have come to light in the past few years that finding an interesting topic is very easy to do and I can do it late night at home or during lunch in my office.

Thanks

Dr Bruno

CommentID: **237105**

Commenter: Patrick Caiafa

9/10/25 11:42 am

CE online

I am opposed to reducing online requirements for CE. I believe that allowing doctors to decide to do in person or online should be their decision. Its very convenient and very much cost effective to do online training. I understand the value of in person classes with hands on components, however for other types of CE classes I believe online is an invaluable resource.

CommentID: **237106**

Commenter: Tara Bath, DC

9/10/25 11:44 am

Opposed to in person CEU

As a parent I would need to arrange child care, change office hourse for traveling (loss in revenue) , and then the financial burden of travel expenses on top of the actual class itself. This would force me to take classes that may not benifit my practice or stregthen my knowledge of anything if I am foced to find a weekend that works for my family and then what would be affordable at that time. This does not mean I have not done in person classes at all, just means I have more freedom to choose when I might be able to do so and find classes that would benifit myself and my patients. I have learned a great deal online classes, it allows me to pause to take notes, rewatch segments I may not of understood the first time or grasped, and allows me to have direct contact to ask questions when I think of them. Everyone has different learning styles and we should embrace that, being stuck in a convention all for 8 hours a day sitting still is not how I am able to focus. If it is a hands on technique then yes I am in person, but not things that benifit our profession needs to be hands on. If this becomes a new rule it should be across the board. We are under the board of medicine then it should be everyone who licensed with the board then should have to do their CEUs in person and not be singled out.

CommentID: **237107**

Commenter: Robert Egan DC

9/10/25 12:07 pm

cont ed for chiropractic

I support removing the requirement that Doctors of Chiropractic obtain a specific number of clinical continuing education hours. This change allows us, like our fellow primary care colleagues, to choose education most relevant to our practices and patients.

However, I oppose the requirement that 24 of the 30 hours be obtained face-to-face. Such a high number restricts access to diverse topics, increases time and cost burdens, and is inconsistent with the continuing education standards of other Virginia medical professionals. Online education provides flexibility and equal quality, and our requirements should remain consistent with our primary care peers.

Thank you for your consideration.

CommentID: **237108**

Commenter: Lola Capps

9/10/25 12:12 pm

Opposed

I am opposed to in person CEUs. in the last several years and the last five especially online continuing education has become a very valuable resource. The quality, quantity and variety of CEU's is by far a much better option for continuing to learn. Well, in person, CEUs are wonderful at this point there does not seem to be an advantage for needing to be in person.

thank you for considering my comments.

Lola Capps, DC

CommentID: **237109**

Commenter: Dr Michael Seery

9/10/25 12:14 pm

ridiculous to have in person only CCE

It has been obvious throughout my 28 year career that chiropractocrs have been constantly fighting for ther right to practice , reimbursemet and refferals. this is another attempt to restrict and hurt our profession and it for only chiropractors it is apparent that this is another attempt to hurt the profession. discrimatory at very least this should not even been considered. I am admantly against this.

CommentID: **237110**

Commenter: Michael Vanella

9/10/25 4:42 pm

opposed

I respectfully oppose the amendment to chiropractic continuing education that removes the clinical component and mandates face-to-face delivery. Chiropractic is a hands-on, clinical profession; eliminating defined clinical/skills hours risks skill decay in assessment, adjusting technique, clinical

decision-making, and risk recognition—concerns that are amplified for pediatric and prenatal populations. Public safety is best protected by competency-based CE with measurable outcomes (case exams, OSCE-style checklists, simulation check-offs) rather than by weakening the clinical requirement.

A blanket face-to-face mandate is unnecessarily restrictive and does not guarantee higher quality. It raises costs, disrupts care for solo and rural clinicians, and limits access for those with caregiving responsibilities or disabilities, while reducing resilience during weather or public-health emergencies. High-quality hybrid and online formats can deliver rigorous interaction, feedback, and proctored assessment. I urge the Board to retain a minimum number of clinical/skills hours each cycle and allow multiple delivery modalities that meet clear accreditation and assessment standards—focusing on outcomes, not venue.

CommentID: **237114**

Commenter: Daniel Kim

9/10/25 5:42 pm

Oppose

I strongly oppose any requirement mandating that CEUs be completed in person. If the Board were to implement such a change, it should be applied equitably across all healthcare professionals in Virginia, not solely to DCs.

CommentID: **237117**

Commenter: Chak H Chong, DC

9/10/25 6:50 pm

Oppose the change

I strongly oppose the proposed in-person only CEU requirement. It's inconvenient, costly, and limiting. Most of all, making more restriction to DCs is unfair. Mandating attendance in person undermines accessibility, affordability, and equity in continuing education.

CommentID: **237119**

Commenter: David Capps

9/11/25 7:10 am

Oppose

I oppose the changes to require in person continuing education requirements. The requirement would be costly and inconvenient. Doing so also unfairly targets our profession and not all healthcare professionals as they would not be held to the same requirements.

Thank you.

CommentID: **237123**

Commenter: Anonymous

9/11/25 10:35 am

Proposed Amendment to Chiro CE

I'm writing to share my perspective on the recent chiropractic CE petition. After reviewing the materials, here's where I stand:

I support removing "clinical" from the statute. As practitioners, we need CE flexibility beyond just clinical topics—risk management, documentation, HIPAA compliance, and ethics are all essential to running a safe, compliant practice.

However, I am opposed to requiring CE to be in-person only (or sharply capping online hours).

Many excellent online live stream/on demand programs come from accredited institutions and often provide better learning outcomes through replay and review capabilities.

Also, in person CE would limit us to what's offered on a given weekend not what would make us a better practitioner. The added burden of travel, lodging, and time away from practice hits smaller practices especially hard.

I'd encourage the Board to maintain the current flexibility, allowing us to choose between online and in-person CE based on what works best for our practices and learning styles. This professional discretion has served our profession well and ensures we can all stay current without unnecessary barriers

Thank you for considering my input on this important issue.
CommentID: **237124**

Commenter: Dr. Theresa Graf

9/11/25 12:35 pm

Proposed CE changes for chiropractors

I am adamantly opposed to the proposed change that would require all CE hours for chiropractors to be completed in person. This proposed change would only apply to DCs while the remainder of the professionals licensed by the Board of Medicine would still be allow to do their CE remotely. For the large number of DCs who are solo practitioners or operate small practices with one or two doctors, requiring all hours to be in-person may present a financial hardship for them and decreased availability for their patients. There are many, many things chiropractors can, and should be staying up-to-date on, ie newest research on many of the complaints our patients present, that can be done remotely and not impact patient treatment hours. Furthermore, setting a different standard for DCs than for all other professions licensed by the Board of Medicine is unreasonable. What is the benefit of increasing the burden on one profession?

I do, however, support removing the "clinical" requirement. As mentioned before, a large number of DCs in the state not only practice chiropractic but they are also running small businesses. CE hours pertaining to business ownership, customer service and employee management strategies are important as well.

CommentID: **237126**

Commenter: Dr. Bradley Richmond

9/11/25 3:06 pm

Oppose

I oppose the proposed change that would require all CE hours for chiropractors to be completed in person. Having a different standard for DCs than other medical professionals licensed by the Board of Medicine is unfair and unreasonable.

CommentID: **237128**

Commenter: Rebekah Liberty, DC

9/11/25 5:15 pm

Yes to 1, no to 2

Agree with reducing the number of hours, strongly disagree with requiring in person CE

CommentID: **237129**

Commenter: Shawnté Hudgins DC

9/11/25 5:53 pm

No forced in-person CEs

I am a solo practitioner. Time attending in-person classes will greatly affect my practice and my patients. Forcing in-person CEs, and all that comes with it (travel, accommodations, etc) would be a detriment to many businesses, including mine. My recommendation would be to keep it as an option for those who desire it, but make it non-mandatory.

CommentID: **237130**

Commenter: Lisa Griffith

9/12/25 6:11 am

Opposed to in person CEU requirement

Although I enjoy in person trainings and prefer them, they can be extremely cost prohibitive and challenging to get all required hours with. Being able to do some or all hours online is extremely helpful and opens up a wider scope of topics we can learn about. During times where I had a young baby and the pandemic, online CEUs were such an incredible asset to be able to utilize to fulfill my requirements as travel was nearly impossible. I am opposed to solely in person CEU's being required as that is quite restrictive to our opportunities to learn.

CommentID: **237131**

Commenter: Natalie White

9/12/25 7:34 am

CE Requirements Chiropractors

I am NOT in favor of the bill being presented to require in person CE requirements

CommentID: **237132**

Commenter: kc

9/12/25 11:19 am

CEU changes

Thank you for the opportunity to participate in this dialog. I am in favor of the 30 CEU's for license renewal every 2 years. Opposition is expressed with the **mandate** of 24 of the 30 hours being in-person. This is a personal choice. The word "clinical" can be removed.

Thank you for your consideration.

CommentID: **237133**

Commenter: Sam Spillman

9/12/25 2:14 pm

Opposed

While I can appreciate the sentiment behind this petition, I feel that it would discourage chiropractors from engaging in any online education because it “wouldn’t count.” While in person courses can be excellent, there are lot of excellent online courses available to us from experts that we might not otherwise have a chance to learn from. Because of that, I oppose this measure.

CommentID: **237134**

Commenter: Dr. Todd Fichtel, D.C.

9/12/25 3:03 pm

Opposed to In-Face Continuing Education Requirements

Hello,

I am responding to the proposal that Chiropractors in Virginia be required to meet face-to-face for our continuing education. I have been practicing chiropractic for approximately 35 years and have been licensed and practiced in 3 states during that time. I have had to complete continuing education for each of those states and had to meet the various state requirements for each. I feel that the current requirements for Virginia are perfectly suited to keep a chiropractor licensed in Virginia to be completely competent. I also feel that with the ongoing electronic improvements in computers and video conferencing, etc. it is rather archaic to make in-person or face-to-face learning a requirement. Basically this would be forcing our profession back about 20 years.

Furthermore, anyone in my profession that proposes this change is allowed to take ALL or ANY of their courses in person or face to face. I am also slightly concerned that efforts to make chiropractors meet face to face may be motivated by concerns that our annual convention is seeing less and less attendance and that this might threaten certain individuals who might have concerns about the future of our State Association. Their concerns of self-preservation should in no way influence what laws go into place for our entire profession. I do think that my peers do believe that their efforts are justified and that they are morally trying to do what is right in their opinion, however my opinion still stands.

Therefore, please take my words into consideration and mark me down as opposed to changing our continuing education requirements.

Sincerely,

Dr. Todd Fichtel, D.C.

CommentID: **237135**

Commenter: Bill Asimacopoulos, D.C.

9/12/25 7:39 pm

Opposed!

Absolutely ridiculous that you would require doctors, who have undergone rigorous schooling and clinical work, to require face to face CE. Years of clinical experience in care of patients from day to day is enough real world face to face.

CommentID: **237139**

Commenter: Katrina Mayes, Quintessential Chiropractic

9/12/25 8:37 pm

Support removing clinical requirement; Oppose in-person requirement

The regulations for chiropractors' CE hours should mirror that of our fellow governed professions, especially since statistics demonstrate we are significantly less likely to cause harm to a patient in the normal course of our professional duties. In person hours can be quite beneficial for learning a new adjusting style; however, we have been through all the education required to get a degree and all of the testing required to obtain a license. We then go into practice, where we do our jobs day in and day out, constantly learning in real time as we help people return toward proper health. We are also financially responsible for ourselves, our staff and our families; time is a valuable commodity to the small business owner and we always need more than we have to use. Requiring that our continuing education be in a specific place or on certain topics is presumptuous as we do not fit one mold. I practice an instrument-based technique in a hybrid mobile setting and don't take insurances; my educational needs are wildly different from a manual adjuster with multiple brick-and-mortar offices who sees Medicare patients. We should be allowed to pursue relevant topics that interest and provide value to us as well as our patients.

CommentID: **237140**

Commenter: Chelsea McLane

9/13/25 3:02 pm

Opposed to in person CEUs

I am opposed to in person continuing education. While it is nice to have in-person meetings most of them are not offered anywhere close to where I am. I would be extremely difficult with my work schedule and finances to have to travel for the majority of continuing education. Please do not make this a requirement.

CommentID: **237141**

Commenter: Nathaniel Tuck, DC - Tuck Chiropractic

9/14/25 3:32 pm

Strongly Against Proposed Changes

I am strongly opposed to increasing the requirements for in-person CE. While engagement may be greater in-person, has our profession experienced issues with the way CE has been handled previously? To my knowledge, it has served us well, and these proposed changes would place unnecessary strain on chiropractors across Virginia.

As a chiropractor practicing in Southwest Virginia, I can attest that local in-person opportunities are limited, which means added time, travel, and expense to meet these new requirements.

I appreciate the ongoing efforts to elevate our profession as a whole, but I believe more collective input and discussion are needed before implementing such changes in the future.

CommentID: **237144**

Commenter: Adam J. Keefe,D.C.

9/15/25 11:59 am

Opposition to Proposed Mandate of in-person CEUs for Doctors of Chiropractic

I am writing to express my opposition to the proposed requirement mandating in-person attendance for continuing education (CE) for Doctors of Chiropractic (D.C.s).

First, no other professional group licensed by the Virginia Board of Medicine is subject to such an in-person CE requirement. Chiropractors should be afforded the same professional autonomy and respect in choosing whether to complete CE online or in person. Imposing this requirement exclusively on D.Cs creates an unnecessary and inequitable distinction among the Board's licensees.

Second, this proposal would undermine the prior Governor's initiative to reduce regulatory burdens for licensed professionals. Increasing restrictions on how chiropractors fulfill CE obligations moves in the opposite direction, adding complexity and inconveniences rather than reducing barriers.

Third, requiring in-person CE can disrupt patient care. Many D.C.s operate solo or small practices and mandatory in-person CE often requires travel and would necessitate closing the office directly limiting patient access and continuity of care.

Finally, the COVID-19 pandemic underscored the importance of flexible, remote learning options. If in person CE had been required during 2020-2021, it could have jeopardized public safety by forcing providers to travel and interact in large groups, then return to work in close contact with patients and staff. Maintaining online CE options is both a public health and professional best practice.

That said, I do support the proposed removal of the "clinical" content requirement for chiropractic CE. This change is long overdue and brings our profession into alignment with others under the Board's jurisdiction. Removing this restriction promotes fairness and professional parity across licensed healthcare providers in the Commonwealth.

Thank you for your time and thoughtful consideration of these comments.

CommentID: **237149**

Commenter: Jordan Speares

9/16/25 1:16 pm

Opposed to solely in person CEU's

I am opposed to changing the requirements of CEU's to be solely in person. In person options, although beneficial, can be cost prohibitive and limit topics/classes providers can take. The option to take CEU's online allow providers to fit learning time into their busy work and family schedules. Online CEU's continue to promote learning in a way that is convenient for the provider. I am opposed to solely in person CEU's being required.

CommentID: **237156**

Commenter: Anonymous

9/19/25 1:24 pm

Opposed to proposed changes

I am opposed to both portions of the proposed changes.

The recent changes to the number of CE hours required (along with other changes) were made in an effort to reduce the barriers to licensure, and requiring in-person CEs would significantly increase the barriers for many, particularly in our profession. It is well known that we are not in hospitals but often in very small practices without the ability to take time off to attend conferences, etc. Not to mention, we make FAR less money than the medical doctors Joe Foley was comparing us to, we make a fraction of what they make and adding additional financial liability to us, just so we can remain in practice is creating a barrier which may push some out of practicing altogether.

Online hours also allows us to learn from individuals on the other side of the country, it is moving us forward as a profession (and a state), and may help keep people practicing longer which is something we should support and encourage.

As far as the argument of "we are a hands-on profession," so is nearly every other medical profession, meeting in a conference room and watching and listening to someone isn't significantly difference than watching it online. If someone prefers in-person hours, they are welcome to do that, but everyone should have the choice, we should be reducing barriers to encourage people to continue practicing and even come to VA to practice.

Several mentions were made in the UVCA email about practitioners practicing "in isolation." Many are connected with various colleagues even around the world, because of the internet and the ability to take courses, create groups, and meet online. Many of us are far from isolated, but instead are extremely connected with colleagues around the world, something that being forced to meet in-person, would take away. Comparing 2025 to the 1980's is ... just not reasonable (many practicing now weren't even alive in the 80's!). There are many ways to connect with people that do not involve forcing people into a room, going through motions just to keep their license. This isn't how we move a profession forward. It is also important to remember that many of us have specialized in various ways and in-person would not be possible unless we traveled the entire country. It's also important to remember that because of COVID, many conferences offering CEs have moved to being only online.

In reference to the word "clinical," in the email from UVCA, Joe states, "There are many important topics for the doctor of chiropractic to keep updated on that are not clinical in nature, such as HIPAA, No Surprises Act, Ethics and Boundaries, Human Trafficking etc."

First and foremost, appears as though there may be a misunderstanding as to what the word "clinical" means in "*1. Type 1 hours in chiropractic shall be clinical hours that are approved by a college or university accredited by the Council on Chiropractic Education or any other organization approved by the board.*"

I had always assumed that Type 1 hours were ones that were approved by a college or university accredited by the CCE or any other organization approved by the board (just like it states). I reached out to the board for clarification and received this information ...

""Clinical" might be best understood as those processes and procedures relative to the care of patients.

The Board's law addresses the scope of practice, failing to meet the standard of care, substance abuse, fraud, aiding and abetting unlicensed practice, ethics, dangerous practice, deceit, harm, surprise billing, and more. The Board's regulations address treating self & family, patients records, confidentiality, practitioner-patient communication, practitioner responsibility, advertising ethics, sexual contact, and refusal to provide information to the Board.

It would be reasonable to find continuing education activities on a number of these topics provided by sponsoring organizations."

So, you are welcome to go to one of these many places, many offer courses for CE credit in the exact subjects that Joe mentioned and, from what the board response states, they will count toward your Type 1 hours. This isn't something that needs to be changed, just perhaps a better understanding is needed.

I do think, unfortunately, our field DOES need the word "Clinical" in the requirement. It is important we are taking CE hours that are designed to help us as we care for patients and we haven't yet proven, as a field, that we would be taking appropriate hours as medical professionals. I think if that word was taken out, we would have some taking courses on green books and the like, and counting it as their CE hours which I don't think is appropriate for a medical professional. I think it's

fine if someone does it on their own, but not for CE hours.

I strongly oppose both changes, let's move forward and not backward.
CommentID: **237223**

Commenter: Dr. Elaine Bolte

9/22/25 8:55 am

Opposed to CE changes

The change is unnecessary and limiting CE's that count towards required hours to only in person limits a doctors ability to take CE's in fields of study/topics that may not allow the doctor to better themselves for practice.

Please oppose.

Dr. Elaine Bolte

CommentID: **237342**

Commenter: Adriana Backus, DC

9/22/25 4:20 pm

Opposed to "in person", in support of removal of Type 1 separate requirement

I respectfully request the Board vote "no" for the proposed “in person attendance” requirement (for any number of hours); and rescind or reduce the separate Type 1 “clinical” category of CEU’s for chiropractors.

Addressing first the reasons against the new petition for “in person attendance”:

1. Chiropractors are unique from many other providers in our *inability* to provide care when away from our patients, as chiropractic services are typically performed in-person for our pain patients. An “in-person” CEU requirement forces providers to be unavailable to pain patients during travel and puts in place unnecessary logistics such as travel time and sometimes days away with travel for in person multi-day conferences. With a virtual option, unavailability need not be an issue--for example attending a virtual partial day conference, then seeing patients for the remainder of the day--as well as eliminating travel time. Offering even more flexibility, virtual “On Demand” CEU’s eliminates the conflict with provider patient availability altogether, allowing providers to attend virtually outside of office hours, again without travel time. With the virtual option, practice closure to complete CEU’s need not be an issue, but if the in-person attendance mandate is passed, provider availability to patients suffers.

2. **I also urge the Board to consider the impact of pulling front line pain care providers from our practices during the ongoing Opioid Epidemic still being monitored closely by the Virginia Department of Health (as of June 2025 in its most recent report) and estimated as of 2021 to have cost $5 billion, according to the VDH website**. The costs of forcing providers to temporarily close our practices I believe conflicts with the stated priority in combatting the Opioid Epidemic of increasing provider availability to combat patients in pain, directly impacting the reach of the Opioid Epidemic in Virginia. The needs of pain care patients and their treatment should be prioritized when determining whether to arbitrarily require providers to be unavailable for these patients’ needs in order to attend an in-person conference for Type 1 credits, which could just as easily be completed online/virtually without impacting patient care.

3. As practices are just exiting the turmoil of the Covid pandemic and regaining their footing, adding an in-person attendance requirement creates an additional cost burden for practitioners, sometimes amounting to hundreds of dollars in travel costs. In many cases these costs more than double the base cost of

conference attendance ***at a time when financial resources must be used especially wisely by post-pandemic practices just regaining their footing***.

Virtual attendance is mainstream, a beneficial option to providers and their pain patients, has far reaching impacts on patient pain care and provider availability across the state of Virginia if removed as an option and should accordingly continue to be an accepted option.
Those who wish to attend "in person" should be allowed to do so; chiropractors who deem it best to attend virtually should be honored as well.

I also request that chiropractors be held to the same standard as are other professions regarding Type 1 credit hours. The medical field is one of the most heavily regulated fields in the United States and practitioners are required to stay abreast of many, many areas outside of clinical expertise that relate directly to accepted standards of care and education. This modern practicality should be taken into consideration in delegating requirements types for CEUs and the Type 1 requirement should be rescinded accordingly.

I respectfully request that the Board vote "no" in response to the petition for an "in person" requirement and that the Type 1 requirement be dropped altogether to bring our requirements more in line with the commonly accepted CEU requirements of other providers across Virginia.

On a separate note, since I am unsure of whether the Board considers suggestions included in individual petitioner's responses, I wanted to address and respectfully request the Board disregard the suggestion included in a *petitioner's response* calling for the addition of a "hands on" requirement; it is not a request echoed by our profession as a whole. As the Board is aware, chiropractors have extensive education—with "hands on" training starting in the first quarter of school and continuing for the entirety of our 4 years of education which is a year-round program—as well as four separate National Boards (each testing acumen, understanding, and mastery of the knowledge and skills required within the chiropractic field) which must be passed to obtain licensure. Following licensure, each chiropractor then goes on to have further extensive "hands on" hours, honing that educational expertise everyday in treating their patients. Beyond office hours, many chiropractors then see other chiropractors for manual therapy and this service is often and regularly exchanged free of charge between licensed chiropractors in the field. In short, we have many ways that we work with eachother that don't necessitate our being required to have further "hands on" mandatory CEU's. I would very much appreciate the Board's dismissing this separate suggestion from the petition being discussed out of hand.
CommentID: **237343**

Commenter: Siobhan Conklyn, DC

9/23/25 3:49 pm

Opposition to chiropractic CEU changes

I am opposed to our CEUs be changed to in-person. There are several reasons for this opposition. One is the financial strain it could put on the practitioner, not only for the courses but also for the travel, room and board that is usually required. Second, there are so many CEUs available to us online, that may suit our interests and our patients better. It should be left to the individual practitioner to decide what suits their practice needs the best.

CommentID: **237348**

Commenter: Susan Kilmer

9/24/25 10:28 am

opposed to CEU in person

Opposed to in person only to CEU requirements.

CommentID: **237349**

Commenter: Larry L. Stine, D.C., D.A.B.C.O. 9/24/25 11:54 am

18VAC85-20-235. Continued competency requirements for renewal of an active license. (OPPOSED)

I am opposed to the changes, in fact, I believe the BOM should direct more rigorous continued education focusing on clinical content rather than philosophy. To include:

1. X-ray positioning, interpretation and diagnosis.
2. MRI- interpretation and diagnosis
3. Laboratory- interpretation and diagnosis
4. Differential diagnosis of all systems in the body.
5. Clinical research studies- creating and reporting case studies and others.
6. Pharmacology and toxicology- medications side effects and complications seen in the musculoskeletal system and visceral systems. Also to include laboratory markers on how to identify these problems.
7. Nutrition- As we already have this in chiropractic college, we still need continued education on nutrition considerations for alternative medicine.
8. Injection of vitamins and minerals- trigger point injections, IV administration, etc.

We need to continue to push for the advancement of chiropractic as a primary care contact to offer the greatest benefit to our patients health that we can.

CommentID: **237350**

Commenter: Dr. Michelle Rose 9/24/25 4:27 pm

Amendment of chiropractic continuing education

I agree with removing the term "clinical" from our guidelines. Removing it would allow us the ability to do more classes such as HIPAA and sex trafficking.

I also agree with doing 24 CE hours in person. I believe learning is greater in a classroom setting. It provides greater feedback, discussions, stimulates thoughts and ideas amongst attendees.

Since auditing of CE credits by the Board of Medicine is no longer going to take place, how do we ensure our doctors are taking CE classes? CE Credits are there for practitioners to further their education and better themselves in their profession. It is a public safety issue if doctors do not continue to get and stay educated.

I do not think doctors should view going to in person classes as inconvenient or time consuming. We are doctors, we should have higher standards.

I believe it is our professional duty and responsibility to our patients to get proper continuing education.

CommentID: **237375**

Commenter: Rhonda Huff, Harmonized Neurology Family Chiropractic 9/24/25 8:11 pm

CE Changes Opposed

I am writing to oppose the petition that would require chiropractors—and only chiropractors—to complete continuing education solely in person.

This proposal does not serve public health and safety. Continuing education is about ensuring competency, growth, and patient protection. Online learning platforms have been proven effective across professions, including for medical doctors and surgeons whose procedures often carry higher risks than those performed by chiropractors.

Singling out chiropractors while exempting other healthcare professionals regulated by the Virginia Board of Medicine creates an unnecessary and discriminatory burden. If in-person CE were truly essential for safety, it should apply equally to all professions. To impose it on chiropractors alone is not reasonable, nor is it supported by evidence.

Modern education methods—including interactive online courses, peer discussion, and virtual case review—offer quality, flexibility, and accessibility that serve both doctors and the patients they care for. Restricting chiropractors to in-person learning does not improve patient outcomes, but instead diverts time and resources away from clinical practice.

For the sake of fairness, efficiency, and true public safety, I urge you to reject this proposal.

Dr. Rhonda Huff, DC

CommentID: **237384**

Commenter: Crystal Witte

9/24/25 9:00 pm

Opposed to in-person CEU requirement for DCs

It seems unreasonable and unnecessary for DCs to be subjected to mandatory in-person CEUs only. For many, the time, financial investment, and travel burden that is involved with attending only in-person CEUs is limiting and burdensome. Please reconsider allowing DCs to have the freedom to select the continuing education style that works best for them and their current practice population.

CommentID: **237385**

Commenter: Joe Foley, DC

9/24/25 11:54 pm

Support Petition

I am not surprised at all by the responses in opposition. It was expected. Of course, many will oppose this change. It seems simple, but it's actually more complicated.

The chiropractic profession has 1,400 doctors in the Commonwealth. The total response rate is less than 7%. Opposition to change is always more vocal. So, 93% choose not to post a comment.

The majority of the responses indicate that it would be a burden for them to obtain live CE. Being a doctor has rights, privileges, and responsibilities. That comes with burdens. I have no opposition to an exception in the case of pregnancy, illness, care of family members, etc

It has been stated in the comments that other professions in Virginia do not have this live requirement. Not true, Optometry requires “At least 10 hours shall be obtained through real-time, interactive activities, including in-person or electronic presentations, provided that during the course of the presentation, the licensee and the lecturer may communicate with one another.” Psychology requires “At least six of the required hours shall be earned in face-to-face or real-time interactive educational experiences. Real-time interactive shall include a course in which the learner has the opportunity to interact with the presenter during the time of the presentation”. The Occupational Therapist, another hands of profession regulated by the Board of Medicine, requires a “live event” for a portion of their CE.

In the chiropractic profession, it is not uncommon, 17 states require some live face-to-face CE for the chiropractic profession. I suggest that this trend of requiring live CE will spread to most states.

I choose to “stay in my lane” and not include the MD, DO, and Doctors of Podiatry or any other profession in my petition. Those professions need to have this conversation, and it is not my place to bring it up. The medical colleagues I know get way more CE than the VA requirement. MD and DO are not worried about their BOM CE requirement; they far exceed it every year. If they have a Fellowship or Board certification, hospital privileges, which have many CE requirements and opportunities, much of which are live, to gain educational interactions.

I fully admit that the state of live chiropractic CE in Virginia in very limited.

No chiropractic colleges bring live CE to Virginia anymore. They used to come to Virginia.

None of the independent CE programs comes to Virginia. They used to come here.

Only the state association offers face-to-face CE programs, a spring and fall event. They no longer do regional CE programs across the state as they once did.

The reason is simple…nobody attends.

It is unfortunate that CE has become a victim of an Amazon-like model. Shopping on Amazon is super convenient, it has a massive inventory and the cheapest prices. Amazon has run everyone else out of business. But we are not talking about merchandise; we are talking about the CE for doctors. My proposal does not say doctors cannot take online CE on topics that interest them. It just says you need to be face-to-face in a live classroom at some point.

Image if Virginia Docs came to live events, one time a year or even once every two years. With 1400 DCs in Virginia, the numbers work. It would completely change chiropractic CE in Virginia. The chiropractic schools would once again offer live CE in Virginia. The other CE groups would also come in Virginia. The UVCA would hold more CE events across the state. Nobody would have to take a flight or even stay in a hotel to meet their CE. There would be a large variety of live events in each region of the state. This is what we should expect to see for CE for doctors.

We are witnessing firsthand the impact on our communities of online living. It impacts our communities in so many ways, economically, socially and professionally. The path chosen on this topic will decide the quality of chiropractic in Virginia. If you do not like the number of face-to-face hours suggested, please select another number. Maybe half, 15 of the 30 biannually? Even 10 of the 30 would make a difference.

CommentID: **237388**

Virginia Administrative Code
Title 18. Professional And Occupational Licensing
Agency 85. Board of Medicine
Chapter 20. Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic

Part VI. Renewal of License; Reinstatement

18VAC85-20-235. Continued competency requirements for renewal of an active license.

A. In order to renew an active license biennially, a practitioner shall attest to completion of at least 30 hours of continuing learning activities within the two years immediately preceding renewal. The hours shall be in Type 1 activities or courses offered by an accredited sponsor or organization sanctioned by the profession.

1. Type 1 hours in chiropractic shall be clinical hours that are approved by a college or university accredited by the Council on Chiropractic Education or any other organization approved by the board.

2. Type 1 hours in podiatry shall be accredited by the American Podiatric Medical Association, the American Council of Certified Podiatric Physicians and Surgeons or any other organization approved by the board.

B. A practitioner shall be exempt from the continuing competency requirements for the first biennial renewal following the date of initial licensure in Virginia.

C. The practitioner shall retain in the practitioner's records all supporting documentation for a period of six years following the renewal of an active license.

D. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

E. The board may grant an extension of the deadline for continuing competency requirements for up to one year for good cause shown upon a written request from the licensee prior to the renewal date.

F. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

G. The board may grant an exemption for all or part of the requirements for a licensee who:

1. Is practicing solely in an uncompensated position, provided the licensee's practice is under the direction of a physician fully licensed by the board; or

2. Is practicing solely as a medical examiner, provided the licensee obtains six hours of medical examiner training per year provided by the Office of the Chief Medical Examiner.

Statutory Authority

§54.1-2400 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 16, Issue 4, eff. December 8, 1999; amended, Virginia Register Volume 20, Issue 10, eff. February 25, 2004; Volume 23, Issue 11, eff. April 21, 2007; Volume 23, Issue 25, eff. September 20, 2007; Volume 29, Issue 4, eff. November 21, 2012; Volume 33, Issue 11, eff. March 9, 2017; Volume 35, Issue 24, eff. September 26, 2019; Volume 41, Issue 11, eff. February 27, 2025.

Agenda Item: Consideration of continuing education for the 2028 – 2029 renewal cycle

Included in your agenda package:

- Virginia Code § 54.1-2928.3.

Staff notes: Virginia Code § 54.1-2928.3 permits the Board to specify up to 2 hours of continuing education in specific topics. DHP staff has received a request from the Executive Branch for the Board to consider requiring continuing education in nutrition for the 2028 – 2029 renewal cycle.

If the Board elects to require this continuing education, notification will be sent to licensees prior to the renewal cycle. Upon renewal, licensees will check a box to certify compliance with the directive.

In the past, the Board voted to require one continuing education hour in human trafficking using this statute.

Action at the discretion of the Board:

- Motion to require 1 or 2 hours of continuing education in the subject of nutrition for the 2028 – 2029 renewal cycle.

Code of Virginia
Title 54.1. Professions and Occupations
Subtitle III. Professions and Occupations Regulated by Boards within the Department of Health Professions
Chapter 29. Medicine and Other Healing Arts
Article 2. Board of Medicine

§ 54.1-2928.3. Continuing learning activities

Of the hours of continuing education required for biennial renewal of licensure, any licensee of the Board of Medicine may be required by the Board to complete up to two hours of Type 1 continuing learning activities or courses in a specific subject area. If the Board designates a subject area for continuing learning activities or courses, it shall publish such requirement no later than January 1 of the first year of the term of the license for which the specific learning activity or course is required.

2023, cc. 418, 419.

The chapters of the acts of assembly referenced in the historical citation at the end of this section(s) may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

Agenda Item: Review and adoption of changes to midwifery formulary

Included in your agenda package:

- Revised midwifery formulary adopted by the Ad Hoc Committee on Medications for Midwives;

- Virginia Code § 54.1-2957.9.

Staff notes: On August 25, the ad hoc committee met and discussed changes needed to the midwifery formulary due to changes in the midwife scope of practice as determined by the North American Registry of Midwives Job Analysis.

Virginia Code § 54.1-2957.9 states that a licensed midwife "may obtain, possess, and administer drugs and devices that are used within the licensed midwife's scope of practice as determined by the North American Registry of Midwives Job Analysis."

Action needed:

- Adoption of changes to the midwifery formulary.

~~Adopted: August 4, 2023~~
Revised: October 30, 2025

Virginia Board of Medicine
Formulary and Best Practices
Midwifery Administration of Drugs

Medication listed in this document should be stored as directed by the manufacturer and administered according to best practices. ~~should not be administered to any person after the expiration date listed.~~

The Board recommends that a licensed midwife discuss with each patient the medications that the midwife may provide.

	Drug	Indication	Dose/Route of Administration	Duration of Treatment
Maternal	Rh(D) immune globulin (Rhig) (RhoGAM/WinRho/Rhophylac)	Prevention of isoimmunization	300 mcg IM	After SAB, third trimester, and within 72 hours postpartum.
	Lidocaine HCl (1% or 2%)	Local anesthetic for suturing	Maximum 50 mL (1%) Maximum 15 mL (2%) Administered percutaneously	Completion of repair
	Medical Oxygen	Maternal hemorrhage or fetal distress	4-15 L/min by mask or bag/mask as needed to keep SpO2>93% or for fetal distress	Until maternal/fetal stabilization is achieved or transfer to the hospital is complete.
	Oxytocin (Pitocin)	Postpartum uterine atony	10 units IM per dose, 20-40 units in 500-1000 mL IV NS or LR	PRN during immediate postpartum care
	Misoprostol (Cyotec)	Postpartum hemorrhage	Prevention • Buccal or sublingual 200-400 mcg single dose immediately after delivery • Oral: 600 mcg single dose after delivery Treatment • Oral or rectal 600 to 1000 mcg single dose	PRN during immediate postpartum care

			• Sublingual 800 mcg single dose	
	Methylergonovine Maleate (Methergine)	Postpartum hemorrhage	0.2 mg IM or PO	Single dose IM or every six hours PO, may repeat 3 times. Contraindicated in hypertension and Raynaud's Disease.
	Tranexamic acid (TXA)	Postpartum hemorrhage	1 gram via IV 1300 mg orally	10 minutes
	Prostaglandin F2 alpha (carboprost)	Postpartum hemorrhage	250 mcg IM	Q 15-90 minutes (max 2 mg); avoid in asthma
	Terbutaline	Decrease or stop uterine contractions	0.25 mg subcutaneous	Once. If no significant decrease in contractions within 15-30 minutes, second dose of 0.25 mg may be administered.
	IV Fluids: ➢ Normal Saline (0.9%) ➢ Ringers Lactate ➢ Ringers Lactate with 5% Dextrose	Dehydration, exhaustion, volume replacement	1000 mL or 500 mL bolus as needed for dehydration, maternal exhaustion, inability to tolerate PO hydration and/or food, postpartum hemorrhage	Antepartum, intrapartum, and postpartum, as indicated.
	Sterile water	For intradermal injections for pain relief	1 mL sterile water per injection site; 4 injection sites using a 1 mL tuberculin syringe	May be repeated during labor
	Penicillin G (Pfizerpen) (Recommended)	GBS prophylaxis	5 million units IV in>=100 mL LR, NS, or D5LR initial dose, then 2.5 million units IV in>=100 mL LR, NS, or D5LR every 4 hours until birth	Throughout labor until birth of baby
	Ampicillin Sodium (Alternative)	GBS prophylaxis	2 grams IV in>=100 mL NS or D5LR initial dose, then 1 gram	Until birth of baby

			IV in NS >=100 mL every 4 hours until birth	
	Cefazolin Sodium (Ancef) (Alternative if allergic to PCN, high risk for anaphylaxis, and GBS is susceptible)	GBS prophylaxis	2 grams initial dose IV in>=100 mL LR, NS, or D5LR, then 1 gram IV in>=100 mL LR, NS, or D5LR every 8 hours	Until birth of baby
	Clindamycin Phosphate (Cleocin) (Alternative if allergic to PCN, high risk for anaphylaxis, and GBS is susceptible)	GBS prophylaxis	900 mg IV in>=100 mL LR, NS, or D5LR every 8 hours	Until birth of baby
	Dicloxacillin (Recommended)	Treatment of mastitis	500 QID	7 – 10 days
	Clindamycin (Alternative)	Treatment of mastitis	300 mg QID	7 – 10 days
	Cephalexin/Keflex (Alternative)	Treatment of mastitis	500 mg QID	7 – 10 days
	Epinephrine HCl 1:1000	Allergic reaction	0.3 mL IM	Every 20 minutes or until emergency medical services arrive. Administer the first dose then immediately request emergency services.
	Magnesium sulfate	Prevention of maternal seizures pending transport	10 grams IM, 5 grams in each buttock (preferred) 4 grams IV (alternative) If choosing IV, must have calcium gluconate available for IV administration at 1 gram over 5 – 10 minutes.	Once Over 30 minutes

	Nitrous oxide	Analgesic	Self-administered by patient per manufacturer of delivery system's guidelines	Per manufacturer of delivery system's guidelines
	Zofran/ondansetron (preferred during labor)	Anti-nausea	Sublingual 4 mg Sublingual 8 mg IV 4 mg	Every 4 hours Every 8 hours Once
	Meyer's cocktail (IV fluids including IV thiamine and IV multivitamin)	Anti-nausea	IV over 20-60 minutes; IV therapy provided slowly	Once
	Phenergan	Anti-nausea	12.5 mg or 25 mg suppository	Once
	Iron infusions	Anemia	Pursuant to best practices	Pursuant to best practices
	Vaccination against infectious diseases (including, but not limited to, Tdap, MMR, HBV, HBIG, influenza, and COVID)	Prevention against infectious diseases	Per FDA-approved manufacturer recommendations	Per manufacturer directions
	Opioid reversal agent	Suspected opioid overdose: unresponsive patient (not following commands but has a pulse) AND hypoventilating (respiratory rate of 8 or below and/or presence of gasping or agonal respirations) OR apneic	4mg/0.1mL nasal spray single spray intranasally into one nostril. If no response after initial treatment, give additional dose in opposite nostril.	Additional doses may be administered every 2-3 minutes until emergency medical services arrives.

~~Adopted: August 4, 2023~~
Revised: October 30, 2025

	Drug	Indication	Dose/Route of Administration	Duration of Treatment
Neonate	Vitamin K1 (Phytonadione/Phylloquinone)	Prevention of vitamin K deficiency bleeding (hemorrhagic disease of the newborn)	1 mg IM Oral	Once, soon after birth According to manufacturer directions
	Erythromycin ophthalmic ointment (0.5%)	Prevention of ophthalmia neonatorum	1 cm strip ophthalmic administration inside each eyelid	Once, soon after birth
	Medical Oxygen	Neonatal resuscitation	2-8 L/min mask, bag and mask, and/or laryngeal mask airway as needed to keep SpO2 within NRP guidelines	Until neonatal stabilization is achieved or transfer to the hospital is complete
	Epinephrine HCl 1:10,000	Neonatal resuscitation	0.01 mg/kg umbilical vein catheter or intraosseous injection (0.1 ml/kg of 1:10,000 concentration)	Every 20 minutes or until emergency medical services arrive. Administer the first dose then immediately request emergency services.

Code of Virginia
Title 54.1. Professions and Occupations
Subtitle III. Professions and Occupations Regulated by Boards within the Department of Health Professions
Chapter 29. Medicine and Other Healing Arts
Article 4. Licensure and Certification of Other Practitioners of the Healing Arts

§ 54.1-2957.9. Regulation of the practice of midwifery

The Board shall adopt regulations governing the practice of midwifery, upon consultation with the Advisory Board on Midwifery. The regulations shall (i) address the requirements for licensure to practice midwifery, including the establishment of standards of care, (ii) be consistent with the North American Registry of Midwives' current job description for the profession and the National Association of Certified Professional Midwives' standards of practice, except that prescriptive authority shall be prohibited, (iii) ensure independent practice, (iv) require midwives to disclose to their patients, when appropriate, options for consultation and referral to a physician and evidence-based information on health risks associated with birth of a child outside of a hospital or birthing center, as defined in § 54.1-2957.03, including risks associated with vaginal births after a prior cesarean section, breech births, births by women experiencing high-risk pregnancies, and births involving multiple gestation, (v) provide for an appropriate license fee, and (vi) include requirements for licensure renewal and continuing education. Such regulations shall not (a) require any agreement, written or otherwise, with another health care professional or (b) require the assessment of a woman who is seeking midwifery services by another health care professional. A licensed midwife may obtain, possess, and administer drugs and devices that are used within the licensed midwife's scope of practice as determined by the North American Registry of Midwives Job Analysis. The Board of Medicine shall develop and publish best practice and standards of care guidance for all such drugs. The formulary shall not include any drug, as defined in § 54.1-3401, in Schedule I through V of the Drug Control Act. A licensed midwife may obtain medications and devices to treat conditions within the licensed midwife's scope of practice from entities including a pharmacy, as defined in § 54.1-3300, or a manufacturer, medical equipment supplier, outsourcing facility, warehouser, or wholesale distributor, as these terms are defined in § 54.1-3401. An entity that provides a medication to a licensed midwife in accordance with this section, and who relies in good faith upon the license information provided by the licensed midwife, is not subject to liability for providing the medication.

Completing all Alliance for Innovation on Maternal Health patient safety bundles advanced by the Virginia Neonatal Perinatal Collaborative shall be required of any licensed midwife who obtains, possesses, and administers drugs and devices within the scope of his practice.

License renewal shall be contingent upon maintaining a Certified Professional Midwife certification.

2005, cc. 719, 917;2009, c. 646;2016, c. 495;2023, cc. 673, 674.

The chapters of the acts of assembly referenced in the historical citation at the end of this section(s) may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

Agenda Item: Amendments to Guidance Document 90-56 Following General Assembly Action

Included in your Agenda Package:

- Redlined version of 90-56

Staff Note: These amendments are being made following the passage of Chapter 404 of the 2024 Acts of Assembly, which reduced the number of years of practice required for APRNs to practice without a practice agreement. Regulatory changes went into effect late last year, however guidance document changes were not made at that time.

Action Needed:

- Motion to amend guidance document 90-56.

Guidance document: 90-56 Revised: ~~November 15, 2022~~September 9, 2025 (Nursing)
December ~~2, 2022~~5, 2025 (Medicine)
~~Effective: February 2, 2023~~

Practice Agreement Requirements for Licensed Nurse Practitioners (Advanced Practice Registered Nurses)

KEY POINTS:

- Certified Registered Nurse Anesthetist ("CRNA") – A practice agreement is *not* required for nurse practitioners licensed in the category of CRNA. The CRNA practices under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry.
- Certified Nurse Midwife ("CNM") – Prior to completion of 1,000 practice hours, a nurse practitioner licensed in the category of CNM must enter into a practice agreement with either a CNM who has practiced for at least two years or a licensed physician.
- Clinical Nurse Specialist ("CNS") – A nurse practitioner licensed in the category of CNS and who prescribes controlled substances must enter into a practice agreement with a licensed physician.
- Nurse Practitioner ("NP") – A nurse practitioner with less than ~~5~~ 3 years of clinical experience must enter into a practice agreement with a patient care team physician; this requirement does not apply for ~~NPs~~ APRNs in the categories of CNM, CRNA, or CNS.
- Nurse practitioners who are required to have a practice agreement are responsible for maintaining the practice agreement and making it available for review by the Board of Nursing upon request.
- Practice agreements do *not* need to be submitted to the Board of Nursing to obtain or renew the professional license.

Applicable statutes by category:

CNM

- A practice agreement entered into between a CNM and a CNM with more than 2 years of experience or a licensed physician must address the availability of the consulting CNM or the licensed physician for routine and urgent consultation on patient care. (Va. Code § 54.1-2957(H).)
- If the CNM will prescribe, the practice agreement must include the parameters of such prescribing of Schedules II through VI controlled substances. (Va. Code § 54.1-2957.01(G).)
- Virginia Code § 54.1-2957(H) describes the requirements for CNMs to practice without a practice agreement.

CNS

A CNS who prescribes controlled substances must practice in consultation with a licensed physician in accordance with a practice agreement.

- A practice agreement entered into between a CNS and a licensed physician must address the availability of the physician for routine and urgent consultation on patient care. (Va. Code § 54.1-2957(J).)
- If the CNS will prescribe, the practice agreement must include the parameters of such prescribing of Schedules II through V controlled substances. (Va. Code § 54.1-2957.01(B).)

NP

A nurse practitioner with less than ~~5~~3 years of clinical experience must enter into a practice agreement with a patient care team physician as defined in Virginia Code § 54.1-2900. Pursuant to Virginia Code §§ 54.1-2957(C), (D), and 54.1-2957.01(B), when a practice agreement is required for NP practice, it must include:

- Provisions for the periodic review of health records by the patient care team physician and may include provisions for visits to the site where health care is delivered in the manner and at the frequency determined by the patient care team;
- Provisions for appropriate input from health care providers in complex clinical cases and patient emergencies and for referrals;
- Categories of drugs and devices that may be prescribed;
- Guidelines for availability and ongoing communications that provide for and define consultation among the collaborating parties and the patient;
- Provisions for periodic joint evaluation of services provided;
- Provisions for periodic review and revision of the practice agreement; and
- The signature of the patient care team physician or the name of the patient care team physician clearly stated.

Virginia Code § 54.1-2957(I) describes the requirements for NP autonomous practice.

Agenda Item: Consideration of biennial CE topic 2026-2027

Staff Note: The General Assembly gave the Board the authority to designate a CE topic each biennium as a requirement for renewal. The Board can choose to exercise this authority or not. If it chooses to exercise the authority, it could designate any topic for any group of licensees. The requirement is that those subject to the required CE must be notified prior to January 1st of the upcoming biennium. Included in your packet is the enabling law and a brief outline of a PowerPoint CE activity developed by the Virginia Department of Health on completing death certificates.

Action: Discussion as to whether to exercise the authority for the coming biennium and if so to select a topic.

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 29. Medicine and Other Healing Arts

§ 54.1-2928.3. Continuing learning activities.

Of the hours of continuing education required for biennial renewal of licensure, any licensee of the Board of Medicine may be required by the Board to complete up to two hours of Type 1 continuing learning activities or courses in a specific subject area. If the Board designates a subject area for continuing learning activities or courses, it shall publish such requirement no later than January 1 of the first year of the term of the license for which the specific learning activity or course is required.

2023, cc. 418, 419.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

10/22/2C

MEDICAL CERTIFICATION OF DEATH CERTIFICATES

WORKING DRAFT – OCTOBER 21 2025

[Virginia Department of Health & Department of Health Professions Provider Training]

CME OBJECTIVES

1. Recognize the importance of completing a death certificate as a provider's last act of patient care.

2. Using multiple vignettes, review common causes of delays in medical certification of natural deaths when patients die at home and how they can be resolved.

3. Understand what types of cases falls under the prevue of the Virginia Department of Health's Office of the Chief Medical Examiner (OCME) versus a decedent's medical provider.

4. Review the requirement for providers to utilize the state's electronic death registry system (EDRS).

5. Review key steps in completing a death certificate, including differentiating between cause of death (cod) versus mechanisms of death, when it is appropriate to list "pending" for the cause and how to submit changes or amendments.

6. Discuss possible recourse for providers that do not complete a death certificate when responsible.

Reducing Barriers to Ensure Timely Certification of Death Certificates

Parham Jaberi, MD, MPH

Deputy Director for Medical Services, Fairfax Health District

October 2025

Background

- **Timely medical certification of death certificates is essential**
  - Required by law
  - Planning of funeral & memorial services/managing affairs of the decedent.
- **For "natural deaths" that occur at home, significant majority of cases are processed without incident** (See Appendix A)
- **In a subset of cases, a repeating pattern of incidents and delays occur** (See Appendix B).
  - Leads to additional distress for grieving families
  - Significant investments in time by stakeholders above and local health directors/depts
  - Disruptions to workflow of busy provider practices.

Agenda Item: Adoption of proposed regulatory language pursuant to HB995 (2024) regarding foreign trained physicians

Included in your agenda package:

- Draft proposed regulatory language as recommended by the Legislative Committee;
- Unfinished draft guidance document that will be completed during the final action phase of the regulatory process;
- Comments received via Town Hall following the publication of the NOIRA stage;
- Advisory Commission on Additional Licensing Models Guidance Document (FSMB, August 2025); and
- HB995 (2024).

Staff notes: HB995, passed in 2024, requires the Board to provide a new pathway to licensure for foreign-trained physicians. This pathway includes a provisional license and a restricted license. The Legislative Committee met three times to discuss proposed regulatory language and each meeting included robust discussion and significant public comment.

While a draft guidance document is included in your agenda materials, **no action is needed on the guidance document at this time.** The Legislative Committee will provide a recommendation on the guidance document at the time the Legislative Committee recommends final regulatory language.

The Legislative Committee needs the full Board of Medicine to review and make a decision regarding optional definitions for indirect supervision. The Legislative Committee could not come to a majority agreement on which definition would be appropriate, particularly considering the definition would not be limited to provisionally licensed physicians under this pathway.

Please note that explanatory footnotes included in the draft regulatory document will not be part of the regulatory language. These references were used by the Legislative Committee and may be useful as the full Board considers the proposed action.

Action needed:

- Selection of definition of “inactive practice” from the options provided by the Legislative Committee; and
- Adoption of proposed regulatory language governing foreign physicians as recommended by the Legislative Committee or as amended by the Board.

NOTE: The following is an existing regulatory section. Changes here will impact practice beyond foreign physicians practicing under provisional licensure.

18VAC85-20-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2900 of the Code of Virginia:

Board

Healing arts

Practice of chiropractic

Practice of medicine or osteopathic medicine

Practice of podiatry

B. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Approved institution" means any accredited school or college of medicine, osteopathic medicine, podiatry, or chiropractic located in the United States, its territories, or Canada.

"Direct supervision" means the supervising physician is physically present in the facility and immediately available to the supervised individual and the patient.

"Indirect supervision" means the supervising physician is immediately available and is physically within the hospital or other site of patient care and is immediately available to provide direct supervision.

OR

"Indirect supervision" means the supervising physician is immediately available but is not physically present within the hospital or other site of patient care but is immediately available by electronic or telephonic means and is available to provide direct supervision.

"Principal site" means the location in a foreign country where teaching and clinical facilities are located.

18VAC85-20-20. Required fees.

A. Unless otherwise provided, fees established by the board shall not be refundable.

B. All examination fees shall be determined by and made payable as designated by the board.

C. The application fee for licensure in medicine, osteopathic medicine, and podiatry shall be $302, and the fee for licensure in chiropractic shall be $277.

D. The fee for a temporary authorization to practice medicine pursuant to clauses (i) and (ii) of § 54.1-2927 B of the Code of Virginia shall be $25.

E. The application fee for a limited professorial or fellow license issued pursuant to 18VAC85-20-210 shall be $55. The annual renewal fee shall be $35. For renewal of a limited professorial or fellow license in 2020, the fee shall be $30. An additional fee for late renewal of licensure shall be $15.

F. The application fee for a limited license to interns and residents pursuant to 18VAC85-20-220 shall be $55. The annual renewal fee shall be $35. For renewal of a limited license to interns and residents in 2020, the fee shall be $30. An additional fee for late renewal of licensure shall be $15.

G. The application fee for a provisional license to practice as a foreign physician shall be $55. The application fee for a restricted license to practice as a foreign physician shall be $302. The fee for biennial renewal of a restricted license to practice as a foreign physician shall be $377.

~~G.~~ H. The fee for a duplicate wall certificate shall be $15. The fee for a duplicate license shall be $5.00.

~~H.~~ I. The fee for biennial renewal shall be $337 for licensure in medicine, osteopathic medicine, and podiatry and $312 for licensure in chiropractic, due in each even-numbered year in the licensee's birth month. An additional fee for processing a late renewal application within one renewal cycle shall be $115 for licensure in medicine, osteopathic medicine, and podiatry and $105 for licensure in chiropractic. For renewal of licensure in 2020, the fee shall be $270 for licensure in medicine, osteopathic medicine, and podiatry and $250 for licensure in chiropractic.

~~I.~~ J. The fee for requesting reinstatement of licensure or certification pursuant to § 54.1-2408.2 of the Code of Virginia or for requesting reinstatement after any petition to reinstate the certificate or license of any person has been denied shall be $2,000.

~~J.~~ K. The fee for reinstatement of a license issued by the Board of Medicine pursuant to § 54.1-2904 of the Code of Virginia that has expired for a period of two years or more shall be $497 for

licensure in medicine, osteopathic medicine, and podiatry ($382 for reinstatement application in addition to the late fee of $115) and $472 for licensure in chiropractic ($367 for reinstatement application in addition to the late fee of $105). The fee shall be submitted with an application for licensure reinstatement.

~~K.~~ L. The fee for a letter of verification of licensure shall be $10, and the fee for certification of grades to another jurisdiction by the board shall be $25.

~~L.~~ M. The fee for biennial renewal of an inactive license shall be $168, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $55 for each renewal cycle. For renewal of an inactive license in 2020, the fee shall be $135.

~~M.~~ N. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $75, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $25 for each renewal cycle. For renewal of a restricted volunteer license in 2020, the fee shall be $60.

~~N.~~ O. The handling fee for a returned check or a dishonored credit card or debit card shall be $50.

18VAC85-20-211. Provisional licensure of foreign physicians.

A. A physician that has practiced in a foreign country for at least five years after medical training may apply for a provisional license as a physician. The applicant shall:

1. Provide evidence of licensure or authorization to practice medicine in a foreign country for five years and evidence of good standing;[1]

2. Provide evidence of a standard Educational Commission for Foreign Medical Graduates (ECFMG) certificate or other credential evaluation services approved by the board;[2]

3. Provide evidence of passage of Step 1 and Step 2 of the United States Medical Licensing Examination;[3]

4. Provide evidence of receipt of a degree of doctor of medicine or equivalent from a medical school in a foreign country accredited by an organization approved by the

[1] Identical to 18VAC85-20-210 for limited licenses to foreign medical graduates. This is also statutory requirement, Virginia Code § 54.1-2933.1(B).
[2] Identical to 18VAC85-20-210 for limited licenses to foreign medical graduates. This is also statutory requirement in Virginia Code § 54.1-2933.1(B)(2).
[3] Statutory requirement, Virginia Code § 54.1-2933.1(B)(3).

board;[4] and

5. Provide evidence of an active agreement with a medical care facility defined in § 32.1-3 of the Code of Virginia which is consistent with requirements in 18VAC85-20-212 and which shall contain information regarding the assessment and evaluation program consistent with 18VAC85-20-213 and 18VAC85-20-214. The agreement shall be executed and shall clearly define the scope of employment and the participation of the provisionally licensed physician in the assessment and evaluation program.

B. The applicant must have practiced medicine within the four years preceding application.

C. The applicant shall have no grounds for denial based on provisions of § 54.1-2915 of the Code of Virginia or regulations of the board.

18VAC85-20-212. Requirements for maintenance of provisional licensure for foreign physicians.

A. A physician holding a provisional license issued pursuant to 18VAC85-20-211 must maintain full-time employment at a medical care facility for which evidence has been provided to the board pursuant to 18VAC85-20-211 A 5 for two years.

B. A physician holding a provisional license issued pursuant to 18VAC85-20-211 shall ensure that the medical care facility documents quarterly evaluations during the provisionally licensed physicians assessment and evaluation program.

C. A provisional license shall immediately expire if the board receives notification pursuant to 18VAC85-20-213 H or I. Practice on an expired provisional license constitutes unlicensed practice and may result in discipline or criminal penalties.

18VAC85-20-213. Medical care facilities providing evaluation programs for foreign physicians.

A. Only medical care facilities as defined by § 32.1-3 of the Code of Virginia[5] are eligible to provide an assessment and evaluation program to a foreign physician practicing with a provisional license.

B. The provisionally licensed physician will enter into an agreement with the medical care facility for the facility to provide assessment, evaluation, and clinical training to the provisionally licensed physician. The provisionally licensed physician will enter full-time

[4] Statutory requirement, Virginia Code § 54.1-2933.1(B)(1).
[5] Requirement of Virginia Code § 54.1-2933.1(B)(4).

employment with the medical care facility upon issuance of the provisional license by the board.[6]

C. The extent and scope of the duties and professional services rendered by the provisionally licensed physician shall be confined to persons who are bona fide patients within the medical care facility or who receive treatment and advice in an outpatient department or outpatient clinic of the medical care facility.[7]

D. The provisionally licensed physician must practice under direct supervision for the first 12 months. If deemed appropriate by the supervising physician, the provisionally licensed physician may practice under indirect supervision after the first 12 months.

E. The medical care facility will provide an assessment and evaluation program for the provisionally licensed physician designed to develop, assess, and evaluate the physician's nonclinical skills and familiarity with standards appropriate for medical practice in the Commonwealth. The assessment and evaluation program shall:

1. Include a program director that meets the following requirements:

a. Holds an active, unrestricted license to practice medicine in the Commonwealth;

b. Practices medicine at the medical care facility; and

c. Substantially participates in supervision of the provisionally licensed physician;

2. Include no fewer than three additional supervising physicians that provide supervision;

3. Develop, assess, and evaluate the provisionally licensed physician's clinical and non-clinical skills; and

4. Utilize a defined curriculum for development, assessment, and evaluation of the provisionally licensed physician in the following areas:

a. Patient care;
b. Medical knowledge;
c. Interpersonal communication skills;
d. Professionalism;
e. Practice-based learning and improvement; and
f. Systems-based practice.

[6] Requirement of Virginia Code § 54.1-2933.1(B)(4).
[7] This is similar to intern/resident requirements found in 18VAC85-20-220(D).

F. The medical care facility's assessment, evaluation, and clinical training program shall utilize a clinical competency committee made up of three physicians which meets to assess and evaluate the provisionally licensed physician no less than quarterly. The program director shall not participate on the clinical competency committee. The committee will provide quarterly feedback to the provisionally licensed physician in the subject areas included in subsection E 4.

G. An assessment and evaluation program must use a defined successful completion of the program which includes the following:

1. Defined criteria for successful completion in the practice areas described in subsection E; and

2. An evaluation form signed by the program director and all members of the clinical competency committee which provides the following:

a. A description of the criteria for successful completion of the assessment and evaluation program;

b. An attestation to the provisionally licensed physician's successful completion of the program; and

c. An attestation that the provisionally licensed physician's clinical and non-clinical skill reflects the ability to provide safe and competent medical care in the Commonwealth.

H. The program director of a medical care facility providing an assessment and evaluation program for provisionally licensed physicians shall notify the board if a provisionally licensed physician stops participating in the assessment and evaluation program.

I. The program director of a medical care facility providing an assessment and evaluation program for provisionally licensed physicians shall notify the board if the facility stops providing assessment and evaluation programs. The program director shall provide the names of all provisionally licensed physicians participating in the assessment and evaluation program as part of such notice.

18VAC85-20-214. Supervision of provisionally licensed foreign physicians.

All physicians providing supervision of the provisionally licensed physician must meet the following requirements:

1. Hold a current, unrestricted license from the board;

2. Hold a current board certification in the same specialty as the specialty in which the provisionally licensed physician intends to practice; and

3. Practices medicine at the medical care facility which entered an employment agreement with the provisionally licensed physician pursuant to 18VAC85-20-212.

18VAC85-20-215. Restricted licensure of foreign physicians.

A. A provisionally licensed physician may apply for a restricted license pursuant to § 54.1-2933.1 C of the Code of Virginia upon completion of two years of practice as a provisionally licensed physician. The application must be filed within one year of expiration of the provisional license. The applicant shall submit the following to the board for consideration:

1. Evidence of successful completion of an assessment and evaluation program[8] pursuant to 18VAC85-20-213, which shall include:

a. Quarterly reports produced by the clinical competency committee pursuant to 213 F;

b. A certification from an official or responsible party of the medical care facility which provided the assessment and evaluation program to the applicant pursuant to 18VAC85-20-213 that states that the applicant satisfactorily completed the assessment and evaluation program;

2. Evidence of a passing score on Step 3 of the United States Medical Licensing Examination[9];

3. Verification of full-time employment with a medical care facility in a medically underserved area identified by the Board of Health pursuant to § 32.1-122.5 of the Code of Virginia or a health professional shortage area designated in accordance with the criteria established in 42 C.F.R. Part 5[10]; and

4. A current report from the U.S. Department of Health and Human Services National Practitioner Data Bank.

B. A physician practicing under a restricted license pursuant to this section must practice in a medically underserved area identified by the Board of Health pursuant to § 32.1-122.5 of the Code of Virginia or a health professional shortage area designated in accordance with the criteria established in 42 C.F.R. Part 5. Practice outside of any such area is prohibited and may result in disciplinary action by the board.

[8] Required by § 54.1-2933.1 C 1
[9] Required by § 54.1-2933.1 C 2
[10] Required by § 54.1-2933.1 C 3

C. A restricted license may be renewed pursuant to the requirements of 18VAC85-20-230, 18VAC85-20-235, 18VAC85-20-236, and 18VAC85-20-240.

18VAC85-20-216. Patient notification of status of physician holding a provisional license.

A physician holding a provisional license pursuant to 18VAC85-20-211 shall inform patients that the physician holds a provisional license verbally or in writing. If notification is provided verbally, the provision of verbal notification shall be included in the patient medical record.

Potential guidance document language
For Board discussion only

Guidance Regarding Foreign Physicians Obtaining Provisional Licenses

A. Evidence of Good Standing

18VAC85-20-211(A)(1) requires an applicant to practice under a provisional license to provide evidence of good standing as a condition of licensure. The Board interprets the phrase "evidence of good standing" to include:

- A document issued by a foreign regulatory authority under which the applicant practiced;
- Proof of active practice for [number of] years [Board to determine number of years at a later date];
- At the Board's discretion, certification provided by the Educational Commission for Foreign Medical Graduates ("ECFMG") assessing the applicant's readiness to enter the U.S. training program;
- A criminal history background check or other generalized report regarding professional misconduct; or
- A letter of recommendation [Board to determine parameters at a later date].

B. Evidence of Receipt of a Degree of Doctor of Medicine or Equivalent

Virginia Code § 54.1-2933.1(B)(1) requires an applicant for provisional licensure submit evidence to the Board that the applicant "received a degree of doctor of medicine or its equivalent from a legally chartered medical school outside of the United States recognized by the World Health Organization . . ." The World Health Organization ("WHO") does not recognize medical schools.

In the absence of such recognition by the WHO, the Board will accept recognition from the following organizations that perform the function implied by the statute:

- The World Federation for Medical Education ("WFME");
- The Liaison Committee on Medical Education ("LCME"); and
- The Education Commission for Foreign Medical Graduates ("ECFMG").

C. Evaluation and Assessment Subjects

The Board interprets the following terms regarding subjects for an assessment or evaluation program under 18VAC85-20-213(E)(4) as follows:

- Patient care requires the provisional licensee to demonstrate abilities in providing patient care that is compassionate, appropriate, and effective for the treatment of health problems.

- Medical knowledge requires the provisional licensee to demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of knowledge to patients.

- Interpersonal communication skills requires the provisional licensee to demonstrate skills that are effective in the exchange of information and collaboration with patients, their families, and health professionals.

- Professionalism requires the provisional licensee to demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

- Practiced-based learning and improvement requires the provisional licensee to investigate and evaluate the licensee's care of patients, appraise and assimilate scientific evidence, and continuously improve patient care based on constant self-evaluation and lifelong learning.

- Systems-based practice requires the provisional licensee to demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Export to PDF Export to Excel

Agency **Department of Health Professions**

Board **Board of Medicine**

Chapter

Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic [18 VAC 85 - 20]

Action	**Licensure of foreign physicians through provisional and restricted licenses**
Stage	**NOIRA**
Comment Period	Ended on 4/23/2025

21 comments

All good comments for this forum **Show Only Flagged**

Back to List of Comments

Commenter: Brandi Kilmer, Refugee Physicians Advocacy Coalition (RPA) 4/7/25 7:38 pm

Commending the Board's NOIRA action

The Refugee Physicians Advocacy Coalition (RPA) strongly supported the HB995 legislation and commends the Board of Medicine's rule-making actions. RPA is assisting International Physicians prepare to qualify for the Provisional License and at present we have more than 30 International Physicians in our network (both inside and outside of Virginia) who are eligible for and preparing to qualify. We stand ready to assist Medical Institutions that are interested in moving forward with providing employment opportunities through Provisional License assessment and evaluation programming. Thank you for your thoughtful efforts in establishing the Provisional License pathway rules to help protect both licensees and patients. Submit

CommentID: **233555**

Commenter: Allyson Flinn, Medical Society of Virginia 4/10/25 2:42 pm

NOIRA for the Promulgation of a Licensure Pathway for Foreign Trained Physicians

Dear Dr. Harp,

As you know, the Medical Society of Virginia (MSV) represents Virginia's physicians, PAs, residents, and medical students. We appreciate the Department of Health Professions and the Board of Medicine for beginning this important regulatory action. The MSV worked closely with Delegate Tran on HB995 during the 2024 General Assembly Session, as we recognize that expanding access is a critical puzzle piece in addressing Virginia's healthcare shortage.

We look forward to collaborating with you all through this regulatory process to ensure the proposed regulations create a reasonable pathway to licensure for foreign trained physicians while

protecting the health and safety of the patients of the Commonwealth.

Thank you for your consideration.

Sincerely,

Allyson Flinn

Senior Health Policy Analyst

Medical Society of Virginia
CommentID: **233666**

Commenter: Lily Cameron, MD

4/22/25 5:14 pm

An important and much needed pathway

I am pleased that the Board of Medicine is diligently moving forward to help provide an alternative pathway into the medical field for internationally trained physicians. I do believe these physicians can contribute greatly to providing cultural competent medical care as well as provide expertise to serve the population of Virginia as a whole.

CommentID: **233833**

Commenter: Sultana Salam, MD & Afghan Association of Central Virginia

4/22/25 6:01 pm

Remove Barriers for Foreign Medical Providers to Serve Virginians

My name is Sultana A. Salam, MD, a board-certified Psychiatrist who has been practicing in the US for over 43 years. I am an FMG. I am also a co-founder of the Afghan Association of Central VA since the fall of Afghanistan in 2021.

I have been invited to partner with the Refugee Physician's Advocacy Committee because of the large number of Afghan Physicians that entered the US in 2021.

I would like to share with you some of the challenges faced by these physicians that have been shred WITH MWE, 90 of whom are in VA.

The majority of them have practiced in Afghanistan for more than 5-10 years. Many have been in leadership roles, teaching roles, and have held department chair positions. Many are internists, surgeons, obstetricians, psychiatrists, etc.

They found it difficult to prepare for the ECFMG due to the lack of response or any feedback from them after submitting the necessary documents and Form 186 that were certified by Notarycam.

Many found it difficult to prepare or sit for the USMLE due to the long hours they work to provide for their families (in menial jobs). But even after having worked long hours, the income they generate would not suffice to pay for Kaplan's classes or for the application fees to sit for the examinations. So financially they are limited, specially with the sky rocketing prices of housing rents, auto insurances, medical insurances, food, medical needs, utilities, etc.

Those physicians that did pass ECFMG, USMLE have failed to secure any residency positions, observer ships, or even externships because of the lack of " recommendation letters". How can

they obtain those from their country of origin when many people, who could provide such recommendations on their behalf, have been displaced or are deceased. The fact that some have been able to obtain their transcripts/medical documents is note-worthy.

One physician that I met a few weeks ago has passed ECFMG, all USMLE steps but unable to find a residency program and is paying a clinic $4 K(her husband started business and therefore able to afford it) every 4 weeks for an externship in order to obtain " letters of recommendation" to submit with her residency application

Many have applied for work in the health care field as medical assistants, nurses, etc. but denied because of being " overqualified or need for "certifications" which then mandate >3000 hours of supervision despite passing the examinations. How can they obtain supervision hours when no one hires them under their supervision?

Please note that these physicians have encountered many losses (their country, culture, family, friends, and prestige as professionals in their country) and are clearly experiencing depression, PTSD, anxiety, and demoralization.

I plead with you, to please give them a chance, a probationary period, to test their skills, their level of competency in their field of expertise, their ethics, and patient care. Let them undergo both practical and written exams to ensure they know what they are doing

I would like to propose a structured transitional pathway for the Afghan Medical graduates (as is available in Missouri and Washington). This could be in the form of an accelerated 6 -12 months residency program (for those with medical experiences of 5 years or more) that could open the doors to " provisional licensing " but it will also allow them to review/refresh their knowledge and prepare for the USMLE examinations. A " teaching medical environment" would be more conducive to their acquisition of knowledge faster, pertaining to the USA methods of assessing, managing, and coding for patient care. These doctors learn fast, trust me. They also need to hear all the symptoms, differential diagnoses in English.

I would also like to propose that loans be provided to them to pay for Kaplan's classes and USMLE fees but postpone their payback to when they are licensed (very much like owing tuition fees for college students). This will motivate them to study without having to worry about the financial aspects of the classes and examination fees.

Thank you in advance for your time, dedicated hard work and consideration into the case of these physicians who can definitely assist with the shortage of healthcare providers in VA.

Respectfully,

S. Ayubi-Salam, MD

CommentID: **233834**

Commenter: Agha W. Haider MD, PHD,

4/22/25 11:26 pm

Licensure of physicians through amendments of current licensing rules

Dear Members of the Virginia Board of Medicine,
I am writing to express my support for the Notice of Intended Regulatory Action (NOIRA) regarding HB995, which aims to address the healthcare provider shortage in Virginia. As a member of the Association of Physicians of Pakistani Descent of North America (APPNA), I commend the Board of Medicine and the Department of Health Professions (DHP) for their proactive steps in expanding access to healthcare services across the state.
APPNA has worked closely with Delegate Tran's team to advocate for this legislation, recognizing the critical need to leverage the expertise of international medical graduates who have practiced as specialists abroad for over 10 to 15 years. Many of these physicians have also completed the United States Medical Licensing Examination (USMLE) Steps 1, 2, and 3, albeit over a period exceeding the typical ten-year timeframe. Additionally, some of these physicians have completed residency training, further enhancing their qualifications and readiness to contribute to our healthcare system.
Given their extensive experience and the value they bring to our healthcare system, I urge the Board of Medicine to consider providing a waiver or accommodation for the ten-year rule on USMLE completion. Such a measure would be instrumental in facilitating the integration of these highly skilled professionals into our healthcare workforce, thereby enhancing patient care and addressing existing shortages.
Thank you for your consideration of this important issue. I am confident that with thoughtful regulatory adjustments, we can make significant strides in improving healthcare access and quality for the residents of Virginia.
Sincerely,
Agha W. Haider, MD PHD
Richmond, Commonwealth ofVirginia
CommentID: **233839**

Commenter: Bhushan H Pandya, MD, FACP

4/22/25 11:35 pm

NOIRA for licensing of Internationally trained physicians

Dear Dr. Harp,

I am a Board certified International Medical Graduate (IMG) trained in the US and practicing in Danville Virginia for last 40 years. I am a member of the ABMS task force on Additional pathway for licensing of Internationally trained Physicians (ITP). I am also a delegate to the AMA House of delegates from Virginia and have testified in support of this issue on behalf of our delegation.

I had presented comments to the Advisory Commission set up by FSMB, ACGME and Intealth (ECFMG and FAIMER). I agree with the following guidance they have recommended:

Rulemaking authority should be delegated, and resources allocated, to the state medical board for implementing and evaluating any additional licensure pathways.

- An offer of employment should be required for pathway eligibility. State medical boards should be authorized to define what is an appropriate clinical facility for the supervision and assessment of internationally trained physicians (ITPs) for their provisional licensure period.
- ECFMG Certification and graduation from a duly recognized medical school should be required for pathway eligibility.
- Completion of postgraduate training (graduate medical education) outside the United States should be required for pathway eligibility.
- Possession of authorization from another country or jurisdiction to lawfully practice medicine in that country or jurisdiction, and at least three years of experience in medical practice should be required for pathway eligibility.
- A limit on the physician's time "out of practice" that is consistent with that state's existing re-entry to practice requirements should be considered.
- A successfully completed period of supervision and assessment by an employer should be required of ITPs to transition from provisional licensure to full licensure.
- State medical boards should preserve their authority to assess each candidate for full and unrestricted licensure.
- State medical boards implementing additional licensure pathways should collect and share data to evaluate the program's effectiveness.

I look forward to contributing to the regulatory process that will hopefully help with Health manpower shortage area felt all over our Commonwealth by providing an option of a safe and high quality medical care to our communities.

Best regards,

Bhushan H. Pandya, MD, FACP
CommentID: **233840**

Commenter: Rizwan Ali, MD, DFAPA

4/23/25 8:14 am

International Medical Graduates

Dear Members of Virginia Board of Medicine!!

Thanks for the opportunity to allow us to share our comments regarding this important bill. International Medical Graduates are highly qualified, experienced and hard working physicians. They have years of experience in the different fields of Medicine ranging from Surgery to Dermatology. They have excellent work ethics and administrative skills. If there is a pathway to utilize their skills and tremendous potential, this will be a great service to the people of Commonwealth.

If we allow these IMGs to work under supervision for a probationary period of 12 months before granting them a restricted license for another 12 months, they will be a good addition to our medical community and will address the huge shortage of physicians in the state Virginia.

Sincerely,

Rizwan Ali, MD, DFAPA

President,
Psychiatric Foundation of Virginia
CommentID: **233843**

Commenter: Kenn Speicher, Refugee Physicians Avocacy Coalition 4/23/25 11:18 am

A valuable source of experienced physicians for Virginia

The Refugee Physicians Advocacy Coalition (RPA) strongly championed the HB995 legislation and applauds the Board of Medicine's actions to establish a more practical licensing pathway for qualified and experienced international medical graduates. RPA is assisting International Physicians prepare to qualify for Provisional Licensing, and is prepared to assist Medical Institutions interested in providing employment opportunities and assessment support for this initiative. These physicians offer an untapped source of skilled medical talent and care to serve the people of Virginia. In addition, they can help meet the projected need for more physicians in Virginia in the years ahead, especially for under-served communities. Thank you for your conscientious rule-marking efforts, which will offer a workable way forward for these deserving International Physicians and enhance healthcare for Virginia residents.

CommentID: **233846**

Commenter: Charlie Sheffield, American Board of Medical Specialties 4/23/25 11:30 am

Comment regarding new licensure pathways for internationally trained physicians

William L. Harp, MD
Executive Director
Board of Medicine
9960 Maryland Drive, Suite 300
Richmond, VA 23233

Re: Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic (Notice of Intended Regulatory Action)

Dear Dr. Harp and Members of the Virginia Board of Medicine:

As President and Chief Executive Officer of the American Board of Medical Specialties (ABMS), I am writing to share recommendations on proposed amendments regarding licensure pathways for internationally trained physicians in Virginia.

The ABMS represents the 24 individual Member Boards that collectively certify over 997,000 specialty physicians across 38 primary specialties and 89 subspecialties. ABMS participates in the Accreditation Council for Graduate Medical Education (ACGME), Federation of State Medical Boards (FSMB), and Intealth led Advisory Commission on Additional Licensing Models and conducts its own internal work group on internationally trained physicians. ABMS appreciates the opportunity to comment on proposed regulations governing the practice of internationally trained physicians in Virginia, and we share the Board of Medicine’s priorities of protecting patients and promoting high-quality healthcare throughout the state.

§ 54.1-2933.1. *Temporary licensure of certain foreign graduates* includes some of the recommendations developed both by the Advisory Commission (see **https://www.fsmb.org/siteassets/communications/acalm-guidance.pdf**) and ABMS (see **https://www.abms.org/wp-content/uploads/2025/01/abms-policy-brief-licensing-pathways-internationally-trained-physicians-national-standards-specialty-medical-care20250214.pdf**). State medical boards and other stakeholders have recommended requirements for these new pathways to include, at a minimum:

- An employment offer prior to application by an institution with experience in physician education and training;

- Educational Commission for Foreign Medical Graduates (ECFMG) certification and graduation from a recognized medical school (including passage of the United States Medical Licensing Examinations®);
- Evidence of substantially similar post-graduate training based on national standards for U.S.-based GME;
- Unrestricted medical license in another country with at least three years of full-time practice in the same specialty the physician plans to practice in the U.S.;
- No more than two years of time out of clinical practice; and
- A two-year provisional licensure period under supervision of a board-certified physician in the same specialty.

As the Board of Medicine develops new requirements for licensure of internationally trained physicians, ABMS emphasizes the need for both qualified supervision and oversight of these physicians and independent, objective assessment of new and provisional applicants in the practice of their specialty. Appropriate oversight and assessment of these provisional licensees is essential for ensuring patient safety and promoting high quality care.

Traditionally, most states require physicians to participate in an ACGME-accredited training program in a specialty before being granted a license to practice medicine. These programs are relied upon by state medical boards, physician certifying boards and employers to assess progress toward specific competencies in a medical specialty and to identify needs for additional training and supervision. In these new licensure pathways, state medical boards, employers and other partners will be required to fill these gaps in assessment, supervision, and training. In order to ensure all physicians who intend to practice in a medical specialty meet national standards for that specialty, ABMS further recommends the following additional requirements:

1. **Initial Assessment**: Rigorous evaluation of knowledge, cognitive and procedural skills, and professional behaviors by an independent organization with expertise in the medical/surgical specialty in which the internationally trained physician plans to practice.

2. **Supervision and Progressive Assessment**: Continuous observation and assessment by board-certified physicians during the provisional period, using tools developed by ACGME-accredited training programs.

3. **Access to Training**: Mechanisms to address gaps in knowledge and skills through training provided by certified physicians with expertise in the specialty.

4. **Final Assessment**: Comprehensive evaluation to determine competence in the specialty before issuing an unrestricted medical license.

Comment regarding proposed amendments to 18VAC85-20, Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic

Of the established amendments being considered, ABMS' recommendations are relevant to:

- (ii) application requirements for provisional and restricted licenses;
- (iii) renewal requirements for provisional and restricted licenses;
- (iv) criteria for assessment and evaluation programs of provisional licensees; and,
- (v) criteria to obtain a provisional license

ABMS comments are based on § 54.1-2933.1. *Temporary licensure of certain foreign graduates* (VA HB 995), with recommendations for building amendments re: the development of a licensure pathway for internationally trained physicians using a system of provision and restricted licensure.

B) 1. *Has received a degree of doctor of medicine or its equivalent from a legally chartered medical school outside of the United States recognized by the World Health Organization, has been licensed or otherwise authorized to practice medicine in a country other than the United States, and has practiced medicine for at least five years;*

ABMS Recommendation: In addition to having practiced medicine for at least five years, require that the internationally trained physician be no more than two years of time out of clinical practice.

ABMS Recommendation: Require evidence that the international license is unrestricted.

B) 2. *Has a valid certificate issued by the Educational Commission for Foreign Medical Graduates or other credential evaluation service approved by the Board, provided, however, that the Board may waive such certification at its discretion where the applicant is unable to obtain the required documentation from a noncooperative country;*

ABMS Recommendation: Require, without waiver, evidence of substantially similar post-graduate training based on national standards for specialty training.

B) 4. *Has entered into an agreement with a medical care facility as defined in § 32.1-3 that provides an assessment and evaluation program designed to develop, assess, and evaluate the physician's nonclinical skills and familiarity with standards appropriate for medical practice in the Commonwealth according to criteria developed or approved by the Board;*

ABMS Recommendation: In addition to the ongoing assessment and evaluation of the physician's nonclinical and clinical skills within the hiring institution, require that an independent, third-party assessment of the physician's clinical and non-clinical skills be conducted to hold the employer accountable for providing the necessary training to fill any gaps in knowledge or skills necessary for safe practice in a specialty.

ABMS Recommendation: Include a requirement for a supervising physician who should be board-certified in the same specialty if the internationally-trained physician will be practicing as a medical specialist in the medical care facility to ensure the supervising physician has the knowledge and skills necessary to determine the individual's competence to practice in the medical specialty.

C) 1. *The Board may issue such renewable license to an applicant if the applicant submits evidence acceptable to the Board that the applicant: Has successfully completed the participating medical care facility's assessment and evaluation program required pursuant to subsection B*

ABMS Recommendation: Include a requirement of a final independent assessment to provide an unbiased opinion of not only completion of the sponsoring entity's assessment and evaluation program, but to provide evidence the candidate can demonstrate the clinical and nonclinical skills necessary to practice in a given specialty without jeopardizing patient safety before being granted an unrestricted medical license.

ABMS specialty boards are committed to maintaining the highest standards for the medical profession and protecting public safety. Without access to board certification in a specialty, newly licensed internationally trained physicians may face disparities in employment opportunities and professional growth. Additionally, patients may be confused about the qualifications of these physicians and their ability to meet current standards for practice in their specialty. ABMS, ACGME, and national medical specialty societies are dedicated to developing the tools and resources necessary to help internationally trained physicians meet national standards for medical/surgical specialties.

Thank you for your consideration of this additional guidance on behalf of the American Board of Medical Specialties. Please contact me if ABMS can provide additional assistance on this issue.

Sincerely,

Richard E. Hawkins, MD
President and Chief Executive Officer
American Board of Medical Specialties
CommentID: **233847**

Commenter: Amanda Wibben, Medical Student

4/23/25 12:09 pm

Support of HB996

As a student who has conducted research with many of the refugee physicians in the DMV area, I support and commend the passage of this bill and the advocacy of the Refugee Physician Advocacy Coalition. Thank you for such thoughtful work on the bill's implementation. I look forward to working with many of these skilled physicians in the future. The state of VA would be privileged to benefit from their service.

CommentID: **233849**

Commenter: Saba Naz

4/23/25 12:26 pm

IMGs

This can be a great remedy to an acute shortage of PCPs in the USA.

CommentID: **233850**

Commenter: Fahim F. Karim

4/23/25 1:09 pm

Supporting The Board's Forward-Thinking NOIRA Action On Physician Licensure

I strongly support the proposed Provisional License pathway for foreign-trained physicians.

The U.S.—including Virginia—is facing a growing physician shortage, with projections showing a deficit of up to 124,000 physicians by 2034, particularly in rural and primary care areas. Foreign-trained physicians represent a ready, untapped talent pool to help close this gap—not in the future, but now.

These physicians bring medical expertise, deep cultural competence, and linguistic skills that reflect and serve the growing diversity of Virginia's communities. Research consistently shows that patient outcomes improve when cultural and linguistic barriers are removed—trust increases, adherence improves, and recovery accelerates.

Many of these physicians have also practiced under resource-limited conditions, developing resilience, innovation, and efficiency—traits our healthcare system urgently needs amid ongoing staffing shortages.

The benefits extend beyond patient care. Immigrant professionals who feel supported by their employers demonstrate strong loyalty and long-term commitment, reducing costly turnover in hospitals and clinics. They also come with substantial clinical experience, needing minimal ramp-up time to contribute at a high level.

And the data tells a larger story:
According to Harvard Business Review, while immigrants make up only 14% of the U.S. population, they own nearly 20% of new businesses and are behind 45% of Fortune 500 companies. In fact, four in five founders or top execs at billion-dollar startups are first- or second-generation immigrants. These companies grow faster, survive longer than those founded by natives, and contribute trillions to our economy.

Foreign-trained physicians are no different. With the right support, they will fuel innovation, stability, and long-term growth in our healthcare sector—just as immigrant entrepreneurs have done across industries.

This is not just a licensing proposal. It's a strategic investment in Virginia's health, equity, and economic development. I respectfully urge the Board to advance this essential policy.

Sincerely,

Fahim F. Karim
MBA Healthcare Management | Workforce Development Expert for Healthcare & Social Services

CommentID: **233851**

Commenter: Mary Righi

4/23/25 1:29 pm

Provisional License pathway for foreign-trained physicians.

I strongly support the proposed Provisional License pathway for foreign-trained physicians.

The U.S.—including Virginia—is facing a growing physician shortage, with projections showing a deficit of up to 124,000 physicians by 2034, particularly in rural and primary care areas. Foreign-trained physicians represent a ready, untapped talent pool to help close this gap—not in the future, but now.

These physicians bring medical expertise, deep cultural competence, and linguistic skills that reflect and serve the growing diversity of Virginia's communities. Research consistently shows that patient outcomes improve when cultural and linguistic barriers are removed—trust increases, adherence improves, and recovery accelerates.

Many of these physicians have also practiced under resource-limited conditions, developing resilience, innovation, and efficiency—traits our healthcare system urgently needs amid ongoing staffing shortages.

The benefits extend beyond patient care. Immigrant professionals who feel supported by their employers demonstrate strong loyalty and long-term commitment, reducing costly turnover in hospitals and clinics. They also come with substantial clinical experience, needing minimal ramp-up time to contribute at a high level.

And the data tells a larger story:

According to Harvard Business Review, while immigrants make up only 14% of the U.S. population, they own nearly 20% of new businesses and are behind 45% of Fortune 500 companies. In fact, four in five founders or top execs at billion-dollar startups are first- or second-generation immigrants. These companies grow faster, survive longer than those founded by natives, and contribute trillions to our economy.

Foreign-trained physicians are no different. With the right support, they will fuel innovation, stability, and long-term growth in our healthcare sector—just as immigrant entrepreneurs have done across industries.

This is not just a licensing proposal. It's a strategic investment in Virginia's health, equity, and economic development. I respectfully urge the Board to advance this essential policy.

Sincerely,

Mary Righi, MPH

CommentID: **233852**

Commenter: KEM TOLLIVER

4/23/25 1:58 pm

I strongly support the proposed Provisional License pathway for foreign-trained physicians

Having worked in healthcare settings for more almost 30 years, I've been actively involved in the evolution of healthcare delivery in the Unites States - particularly in DC, MD and VA. Our societal needs have also changed in unprecidented and unexpected ways which requires lawmakers to consider new approaches to population health management.

There are many threats to individual and population health. One of the most significant threats is access to care. The U.S.—including Virginia—is facing a growing physician shortage, with projections showing a deficit of up to 124,000 physicians by 2034.

Working with US born physicians for my entire career, I see how overworked and burdened with non-clinical administrative tasks. Our US born physicians need help. You can help them by including highly capable and available foreign-trained physicians into our stressed healthcare system. Our physician need them. Our patients deserve them. Our communities will thrive with them.

In addition to the wealth of knowledge they bring to our healthcare systems, there are many advocates who are willing, ready and able to develop sustainable entry infrastructures to mitriculate them successfully into US clinical care.

I urge you to prioritize augmenting Virginia's healthcare delivery system by incorporating foreign-trained physicians.
CommentID: **233853**

Commenter: Zahid Rashid MD

4/23/25 2:14 pm

Licensure of foreign medical graduates

Dear Board Members,

Ref: Licensure of physicians through amendments of current licensing

I support the Notice of Intended Regulatory Action (NOIRA) regarding HB995, which aims to address the healthcare provider shortage in Virginia. As a member of the Association of Physicians of Pakistani Descent of North America (APPNA), I commend the Board of Medicine and the Department of Health Professions (DHP) for their proactive steps in expanding access to healthcare services across the state.
APPNA has worked closely with Delegate Tran's team to advocate for this legislation, recognizing the critical need to leverage the expertise of international medical graduates who have practiced as specialists abroad for over 10 to 15 years. Many of these physicians have also completed the United States Medical Licensing Examination (USMLE) Steps 1, 2, and 3, albeit over a period exceeding the typical ten-year timeframe. Additionally, some of these physicians have completed residency training, further enhancing their qualifications and readiness to contribute to our healthcare system.
Given their extensive experience and the value they bring to our healthcare system, I urge the Board of Medicine to consider providing a waiver or accommodation for the ten-year rule on USMLE completion. Such a measure would be instrumental in facilitating the integration of these highly skilled professionals into our healthcare workforce, thereby enhancing patient care and addressing existing shortages.
Thank you for your consideration of this important issue. I am confident that with thoughtful regulatory adjustments, we can make significant strides in improving healthcare access and quality for the residents of Virginia.
Sincerely,
Zahid Rashid MD, FRCP
Petersburg, Commonwealth of Virginia”

CommentID: **233855**

Commenter: Sarah Kureshi, Georgetown University School of Medicine

4/23/25 3:20 pm

Tapping into the Strength of Our Communities: Support for the Provisional License Pathway

As a local Family Medicine physician and co-founder of the Refugee Physician Advocacy Coalition, I want to express my strong support for the Board’s decision to move forward with establishing rules for a Provisional License pathway for International Physicians. For many years, I have worked directly with refugee and immigrant physicians in Virginia -- talented, compassionate

individuals who bring deep clinical experience and cultural humility, yet face enormous structural barriers to contributing their skills in the U.S. health system.

The establishment of this pathway is not just a step toward workforce expansion -- it is a step toward equity, inclusion, and recognizing the untapped potential of our communities. These physicians are already embedded in our neighborhoods, raising families here, supporting patients as interpreters, health navigators, and volunteers. With the right support, supervision, and structured pathways like the Provisional License, they can play a critical role in addressing healthcare shortages and improving outcomes for our most underserved populations.

I commend the Board of Medicine for its leadership and thoughtful consideration of this issue, and I urge you to continue working with community partners, academic institutions, and advocacy groups like ours to ensure that the forthcoming rules are practical, equitable, and grounded in both patient safety and human dignity. We stand ready to support this important work in any way we can.

CommentID: **233862**

Commenter: Anonymous

4/23/25 6:53 pm

I strongly support the proposed Provisional License pathway for foreign-trained physicians

I strongly support the proposed Provisional License pathway for foreign-trained physicians

CommentID: **233885**

Commenter: Fern R. Hauck, MD, MS

4/23/25 7:06 pm

NOIRA for the Promulgation of a Licensure Pathway for Foreign Trained Physicians

Dear Dr. Harp,

We provide primary healthcare services to the large refugee population in Charlottesville and Albemarle County in our International Family Medicine Clinic at the University of Virginia, which is located in our Family Medicine Teaching Clinic on the main campus of UVA Health. We have served more than 4,000 refugee patients since the clinic's inception. Many of our patients were practicing physicians in Afghanistan, Syria and other countries. Our Virginia physician workforce would benefit greatly by adding qualified individuals through the Licensure Pathway. Moreover, our refugee patients and community members would benefit enormously by receiving care from these physicians, who speak their languages and come from the same cultures.

We strongly endorse and appreciate your efforts in creating this Provisional Licensure Pathway. Please don't hesitate to call upon us if we can provide insights or assistance.

Our endorsement is offered as individuals and does not represent the views of the University of Virginia or UVA Health.

Thank you.

Sincerely,

Fern R. Hauck, MD, MS and John Gazewood, MD, MPH

CommentID: **233886**

Commenter: Sidra B.

4/23/25 9:26 pm

Pathway for foreign trained physicians will hep elevate medical deserts

Allowing foreign-trained physicians to practice in the U.S. can significantly alleviate the growing physician shortage and address healthcare deserts, particularly in rural and underserved urban areas. These internationally educated doctors often possess the skills and experience necessary to provide high-quality care but face regulatory and licensing barriers that limit their ability to contribute. By streamlining the accreditation process and offering pathways to practice, the U.S. can tap into this valuable talent pool, increasing access to care, reducing patient wait times, and improving health outcomes in communities with limited medical resources.

CommentID: **233891**

Commenter: Anonymous

4/23/25 10:21 pm

Licensure of foreign physicians through provisional and restricted licenses

I strongly support this motion as it will go a long way for both IMGs and underserved US population.

CommentID: **233893**

Commenter: Sonia Riaz , MD PhD student at VCU

4/23/25 11:29 pm

support IMGs to practice in USA

Yes I endorse and support , I myself is a medical doctor, and I want to practice in USA without the long residency . This will help to fulfill the gap of primary care physicians in Rural areas as well .

CommentID: **233895**

Advisory Commission on Additional Licensing Models
GUIDANCE DOCUMENT

Introduction

The *Advisory Commission on Additional Licensing Models*, co-chaired by the Federation of State Medical Boards (FSMB), the Accreditation Council for Graduate Medical Education (ACGME) and Intealth™ (which oversees the Educational Commission for Foreign Medical Graduates - ECFMG), was established in December 2023 to guide and advise state medical boards, state legislators, policymakers and others, to inform their development and/or implementation of laws specific to the licensing of physicians who have already trained and practiced medicine outside the United States or Canada. In this document, the commission offers its first set of recommendations for consideration by all relevant stakeholders.

Internationally-trained physicians (ITPs), as described in some of the state laws enacted to streamline medical licensure to increase access to care in undeserved and rural communities, are usually referred to as physicians educated and trained abroad who *must* also be licensed and have practiced medicine in another jurisdiction. This cohort of physicians represents a relatively small category of international medical graduates (IMGs), the broader term used to describe physicians who received their medical degree outside the United States. Individuals who are ITPs, in most legislative descriptions, *must* have previously completed graduate medical education (also known as postgraduate medical education or postgraduate training) that is "substantially similar" to that which is recognized in the United States.

The purpose of the commission's recommendations, those contained herein and those that may follow, is to support the alignment of policies, regulations and statutes, where possible, to add clarity and specificity to statutory and procedural language to better protect the public – the principal mission of all state and territorial medical boards – and to advance the delivery of quality health care to all citizens and residents of the United States. This guidance, which should not be viewed as an endorsement, is provided to support those states and territories implementing new licensure pathways where legislation has been adopted and where legislation has been introduced or is being considered for introduction.

This first set of recommendations is focused on eligibility requirements and related considerations for entry by an ITP into an additional licensure pathway. To ensure that physicians entering these pathways are ultimately ready to safely practice medicine in the United States, these additional licensing pathways should optimally include assessment and supervisory elements during the period of provisional licensure, for which additional

guidance from the commission to state medical boards and relevant stakeholders should be forthcoming later in 2025.

Background

There are two primary pathways by which international medical graduates (IMGs) are eligible for medical licensure from a state medical board in the United States and its territories:

1. Completion of one to three years, depending on the state or territory,[1] of U.S.-based graduate medical education (GME) that is accredited by the ACGME, accompanied by certification by ECFMG® and successful passage of all three Steps of the United States Medical Licensing Examination® (USMLE®), is the most common pathway to medical licensure for international medical graduates (IMGs) in the United States. In addition to expanding a physician's knowledge and skills in one or more medical or surgical specialties, U.S.-based GME affords time for participants (whether previously trained and licensed abroad or not) to acclimate to the U.S. health care system, culture and social norms, and the medical illnesses and conditions that are most prevalent (e.g., heart disease, cancer, accidents) among those residing in the United States.
2. "Eminence" pathways (for prominent mid-career physicians) have long existed in many states, typically do not require ECFMG Certification or successful passage of any Step of the USMLE, and are likely to continue to be an option for highly qualified and fully-trained international physicians. These pathways are most often used by individuals deemed to have "extraordinary ability," including those classified as "eminent specialist" or "university faculty" pursuing academic or research activities, and typically align with the O-1 (extraordinary ability) visa issued by the U.S. State Department.[2] Of note, most state medical boards also have statutes or regulations allowing for the licensing of IMGs at their discretion[3], though in practice these are not easy to achieve or commonly available. A few medical boards explicitly allow postgraduate training (PGT) – also known as graduate medical education (GME) or postgraduate medical education (PGME) –completed in specific countries, such as England, Scotland, Ireland, Australia, New Zealand and the Philippines, to count toward the U.S.-based GME requirement for licensure.

[1] International Medical Graduates GME Requirements, Board-by-Board Overview, FSMB

[2] https://www.uscis.gov/working-in-the-united-states/temporary-workers/o-1-visa-individuals-with-extraordinary-ability-or-achievement

[3] Several states have authority to issue licenses to internationally trained physicians though other innovative approaches. For example, New York offers licensure without requiring a provisional supervisory period to highly qualified IMGs. California offers a three-year non-renewable license for up to 30 Mexican physicians a year to work in community health centers. Washington has a "clinical experience license" to help IMGs compete for residency matching.

Since January of 2023, nine (9) states have enacted legislation creating additional licensing pathways for internationally trained physicians that does <u>not</u> require completion of U.S.-based ACGME-accredited GME training.

These additional licensing pathways are designed principally for ITPs who wish to enter the U.S. healthcare workforce.

A primary goal of these pathways in many jurisdictions, reflected in public testimony and written statements submitted by sponsors and supporters, is to address U.S. healthcare workforce shortages, especially in rural and underserved areas. It must be noted that U.S. federal immigration and visa requirements will impact the practical ability of physicians who are not U.S. citizens or permanent U.S. residents (Green Card holders) to utilize any additional licensure pathway. Furthermore, the ubiquity of specialty-board certification as a key factor in employment, hospital privileging, and insurance panel inclusion decisions is likely to impact the efficacy of non-traditional licensing pathways. States may, therefore, wish to consider other healthcare workforce levers that could be more effective in increasing access to care, such as advocating for increased state and Medicare/Medicaid funding to expand U.S. GME training positions, offering some means of transition assistance to IMGs, and expanding the availability and utilization of enduring immigration programs like the Conrad 30 waiver program, U.S. Department of Health and Human Services (HHS) waivers, regional commission waivers, and United States Citizenship and Immigration Service (USCIS) Physician National Interest Waivers.

While the additional pathway legislation recently introduced and enacted varies from state to state, the commission's consensus-driven guidance highlights areas of alignment and suggests specific considerations and resources for implementation and evaluation of these pathways, where that may be possible. The commission drafted its first set of recommendations based on areas of concordance in legislation already introduced and enacted, as well as expert opinion. The following recommendations are offered for consideration by state medical boards, state legislators, policymakers, and other relevant parties:

1. **Rulemaking authority should be delegated, and resources allocated, to the state medical board for implementing and evaluating any additional licensure pathways.**
2. **An offer of employment should be required for pathway eligibility. State medical boards should be authorized to define what is an appropriate clinical facility for the supervision and assessment of internationally trained physicians (ITPs) for their provisional licensure period.**
3. **ECFMG Certification and graduation from a duly recognized medical school should be required for pathway eligibility.**
4. **Completion of postgraduate training (graduate medical education) outside the United States should be required for pathway eligibility.**

5. **Possession of authorization from another country or jurisdiction to lawfully practice medicine in that country or jurisdiction, and at least three years of experience in medical practice should be required for pathway eligibility.**
6. **A limit on the physician's time "out of practice" that is consistent with that state's existing re-entry to practice requirements should be considered.**
7. **A successfully completed period of supervision and assessment by an employer should be required of ITPs to transition from provisional licensure to full licensure.**
8. **State medical boards should preserve their authority to assess each candidate for full and unrestricted licensure.**
9. **State medical boards implementing additional licensure pathways should collect and share data to evaluate the program's effectiveness.**

Recommendations

1. **Rulemaking authority delegated, and resources allocated, to the state medical board for implementing additional licensure pathways.**

Many states that have enacted additional pathway legislation have explicitly included and codified state medical board involvement in implementation and operational processes to ensure the ability of the state to support safe medical practice.

Additional licensing pathways will likely incur increased time and resources for state medical board personnel. State legislatures should consider additional funding and resources that may be allocated through state appropriations to implement, operationalize, and evaluate any additional pathway for medical licensure. Insufficient financial resources to support such additional licensing pathways risks inadequate resources and expertise that may lead to rushed or incomplete licensure eligibility decisions, risking the admission of underqualified practitioners or delays in integrating ITPs into the healthcare workforce.

States evaluating how to proceed may wish to consider first authorizing their state medical boards to establish a smaller pilot program, with primary care specialties that typically require a shorter period of GME that is more comparable internationally, and which may serve to better help increase access to care in rural and underserved areas. Such an approach may also enable state medical boards and private partners to build the necessary infrastructure and trust for adoption of the pathways and to evaluate the supervisory provisional licensure period before a substantial increase in applicants, or expansion to other specialties, takes place.

***Recommendation 1a*: States should empower their medical boards to promulgate rules and regulations should they choose to enact additional licensure pathway requirements for qualified, internationally trained physicians.**

Recommendation 1b: **State legislatures should ensure state medical boards have the necessary resources to fully implement, operationalize, and evaluate any new, additional licensure pathways, including the ability to hire or assign staff with knowledge and understanding of licensing international medical graduates.**

2. **An offer of employment prior to application for an additional pathway.**

Internationally-trained physicians (ITPs) applying for a license to practice medicine under newly enacted licensure pathways are being required by statute to have an offer of employment from a medical facility that can assure supervision and assessment of the ITP's proficiency. All states that have enacted additional pathway legislation at the time of this document's writing have included such a requirement, whether it is employment at a hospital that has an associated ACGME-accredited residency program, a Federally Qualified Health Center (FQHC), a Community Health Center (CHC), a Rural Health Clinic (RHC), or other state-licensed clinical facility that has the capacity and experience with medical education and assessment to shoulder the supervisory responsibility. The employer should in all cases be an entity with sufficient infrastructure that allows for supportive education and training resources for the ITP, as well as supervisory and assessment resources that include, but are not limited to, peer-review. For this reason, offers by individual physicians in solo or group practices to serve as employers for ITPs eligible for these pathways are not advisable as such settings may not have the capacity to provide supervision, the breadth and depth of exposure to a variety of clinical experiences may be limited, and because this may raise conflict of interest concerns related to the employer-employee relationship.

Recommendation 2a: **States in consultation with state medical boards should require internationally-trained physicians applying under an additional licensure pathway to have an offer of employment from an appropriate medical facility.**

Recommendation 2b: **States in consultation with state medical boards should define which medical facilities are able to supervise and assess the ITP's proficiency and capabilities (e.g., a facility with an ACGME-accredited program, an FQHC, a CHC, an RHC or other medical facility that has capacity and experience with medical education and assessment).**

3. **ECFMG Certification and graduation from a duly recognized medical school.**

Internationally-trained physicians applying under an additional licensure pathway should be graduates of a duly recognized medical school. All states that have enacted pathway legislation at the time of this document's release have included such a requirement.

Recognition or inclusion of medical schools in directories from organizations such as the World Health Organization (WHO) or the *World Directory of Medical Schools* (*World Directory*)[4] may serve as a useful proxy for this requirement. The latter compendium, launched in 2014 and updated continuously, is jointly managed and operated by the World Federation for Medical Education (WFME) and FAIMER® (a division of Intealth.)

Recommendation 3: **States should require ECFMG Certification for internationally-trained physicians to enter an additional licensure pathway**.
Traditionally, IMGs have been required to obtain ECFMG Certification, a qualification that includes verification of their graduation from a *World Directory*-recognized medical school, passage of USMLE Steps 1 and 2, and demonstration of English language proficiency via the Occupational English Test (OET) Medicine.

State medical boards may also wish to require IMGs to provide additional supporting materials of the medical education they have undertaken outside the United States. In such instances, primary source verification and review of credentials that utilizes resources such as Intealth's Electronic Portfolio of International Credentials (EPIC℠)[5] may be useful.

4. Completion of post-graduate training (PGT) outside the United States.

Most states that have enacted additional pathway legislation have included a requirement that applicants must have completed PGT that is "substantially similar" to a residency program accredited by the ACGME in the United States. There is significant variability, however, in the structure and quality of international PGT. The degree of clinical exposure may be variable and inconsistent across programs. Too, there is not currently an established and accepted recognition system, accreditation system or authority that is in a position to deem an international PGT program to be "substantially similar" to an ACGME-accredited PGT program available in the United States. Most state medical boards, for their part, have limited capacity, resources, or expertise to assess international programs for this purpose.

Until a formal recognition or accreditation system for PGT is created, the term "substantially similar" will need to be defined and determined by state medical boards.[6]

---

[4] https://www.wdoms.org/. Many states that have enacted pathway legislation have included language that the applicant ITP have received a "degree of doctor of medicine or its equivalent from a legally chartered medical school recognized by the World Health Organization" as a requirement. However, the WHO no longer maintains an active list or directory of international medical schools. The "California List" may also be referenced (https://www.mbc.ca.gov/Licensing/Physicians-and-Surgeons/Apply/Schools-Recognized.aspx), however, the California list utilizes the World Directory mentioned above.

[5] https://www.ecfmg.org/psv/

[6] The World Federation for Medical Education (WFME) is developing a program to recognize international accreditation systems for PGT. While a comprehensive list will not be available for several years, this

Arriving at definitions and determinations of substantial similarity, in turn, will have significant implications for state medical boards to plan for and obtain additional resources, support, and expertise to evaluate international training programs that generally have significant variability in structure, content, and quality. In the absence of resources to assist state medical boards in making determinations of substantial equivalency, state medical boards may be asked to make licensure decisions without adequate data on physician training, a challenge that may put patients at risk.

Recommendation 4a: **Completion of formal, accredited PGT outside the United States should be a requirement for entry into an additional licensure pathway.**

Formal postgraduate training and accreditation is not available in all countries and jurisdictions. In its absence, some states and territories may be inclined to consider alternative forms of training abroad. We advise doing so only on a case-by-case basis. The circumstances and experiences involved in these types of training – including apprenticeship, clerkship, or observership models – also differ widely in objective measures of quality (when fellowship training is not involved) and sometimes involve quasi-residency arrangements that may or may not adequately support, in whole or in part, an international physician's ultimate eligibility for a full and unrestricted licensure in a jurisdiction of the United States.

State medical boards may make use of a variety of existing proxies for determining that a PGT program completed outside the United States is "substantively similar" for purposes of additional licensure pathway eligibility for ITPs, including whether the program has been accredited by *ACGME International* (ACGME-I) and/or whether the ITP has completed an ACGME-accredited fellowship training program in the United States. Boards may also wish to ask the ITP to submit their training program's curriculum (and case requirements, for surgical specialties) for consideration and review.

A "number of years in-practice" threshold in a given specialty, in place of a requirement for formal PGT, is not recommended. However, it may be considered on a case-by-case basis by the state medical board as an alternative metric, only if it includes additional requirements and safeguards, such as ECFMG Certification and passage of all three Steps of the USMLE program. Where boards have access to, or can partner with, organizations with relevant experience and expertise, they should seek to determine the nature of such practice, including degree of clinical exposure, interaction with patients, and performance of procedures; where applicable, this information is likely to be valuable in making determinations of competence and practice readiness. Again, it is important to note that many state medical boards lack the resources and expertise to make such determinations themselves.

---

voluntary program, launching in mid-2025, will allow accreditation agencies to apply for recognition. Those meeting predefined criteria will be listed on the WFME website as recognized systems.

5. **Possession of a license/registration/authorization to practice medicine in another country or jurisdiction and medical practice experience.**

Most states that have enacted additional pathway legislation have included a requirement that applicants be licensed or authorized to practice medicine in another country. Practice experience requirements in current legislation for additional pathways vary from three to five years. Such legislation typically also includes a requirement that the license obtained overseas be considered "in good standing" and that an attempt be made by the state medical board to verify the physician's disciplinary and criminal background history. State medical boards should consider primary source verification of any documentation from applicants related to licensure, employment and practice history.

Recommendation 5: **States should require internationally trained physicians applying for a license under an additional licensure pathway to be fully licensed, registered, or authorized to practice medicine in another country or jurisdiction and to provide evidence of medical practice experience of at least three years.**

6. **A limit on "time out of practice" before becoming eligible to apply for an additional licensure pathway.**

An internationally-trained physician's time out of active practice before applying for an additional licensing pathway is limited by statute in a number of states, in line with extant guidelines required for medical licensure renewal of current licensees, whether U.S. graduates or IMGs. "Time out of practice" is a challenge and concern for state medical boards in terms of assuring patient safety and public protection, regardless of where the training occurred or where the initial licensure was obtained, given that the practice of medicine changes rapidly. Many state medical boards already recommend a formal re-entry process when a licensed physician has been out of practice for more than a certain number of years (the most often cited period of time in statutes and regulations is two years).[7]

Recommendation 6: **States should consider limits on "time out of practice" for internationally-trained physicians that are consistent with existing re-entry to practice guidelines for other physician applicants and licensees within their jurisdiction.** States that have enacted additional licensing pathway legislation have listed varying ranges for the number of years of ITP practice that will or should be required, ranging from continuous practice preceding application to within the preceding five years. States should be cognizant that requiring continuous practice may be difficult for many applicants to manage and/or demonstrate, especially if they have to navigate the U.S. immigration system, adjust to displacement, and/or face any number of non-immigration barriers also

[7] board-requirements-on-re-entry-to-practice.pdf (fsmb.org)

faced by domestic physicians, such as time away from active practice, including but not limited to, for sickness, caregiving or raising children.

7. **A requirement for a period of supervised provisional licensure by an employer in the United States.**

All of the states that have enacted additional pathway legislation as of the date of this writing explicitly require ITPs eligible for additional pathways to first complete a temporary supervised period of provisional licensure.

The word "supervision" is mentioned as a part of this provision by some states, and a few states will allow ITPs to practice "under the supervision of a licensed physician for two years" as part of their pathway. Supervision and support for internationally-trained physicians are crucial to navigate and bridge cultural differences, and to enable qualified ITPs to learn the practical, technical and operational sides of the U.S. health care system, including cultural diversity, health system variabilities, billing processes and use of an electronic health record. Such supervision and support are also essential for public protection. Examples of supervisory structures that could be helpful to require of ITPs include a collaborative practice arrangement, preceptorships and/or more formalized training models that include opportunities for progressive assessment of the ITP's caseload and practice. States may also choose to require a "declaration of fitness" that is made by one or more supervising physicians or verification of compliance with a state's continuing medical education (CME) requirements in order to progress to full and unrestricted licensure.[8]

The advisory commission is exploring resources available to assist state medical boards with the potential structure of a meaningful and reasonable assessment program during the period of supervised provisional licensure and anticipates proposing a set of recommendations on this matter by the end of 2025.

***Recommendation 7a*: States should require a period of temporary provisional licensure for qualified internationally trained physicians.**

***Recommendation 7b*: During their period of temporary provisional licensure, applicants should be supervised by licensed physicians within the same specialty as the applicant's intended practice.**

***Recommendation 7c*: During this period of temporary provisional licensure, applicants should undergo assessment (as authorized by statute and defined by the state medical boards) and be provided adequate support by the employer to help the**

[8] Continuing Medical Education, Board-by-Board Overview, FSMB

international physician navigate and bridge cultural and boundary differences, including understanding billing, coding and electronic health records.

States have taken a variety of approaches in specifying the duration of provisional licensure, with two or three years being the most common time periods cited in legislation. However, there have been some legislative proposals for a two-step progression, by which an IMG first becomes eligible for a restricted or limited license after at least two years of provisional licensure, but still practices in areas or specialties with the greatest medical need.

8. **Eligibility for a full and unrestricted license to practice medicine.**

All states that have enacted additional pathway legislation have included a provision that at the conclusion of the provisional or restricted licensure period, the qualified international physician should become eligible to apply for a full and unrestricted license to practice medicine. There is a small but meaningful linguistic divergence in the legislation, however, with wording indicating that state medical boards *may* or *shall* grant a full and unrestricted license to the IMG applicant.

State medical boards ordinarily and typically retain the authority to make licensure decisions for all licensees, even after a period of provisional licensure. Automatic transition to full and unrestricted licensure, by contrast, is neither ordinary nor typical. State medical boards may wish to consider working with their legislatures to retain the ability to exercise their due diligence and the ability to assess each applicant on their merits before determining whether they meet the state's criteria for full licensure.

States may also consider additional explicit requirements for provisional licensees before being granted eligibility for full licensure, such as passing Step 3 of the USMLE (already a requirement for all other IMGs for licensure), passing the employer's (or facility's) assessment and evaluation program, and having neither disciplinary actions nor investigations pending over the course of the provisional licensure period. Most states that have enacted pathway legislation have required a combination of these steps, and there have been some proposals to include a letter of recommendation from the applicant's supervising physician, as well.

***Recommendation 8a*: State medical boards in states that have enacted legislation to create additional licensing pathways for internationally-trained physicians should work with their legislatures, where permitted, to retain their historic and statutory ability to exercise their due diligence and assess each applicant on their merits before they progress from provisional to full and unrestricted licensure.**

***Recommendation 8b:* State medical boards should add a requirement for passing USMLE Step 3 (as already required of all IMGs) for a full and unrestricted license and a**

***proviso* that the applicant not have any disciplinary actions or investigations pending from their provisional licensure period.**

9. **State medical boards implementing additional licensure pathways should collect and share data to evaluate their effectiveness.**

Data collection and dissemination related to additional licensure pathways is going to be critical for state medical boards, state legislators, and other stakeholders to better understand the impact of these legislative efforts. Significant questions remain about the efficacy of these additional pathways to address U.S. health care workforce shortages, in underserved areas and otherwise. Much of the legislation introduced thus far does not address what may be significant barriers to employment and the ability to practice with a full license in other jurisdictions. These questions include whether physicians entering a pathway will be eligible for specialty board certification, whether malpractice insurers will cover their practice, and whether payors will enable reimbursement for the services provided by these physicians.

***Recommendation 9*: State medical boards, assisted by partner organizations as may be necessary, should collect information that will facilitate evaluation of these additional licensure pathways to make sure they are meeting their intended purpose.**

To help answer questions about the efficacy of additional licensure pathways, state medical boards should consider collecting data that includes:

- the number of applicants
- the number of individuals receiving provisional licensure under the pathway and the number denied provisional licensure under the pathway
- the number of individuals achieving full and unrestricted licensure,
- the percentage of individuals that stay and practice in their specialty of training and in rural or underserved areas
- the number of complaints received and disciplinary actions taken (if any)
- the practice setting and specialty of individuals entering additional pathways
- the number of individuals licensed through additional licensure pathways who ultimately remain in the United States versus returning to their home countries
- the number of individuals achieving specialty board certification
- the costs to the board of operating an additional licensing pathway

Conclusion

These recommendations focus largely on additional pathway eligibility requirements and related considerations for entry into an additional licensure pathway. To ensure that international-trained physicians entering these pathways are ultimately prepared to safely practice medicine in the United States, additional licensing pathways should optimally

include assessment and supervisory elements during a period of provisional licensure, for which additional guidance is planned by the commission in the months ahead.

Advisory Commission on Additional Licensing Models
GLOSSARY

The Advisory Commission presents the following glossary to support a common interpretation among stakeholders of key terms related to additional licensing models:

"additional pathway" is a colloquial, broad term referring to states that have proposed and/or passed legislation that, while differing in details, creates a *new* pathway to full medical licensure for internationally-trained physicians, a pathway that distinguishes itself by not requiring U.S.-based or Canadian-based GME, in contrast to the typical IMG licensure pathway, but begins in the U.S. with a provisional licensure period, which may eventually be converted to a full license.

"board certification" is a voluntary process by which a physician demonstrates expertise in a specific medical specialty or subspecialty by meeting standards set by a specialty certifying board. It typically involves completing specialty-specific training and passing comprehensive exams, signaling a higher level of proficiency beyond basic medical licensure. The American Board of Medical Specialties requires successful completion of an ACGME-accredited residency training program in the United States as a prerequisite for physicians to become eligible for board certification.

"graduate medical education" (GME) refers to the period of didactic and clinical education in a medical specialty, subspecialty, or sub-subspecialty that follows completion of undergraduate medical education (i.e., medical school) and which prepares physicians for the independent practice of medicine in that specialty, subspecialty, or sub-subspecialty. Also referred to as residency or fellowship education, GME builds a physician's knowledge and skill, and teaches cultural and societal norms. GME is frequently used synonymously with PGT by state medical boards, although PGT may include a broader range of activities. In the U.S., GME is regulated by the Accreditation Council for Graduate Medical Education (ACGME). Medicare is the principal funder of GME training slots, and Medicaid also contributes, although the level varies state-by-state.

"Educational Commission for Foreign Medical Graduates" (ECFMG) refers to the division of Intealth that assesses the qualifications of international medical graduates (IMGs) who wish to pursue residency or fellowship training and eventually practice medicine in the United States.

"ECFMG certification" is a required credential among IMGs matriculating to United States or Canadian medical licensure along the traditional IMG pathway. ECFMG Certification is required for entry into ACGME-accredited US GME and for licensure in the United States. To be eligible for ECFMG certification, an IMG must 1) graduate from a medical school that meets ECFMG's requirements (schools that meet ECFMG's requirements will be listed in World Directory of Medical of Medical Schools with an ECFMG Sponsor Note) , 2) meet the

medical examination requirements, currently fulfilled by passing USMLE Steps 1 and 2 ; 3) meet the clinical skills and communication requirements (including English language proficiency), currently met by completing ECFMG's Pathways, which includes attaining a satisfactory score on the Occupational English Test (OET) Medicine. Many states that have enacted additional pathway legislation have included ECFMG certification among their requirements for provisional license applicants.

"eminence pathways" refers to pathways to licensure that exist in almost all states for ITPs with "extraordinary ability," are renowned specialists, or are recruited to be university faculty, including those pursuing academic or research activities. Such physicians typically align with the O-1 (extraordinary ability) visa issued by the U.S. State Department.

"international medical graduates" (IMGs) are graduates of a medical school outside the United States and Canada, but who may not *necessarily* be licensed to practice medicine in a foreign country. The location of the medical school, not the citizenship of the individual, is what determines whether they are IMGs. In the traditional IMG pathway, ECFMG-certified IMGs come to the United States for required GME, for a time period that varies from state-to-state, prior to full licensure eligibility.

"international medical programs" are the medical programs from which IMGs were taught. In states that have enacted additional pathway legislation, they have alternatively been defined as a medical school, residency program, or entity that provides physicians with a medical education or training that is "substantially similar" to that received in the United States or Canada; or as a medical school, residency program, or entity approved by the ECFMG.

"internationally-trained physicians" (ITPs) or "international physicians" are IMGs that must already be licensed *and* practicing in a foreign country, as contrasted with an IMG, who may not necessarily be licensed or practicing, but *possess* a medical degree from a school outside of the United States and Canada. This distinction is key in the advisory commission's guidance, although the terms (ITP and IMG) are often used interchangeably in legislation. Among the states that have enacted additional pathway legislation, some have included in their definition of ITPs requirements that the licensee must be in good standing, have a minimum amount of practice experience, and have completed a residency in their resident country, among other requirements.

"postgraduate training" (PGT), a term that is also known as postgraduate medical education (PGME) outside of the United States and Canada, is often used interchangeably with graduate medical education (GME), but may include a wider range of activities (e.g., academic or nonclinical training). In additional pathway legislation, PGT is the term most commonly used by legislators and regulators.

“practice of medicine” is the investigation, diagnosis, treatment, correction, or prevention of, or prescription for, any human disease, ailment, injury, or other condition, physical or mental, by any means or instrumentality that involves the application of principles or techniques of medical science.

“re-entry process” is a formal, structured curriculum that includes clinical experience and prepares a physician to return to clinically active practice following an extended period of clinical inactivity (the most often cited acceptable period of time in most statutes, before further assessment may be necessary, is two years). Physician Reentry Programs follow, and are informed by, a comprehensive assessment of the physician’s competence in order to determine educational needs.

“state medical board” (SMB) is a regulatory body, whose members are usually appointed by the state or territory’s governor, that oversees the practice of medicine within its jurisdiction. Its responsibilities include licensing physicians, creating and revising rules to implement laws enacted by the legislature, ensuring they meet educational and professional standards, investigating complaints of misconduct, and taking disciplinary actions when necessary. The board statutorily aims to protect public health and safety by ensuring that medical professionals provide competent and ethical care.

“substantially similar” is a description used by many states that have passed additional pathway legislation to describe a threshold, when compared to United States or Canadian medical education and residencies, that applicant ITPs must meet, and may refer to the medical school or PGT. “Substantially similar” education or training is generally considered a lower bar than “substantially equivalent” education or training, can be defined as comparable in content and experience, but may differ in format or method of delivery. The term implies reasonable confidence that the international program has prepared its graduates to begin professional practice at the entry level, and is comparable to a program in the United States or Canada. Proxies for determining substantial similarity include accreditation by ACGME International (ACGME-I) and/or whether the IMG has completed an ACGME-accredited fellowship training program in the United States. Many states that have enacted additional pathway legislation have explicitly tasked their medical board with defining “substantially similar” in the context of the legislation.

“supervision” means a medical board-mandated process whereby an experienced supervising physician who meets requirements set forth by the state medical board observes a physician for a defined period and provides feedback, education, and clinical support. Supervision and support for IMGs is crucial to navigate and bridge cultural and boundary differences.

“traditional IMG pathway” describes the typical pathway by which IMGs become fully licensed to practice medicine in the United States and Canada.[9] IMGs are usually required to obtain an MD degree or equivalent from an international medical program, pass USMLE Steps 1 and 2, obtain ECFMG certification, and a visa to enter or stay in the United States, if necessary. The minimum amount of accredited GME varies by state,[10] but typically, the IMG is required to complete one to three years of residency training to be eligible for full licensure.

“United States Medical Licensing Examination” (USMLE) is a three-step standardized test that assesses a physician's ability to apply knowledge, concepts, and principles necessary for safe and effective patient care. Passing all three steps is required for medical licensure in the United States.

[9] https://www.fsmb.org/SysSiteAssets/usmle-step3/pdfs/pathway-to-licensure.pdf
[10] https://www.fsmb.org/siteassets/advocacy/policies/img-gme-requirements-key-issue-chart.pdf

Advisory Commission on Additional Licensing Models

Members[11]

Humayun Chaudhry, DO (co-chair)
Federation of State Medical Boards

John Combes, MD (co-chair)
Accreditation Council for Graduate Medical Education

Eric Holmboe, MD (co-chair)
Intealth

Helen Burstin, MD
Council of Medical Specialty Societies

Robert Cain, DO
American Association of Colleges of Osteopathic Medicine

Sanjay Desai, MD
American Medical Association

Rich Hawkins, MD
American Board of Medical Specialties

Oliver Kim, JD
Virginia Board of Medicine

Nicole Krishnaswami, JD
International Association of Medical Regulatory Authorities

Yolanda Lawson, MD
National Medical Association

Genevieve Moineau, MD
World Federation for Medical Education

Shannon Scott, DO
American Osteopathic Association

Alison Whelan, MD
Association of American Medical Colleges

[11] Organizational affiliations are presented for purposes of identification and do not imply endorsement of any draft or final version of this report.

Danny Takanishi, MD
Hawaii Medical Board

Tim Terranova
Maine Board of Licensure In Medicine

Ex Officio

George Abraham, MD
FSMB Chair-elect, Board of Directors

Thomas Nasca, MD
Accreditation Council for Graduate Medical Education

Katie Templeton, JD
FSMB Chair, Board of Directors

Debra Weinstein, MD
Accreditation Council for Graduate Medical Education

Staff Support

Federation of State Medical Boards
John Bremer
Andrea Ciccone, JD
David Johnson, MA
Lisa Robin, MLA
Andrew Smith, MPP
Mark Staz, MA

Intealth
Lyuba Konopasek, MD
Kara Oleyn, JD
Matthew Shick, JD
Jessica Salt, MD
Tracy Wallowicz, MLS

Accreditation Council for Graduate Medical Education
Kristin Hitchell, JD
Lauren Holton, EdD
Mary Klingensmith, MD

Appendix 1. Visa Options for Physicians

Non-U.S. citizen international medical graduates (IMGs) seeking to engage in clinical training or provide clinical patient care in the United States have several visa options, each with specific requirements.

- **J-1 Visa**: This is the most common visa for physicians participating in clinical training programs. The J-1 visa is issued under the U.S. Department of State's BridgeUSA Program, and are sponsored by Intealth, the sole sponsor in the United States for this visa classification for physicians. While there is a two-year return home commitment for physicians holding this visa classification, there are options for waivers of this two-year requirement under specific circumstances, such as working in medically underserved areas.
- **H-1B Visa**: The H-1B visa is an employment-based visa for foreign nationals working in specialty occupations, including clinical patient care and training. It requires sponsorship from a U.S. employer, who must file a petition on behalf of the physician and pay all associated fees.
- **Other Common Visa Options**: In addition to J-1 and H-1B, there are other visa categories that allow physicians to engage in clinical training or patient care:
    - **O-1 Visa**: For individuals with extraordinary abilities, including highly qualified physicians.
    - **Employment Authorization Document (EAD)**: Available for certain individuals with dependent visa statuses (e.g., J-2, H-4) or other immigration statuses, such as those with Temporary Protected Status (TPS), DACA, or asylum, allowing them to work or engage in clinical training.

TABLE 1: Comparison of J-1 and H-1B for Physicians

	J-1	H-1B
Prerequisite Examinations	USMLE Step 1, Step 2	USMLE Step 1, Step 2, Step 3
Sponsor	Intealth (ECFMG)	Employing hospital
Cost to Hospital	$0	$3000 - $10,000+ per physician
Wage Requirements	None	Prevailing wage*
Dual Intent?**	No, with exceptions	Yes

** The "prevailing wage" is the minimum wage an employer must pay the foreign worker, based on the average wage for similar positions in the job's geographic area. Employers must confirm they will meet or exceed the prevailing wage.*

*** Dual intent refers to a provision in U.S. immigration law that allows a foreign national to enter the U.S. on a nonimmigrant visa while simultaneously seeking to become a permanent resident (green card holder).*

TABLE 2: Other Common Visa Types for Physicians

Visa	Eligibility Criteria	Duration
O-1A	Individuals with an extraordinary ability in the sciences, education, business, or athletics	3 years (1 to 3-year extensions possible)
J-2 EAD/ H-4 EAD	Spouses of J-1/H-1B visa holders	Subject to primary visa holder's status
Temporary Protected Status (TPS)	Nationals of specifically designated countries who are already within the US	Typically assigned this designation for 18 months, but may be extended
Deferred Action for Childhood Arrivals (DACA)	Individuals who were physically present in the United States on June 15, 2012 with no lawful immigration status after having entered the country as children at least five years prior	2 years (renewable)
Asylum	Individuals already in the US seeking protection because they have suffered persecution or have a well-founded fear that they will suffer persecution in the home country	No expiration and can be converted into a green card

CHAPTER 464

An Act to amend and reenact § 54.1-2933.1 of the Code of Virginia, relating to the Board of Medicine; temporary licensure of physicians licensed in a foreign country.

[H 995]

Approved April 4, 2024

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2933.1 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2933.1. Temporary licensure of certain foreign graduates.

A. The Board may issue~~,~~ to a physician licensed in a foreign country~~,~~ a nonrenewable license valid for a period not to exceed two years to practice medicine while such physician is attending advanced training in an institute for postgraduate health science operated collaboratively by a health care system having hospitals and health care facilities with residency and training ~~program(s)~~ *programs* approved by an accrediting agency recognized by the Board and a public institution of higher education. This temporary license shall only authorize the holder to practice medicine in the hospitals and outpatient clinics of the collaborating health care system while he is receiving training in the institute for postgraduate health science.

B. The Board may issue to a physician previously licensed or otherwise authorized to practice in a foreign country a provisional license to practice medicine valid for a period not to exceed two years to an applicant if the applicant submits evidence acceptable to the Board that the applicant:

1. Has received a degree of doctor of medicine or its equivalent from a legally chartered medical school outside of the United States recognized by the World Health Organization, has been licensed or otherwise authorized to practice medicine in a country other than the United States, and has practiced medicine for at least five years;

2. Has a valid certificate issued by the Educational Commission for Foreign Medical Graduates or other credential evaluation service approved by the Board, provided, however, that the Board may waive such certification at its discretion where the applicant is unable to obtain the required documentation from a noncooperative country;

3. Has achieved a passing score on both Step 1 and Step 2 (Clinical Knowledge) of the United States Medical Licensing Examination;

4. Has entered into an agreement with a medical care facility as defined in § 32.1-3 that provides an assessment and evaluation program designed to develop, assess, and evaluate the physician's nonclinical skills and familiarity with standards appropriate for medical practice in the Commonwealth according to criteria developed or approved by the Board;

5. Will enter a full-time employment relationship with such medical care facility after the Board issues a license pursuant to this subsection; and

6. Has satisfied any other criteria that the Board may require for issuance of a provisional license pursuant to this subsection.

C. An individual who successfully obtains a license pursuant to subsection B and practices under such license until its expiration shall be eligible to apply for a renewable two-year restricted license to practice medicine in a medically underserved area in Virginia as defined in § 32.1-122.5 or a health professional shortage area designated in accordance with the criteria established in 42 C.F.R. Part 5. The Board may issue such renewable license to an applicant if the applicant submits evidence acceptable to the Board that the applicant:

1. Has successfully completed the participating medical care facility's assessment and evaluation program required pursuant to subsection B;

2. Has achieved a passing score on Step 3 of the United States Medical Licensing Examination; and

3. Will enter a full-time employment relationship with a medical care facility.

D. After at least two years of practice under a renewable two-year restricted license issued pursuant to subsection C, an internationally trained physician shall be eligible to apply for a full, unrestricted license to practice medicine.

E. The Board may promulgate regulations for ~~such license~~ *licenses issued pursuant to this section*.

Agenda Item: **Licensing Report**

Staff Note: Staff will provide information on note-worthy licensing matters.

Action: None anticipated.

Agenda Item: **Discipline Report**

Staff Note: Ms. Deschenes will provide information on discipline matters.

Action: None anticipated.

Sanctioning Reference Points Instruction Manual

Board of Medicine

Guidance Document 85-11
Adopted July 2004
Revised August 2011
Revised June 2024

Prepared for
Virginia Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico Virginia 23233-1463
804-367-4400 tel
dhp.virginia.gov

Prepared by
VisualResearch, Inc.
Post Office Box 1025
Midlothian, Virginia 23113
vis-res.com

Table Of Contents

General Information

Overview 2
Background 2
Goals 2
Methodology 2
Qualitative Analysis 3
Quantitative Analysis 3

Characteristics of Sanctioning Reference Points (SRP) System

Wide Sanctioning Ranges 3
Sanctioning Thresholds 3
Voluntary Nature 3

Using the SRP System

Which SRP Worksheet to Use 4
Case Types Covered by the Worksheets 4
Worksheets Not Used in Certain Cases 5
Completing the SRP Worksheet and Coversheet 5
Worksheets 5
Coversheets 5
Determining a Specific Sanction 6

Board of Medicine SRP Coversheet, Worksheets, and Instructions

SRP Coversheet 8
Sanctioning Reference Points Worksheet A 9
Sanctioning Reference Points Worksheet Instructions, Worksheet A 10
Sanctioning Reference Points Worksheet B 11
Sanctioning Reference Points Worksheet Instructions, Worksheet B 12

General Information

Overview

The Virginia Department of Health Professions (DHP) has spent the last 20 years studying sanctioning in disciplinary cases. The study has examined all of DHP's health regulatory Boards. Focusing on the Board of Medicine (BOM), this manual contains background on the project, the goals and purposes of the Sanctioning Reference Points (SRP) system, and two revised offense-based worksheets with sanctioning recommendation thresholds used to help Board members determine how similarly situated respondents have been treated in the past.

This SRP system is based on a specific sample of cases, and thus only applies to persons sanctioned by the Virginia Board of Medicine. Moreover, the worksheets have not been tested or validated on any other groups of persons. Therefore, they should not be used to sanction respondents coming before other health regulatory boards, other states, or other disciplinary bodies.

The current SRP system is comprised of two worksheets which score factors identified using statistical analysis and are built upon the Department's effort to maintain consistent sanctioning practices over time. The original BOM SRP Manual was adopted in June 2004 and has been applied to cases closed in violation for 20 years. This lengthy board history allows for a comprehensive look at sanctioning practices and helps define past historical practices, while also serving as a baseline for changing future sanctioning policy.

These instructions and the use of the SRP system fall within current DHP and BOM policies and procedures. Furthermore, all sanctioning recommendations are those currently available to and used by the Board and are specified within existing Virginia statutes. If an SRP worksheet recommendation is more or less severe than a Virginia statute or DHP regulation, the existing law or policy supersedes the worksheet recommendation.

Background

When the Board of Medicine adopted the first SRP manual in 2004, it was understood that a sanctioning system of this type was not intended to be a static document. The culture of the professions regulated by the BOM changes over time as do the case types, the factors related to sanctioning, and the sanctioning decisions themselves. The Board recognizes that ongoing monitoring and updating of the SRP worksheets and manual will be an inherent part of the process of consistency and fairness in sanctioning its licensees with the goal of protecting the public.

This study of the BOM's sanctioning practices relied heavily on a quantitative analysis of the coversheets and worksheets from recent cases ending in violation coupled with a qualitative analysis of Board member and staff input. The analysis resulted in changes to the worksheets and manual for the BOM.

Goals

Since inception, the Department of Health Professions and the Board of Medicine have continually cited the following purposes and goals for establishing SRPs:

- Making sanctioning decisions more predictable
- Providing an education tool for new Board members
- Adding an empirical element to a process that is inherently subjective
- Providing a resource for those involved in proceedings
- Neutralizing sanctioning inconsistencies
- Validating Board member or staff recall of past cases
- Reducing the influence of undesirable factors - e.g., Board member ID, overall Board makeup, race or ethnic origin, etc.
- Helping predict future caseloads and need for services or terms

Methodology

The fundamental dilemma when developing a sanctioning reference system is deciding whether the supporting analysis should be grounded in historical data (a descriptive approach) or whether it should be developed normatively (a prescriptive

approach). A normative approach reflects what policymakers feel sanction recommendations should be, as opposed to what they have been. SRPs can also be developed using historical data analysis with normative adjustments. This approach combines information from past practice with policy adjustments, to achieve a more balanced outcome. The SRP manual, adopted in 2004, was based on a descriptive approach with a limited number of normative adjustments. This newly revised manual continues to make use of the same approach, drawing from historical data to inform worksheet modification.

Qualitative Analysis

Researchers conducted in-depth personal interviews with BOM members, Board staff, and representatives from the Attorney General's office. The interview results were used to build consensus regarding the purpose and utility of SRPs and to further frame the study's analysis. Additionally, interviews helped ensure the factors that Board members consider when sanctioning continued to be included during the quantitative phase of the study. Previous scoring factors were examined for their continued relevance and sanctioning influence.

Quantitative Analysis

In order to update the previous SRP manual, researchers reviewed cases that had closed in violation between November 2021 and October 2022. Over 100 different factors were collected on these cases to describe the attributes interviewees identified as potentially impacting sanctioning decisions. Researchers used data available through the DHP case management system combined with primary data collected from hard copy files. The files contained investigative reports, Board notices, Board orders, and all other documentation made available to Board members when deciding a case sanction.

A comprehensive database was created to analyze the offense and respondent factors which were identified as potentially influencing sanctioning decisions. Using statistical analysis to construct a historical portrait of past sanctioning decisions, significant factors along with their relative weights were derived. Those factors and weights were formulated into worksheet factors and sanctioning thresholds. Although a myriad of factors can help explain sanction variation, only those "legal" factors the Board felt should consistently play a role in sanctioning decisions continued to be included on the worksheets. By using this method, the goal was to achieve more neutrality in sanctioning by ensuring the Board considers the same set of "legal" factors for each case that comes before the Board for sanctioning.

Characteristics of the SRP System

Wide Sanctioning Ranges

The SRPs consider and weigh the circumstances of an offense and the relevant characteristics of the respondent, providing the Board with a sanctioning model that encompasses roughly 70% of historical practice. This means that approximately 30% of past cases receive sanctions either higher or lower than what the reference points indicate, recognizing that aggravating and mitigating factors play a role in sanctioning. The wide sanctioning ranges allow the Board to customize a particular sanction within the broader SRP recommended range.

Sanctioning Thresholds

The Board indicated early in the SRP study that sanctioning can be influenced by several factors: case type, factors specific to the offense and factors specific to the respondent, all of which are unique in any particular case. The empirical analysis supported this notion and subsequently, the SRPs make use of case type, offense factors and respondent factor to arrive at a "Total Worksheet Score" which is then used to determine the statistically driven sanctioning recommendation. Case Types are determined by the criteria stated on either Worksheet A or Worksheet B, both of which hold a variety of factors the Board will use in scoring to determine a recommended sanction.

Voluntary Nature

The SRP system should be viewed as a decision-aid to be used by the Board of Medicine. Sanctioning within the SRP ranges is "totally voluntary," meaning that the system is viewed strictly as a tool and the Board may choose any sanction outside the recommendation. The Board maintains complete discretion in determining the sanction handed down. However, a structured sanctioning system is of little value if the Board is not provided with the appropriate coversheet and worksheet in every case eligible for scoring. A coversheet and worksheet should be completed in cases resolved by Informal Conferences or Pre-

Hearing Consent Orders. The coversheet and worksheets will be referenced by Board members during executive session only after a violation has been determined.

Using the SRP System

Which Worksheet to Use

There are two SRP worksheets, Worksheet A and Worksheet B (see table below). Each worksheet is designed to score a certain defined set of case types. This distinction is based on the most recent historical analysis of Board sanctioning. The SRP factors and points found on each worksheet are those which proved important in determining sanctioning outcomes.

When multiple cases have been combined for disposition by the Board into one order, only one coversheet and worksheet are completed that encompass the entire event. If a case has aspects of both Worksheet A and Worksheet B, complete Worksheet A. The table below assigns the various case types brought before the Board to one of the worksheets. If a case has multiple aspects contained on one worksheet, score the case type that appears highest on the following list. If a case type is not listed, find the most analogous offense type listed and then use the appropriate worksheet.

Case Types Covered by the Worksheets

Worksheet A	Inability to Safely Practice	Impairment due to use of alcohol, illegal substances, or prescription drugs or incapacitation due to mental, physical or medical conditions.
	Inappropriate Relationship	Dual, sexual or other boundary issues. Includes inappropriate touching and written or oral communications.
	Drug Related – Patient Care	Violations of DCA to include: dispensing for non-medicinal purposes, excessive prescribing, not in accordance with dosage, or dispensing without a relationship. Prescription forgery, drug adulteration, patient deprivation, stealing drugs from patients, or personal use.
	Standard of Care - Surgery Related	Improper/unnecessary performance of surgery, improper patient management, and other surgery-related issues.
Worksheet B	Abuse/Abandonment/ Neglect	Any sexual assault, mistreatment of a patient, inappropriate termination of provider/patient relationship, leaving a patient unattended in a health-care environment, failure to do what a reasonable person would do in a similar situation.
	Standard of Care - Diagnosis/Treatment	Instances in which the diagnosis/treatment was improper, delayed, or unsatisfactory. Also includes failure to diagnose/treat & other diagnosis/treatment issues.
	Standard of Care - Medication/Prescription	Prescribing and administration errors. Also includes improper management of patient regimen and failure to provide counseling as well as other medication/prescription related issues.
	Fraud - Patient Care	Performing unwarranted/unjust services or the falsification/alteration of patient records.
	Unlicensed Activity	Practicing a profession or occupation without holding a valid license to include; practicing on a revoked, suspended, lapsed, non-existent or expired license, as well as aiding and abetting the practice of unlicensed activity.
	Fraud – Non-Patient Care	Improper patient billing and falsification of licensing/renewal documents.
	Business Practice Issues	Advertising, solicitation, records, inspections, audits, self-referral of patients, required report not filed, prescription blanks, or disclosure. Using a VA protected title such as MD, without a license, but not practicing in VA.

Worksheets Not Used in Certain Cases

The SRPs are not applied in any of the following circumstances:

- Action by Another Board - When a case which has already been adjudicated by a Board from another state appears before the Virginia Board of Medicine, the Board often attempts to mirror the sanction handed down by the other Board. The Virginia Board of Medicine usually requires that all conditions set by the other Board are completed or complied with in Virginia. The SRPs do not apply to cases previously heard and adjudicated by another Board.
- Compliance/Reinstatement - The SRPs should be applied to new cases only.
- Confidential Consent Agreement (CCA) - SRPs will not be used in cases settled by CCA.
- Formal Hearings - SRPs will not be used in cases that reach a Formal Hearing level.
- Mandatory Suspensions - Virginia law requires that under certain circumstances (conviction of a felony, declaration of legal incompetence or incapacitation, license revocation in another jurisdiction, etc.) the license of a physician must be suspended. The sanction is defined by law and is therefore excluded from the SRP system.
- Pre-Defined Sanctions – The SRP system does not apply to certain cases that have already been assigned pre-determined actions as set by the Board of Medicine.

Completing the SRP Worksheet & Coversheet

Ultimately, it is the responsibility of the BOM to complete the SRP coversheet and worksheet in all applicable cases. The information relied upon to complete a coversheet and worksheet is derived from the case packet provided to the Board and the respondent. It is possible that information discovered at the time of the informal conference may impact worksheet scoring. The SRP coversheet and worksheet, once completed, are confidential under the Code of Virginia. Additionally, the manual, including blank coversheets and worksheets, can be found at: www.dhp.state.va.us (paper copy also available on request).

Worksheets

Scoring instructions are contained adjacent to each of the worksheets in subsequent sections of this manual. Detailed instructions are provided for each factor and should be referenced to ensure accurate scoring. When scoring, the scoring weights assigned to a factor on the worksheet cannot be adjusted. The scoring weights can only be applied as 'yes or no' with all or none of the points applied. In instances where a scoring factor is difficult to interpret, the Board has final authority over how a case is scored.

Coversheets

The coversheet (shown on page 8) is completed to ensure a uniform record of each case and to facilitate recordation of other pertinent information critical for continued system monitoring, evaluation, and improvement. If the Board feels the sanctioning threshold outcome does not recommend an appropriate sanction, the Board should depart either high or low when handing down a sanction. If the Board disagrees with the sanctioning recommendation and imposes a sanction greater or lesser than the recommended sanction, a short explanation should be recorded on the coversheet. The explanation could identify the factors and reasons for departure (see examples below). This process ensures worksheets are revised to reflect current Board practice and to maintain the dynamic nature of the system. For example, if a particular reason is continually cited, the Board can examine the issue more closely to determine if the worksheets should be modified to better reflect Board practice.

Aggravating and mitigating circumstances that may influence Board decisions can include, but should not be limited to, factors such as:

- Age of prior record
- Dishonesty/Obstruction
- Motivation/Intent
- Remorse
- Extreme patient vulnerability
- Restitution/Self-corrective action
- Multiple offenses/Isolated incident

Determining a Specific Sanction

Each worksheet has its own unique set of scoring thresholds which correspond to a set of sanctioning recommendations. The recommendations can include, on the low end, No Sanction or Reprimand and on the high end, Revocation or Suspension. After considering the sanctioning threshold recommendation, the Board should fashion a more detailed sanction(s) based on the individual case circumstances.

Sanctioning Reference Points
Coversheet, Worksheets, and Instructions

Board of Medicine

Sanctioning Reference Points Coversheet

Board of Medicine
Adopted June 2024

1. Choose the appropriate worksheet.
2. Complete the Case Type and Offense and Respondent Factor sections.
3. Determine the Sanctioning Recommendation based on the scoring results and sanctioning table.
4. Complete this coversheet, noting the sanctioning outcome and a reason for departure if applicable.

Case Number(s): _____ _____ _____

Respondent Name: _____ _____ _____

License Number(s): _____ _____

Case Resolution Method:
____ Informal Conference
____ Pre-Hearing Consent Order

Worksheet Used: ____ Worksheet A ____ Worksheet B

Sanctioning Result:
____ No Sanction/Reprimand/Monetary Penalty/Educational Terms
____ Probation/Stayed Suspension/Corrective Terms
____ Formal Hearing/Loss of License

Imposed Sanction(s):
____ No Sanction
____ Reprimand
____ Monetary Penalty, amount, $ _____
____ Probation
____ Stayed Suspension
____ Suspension
____ Revocation
____ Surrender
____ Recommend Formal
____ Other Sanction: _____

Terms:
____ Continuing Education
____ Read and Follow Laws and Regulations
____ Update Practitioner Profile
____ HPMP
____ Prescribing/Admin restrictions
____ Practice restriction
____ Prohibited from performing surgeries
____ Clinical Competency Assessment
____ Quarterly reports
____ Worksite monitor
____ Other Terms: _____

Was imposed sanction a departure from the recommendation? ___ No ___ Yes, give reason below

Reasons for Departure from Sanctioning Recommendation: _____

_____

_____

Worksheet Preparer's Name: _____

Date Worksheet Completed: _____

Confidential pursuant to § 54.1-2400.2 of the Code of Virginia

Sanctioning Reference Points Worksheet A

Board of Medicine
Adopted June 2024

Case Type (score only one)	**Points**	**Score**
a. Inability to Safely Practice	35	_____
b. Inappropriate Relationship	35	_____
c. Drug Related - Patient Care	5	_____
d. Standard of Care - Surgery Related	5	_____

Offense and Respondent Factors (score all that apply)

a. License ever taken away	40	_____
b. Impaired while practicing	30	_____
c. Past difficulties (substances, mental/physical)	20	_____
d. Financial or material motivation	10	_____
e. Respondent failed to initiate corrective action	10	_____
f. Patient injury	10	_____
g. Concurrent malpractice, civil, or criminal action	5	_____
h. Any prior board violations	5	_____

Total Worksheet Score _____

Scoring Ranges	Sanctioning Recommendations
0 - 30	No Sanction Reprimand Monetary Penalty *Educational Terms: Continuing Education Read and Follow Laws and Regulations Update Practitioner Profile
31 - 90	Probation Stayed Suspension *Corrective Terms: HPMP Prescribing/Admin restrictions Practice restriction Prohibited from performing surgeries Clinical Competency Assessment Quarterly reports Worksite monitor
91 and up	Refer to Formal Hearing Revocation Suspension Surrender

* Terms chosen are not limited to those listed here.

Confidential pursuant to § 54.1-2400.2 of the Code of Virginia

Sanctioning Reference Points Worksheet Instructions Worksheet A

Step 1: Case Type Score (score only one)
Enter the point value that corresponds to the case type. If a case has multiple aspects, enter the point value for the case type that is highest on the list. A complete list of all case types covered by Worksheet A can be found on page 4. If a case type is not listed on page 4, score the most analogous offense type.

Step 2: Offense and Respondent Factors (score all that apply)

a. Enter "40" if the respondent's license was previously revoked, suspended, or surrendered in lieu of disciplinary action in any state.
b. Enter "30" if the respondent was impaired while performing the duties of a Department of Health Professions Licensee. This is not limited to the Commonwealth of Virginia or the Board of Medicine.
c. Enter "20" if the respondent has had any past difficulties in the following areas: drugs, alcohol, mental capabilities, or physical capabilities. Scored here would be prior convictions for DUI/DWI, inpatient/outpatient treatment, and bona fide mental health care for a condition affecting his/her abilities to function safely.
d. Enter "10" if there was financial or other material motivation for the offense.
e. Enter "10" if the respondent failed to take corrective action prior to the time at which the SRP worksheet is being considered.
f. Enter "10" if there was any patient injury. This can include: Mental injury that would require psychiatric, psychological or any type of counseling provided by a bona fide health care professional. Physical injury includes requiring medical care ranging from first-aid treatment to hospitalization. Death which resulted from an action, or inaction, by the respondent.
g. Enter "5" if the respondent has a concurrent malpractice, civil, or criminal action related to the current case. These actions do not need to be resolved to be scored.
h. Enter "5" if the respondent has any prior board violations.

Step 3: Combine Case Type Score and Offense and Respondent Factor Scores for a Total Worksheet Score

Step 4: Identify the Sanctioning Recommendation on the Sanctioning Table
The Total Worksheet Score corresponds to the sanctioning recommendation(s) located at the bottom of the worksheet. To determine the appropriate recommended sanction, find the range on the left that contains the Total Worksheet Score. These points correspond to the recommended sanction in the right column. For instance, a Total Worksheet Score of 70 is recommended for "Probation/Stayed Suspension/Corrective Terms."

Step 5: Coversheet
Complete the coversheet, including the recommended sanction, imposed sanction, and reason for departure if applicable.

Sanctioning Reference Points Worksheet B

Board of Medicine
Adopted June 2024

Case Type Score (score only one)	**Points**	**Score**
Abuse/Abandonment/Neglect	20	_____
Standard of Care – Diagnosis/Treatment/Medication/Prescription Related	20	_____
Fraud – Patient Care	20	_____
Unlicensed Activity	10	_____
Fraud – Non-Patient Care	10	_____
Business Practice Issues	10	_____

Offense and Respondent Score (score all that apply)

a. License ever taken away	30	_____
b. Financial or material motivation	20	_____
c. Past difficulties (substances, mental/physical)	20	_____
d. Concurrent malpractice, civil, or criminal action	10	_____
e. Respondent failed to initiate corrective action	10	_____
f. Multiple patients involved	10	_____
g. Any prior board violations	10	_____
h. Concurrent action by an employer	5	_____
i. Patient injury	5	_____
j. Violations of the Drug Control Act	5	_____

Total Worksheet Score _____

Scoring Ranges	Sanctioning Recommendations
0 - 45	No Sanction Reprimand Monetary Penalty *Educational Terms: Continuing Education Read and Follow Laws and Regulations Update Practitioner Profile
46 - 70	Probation Stayed Suspension *Corrective Terms: HPMP Prescribing/Admin restrictions Practice restriction Prohibited from performing surgeries Clinical Competency Assessment Quarterly reports Worksite monitor
71 and up	Refer to Formal Hearing Revocation Suspension Surrender

* Terms chosen are not limited to those listed here.

Sanctioning Reference Points Worksheet Instructions Worksheet B

Step 1: Case Type Score (score only one)
Enter the point value that corresponds to the case type. If a case has multiple aspects, enter the point value for the case type that is highest on the list. A complete list of all case types covered by Worksheet B can be found on page 4. If a case type is not listed on page 4, score the most analogous offense type.

Step 2: Offense and Respondent Factors (score all that apply)

a. Enter "30" if the respondent's license was previously revoked, suspended, or surrendered in lieu of disciplinary action in any state.
b. Enter "20" if there was financial or other material motivation for the offense.
c. Enter "20" if the respondent has had any past difficulties in the following areas: drugs, alcohol, mental capabilities, or physical capabilities. Scored here would be prior convictions for DUI/DWI, inpatient/outpatient treatment, and bona fide mental health care for a condition affecting his/her abilities to function safely.
d. Enter "10" if the respondent has a concurrent malpractice, civil, or criminal action related to the current case. These actions do not need to be resolved to be scored.
e. Enter "10" if the respondent failed to take corrective action prior to the time at which the SRP worksheet is being considered.
f. Enter "10" if the offense involves multiple patients.
g. Enter "10" if the respondent has any prior board violations.
h. Enter "5" if there was a concurrent action by the employer in response to the current incident. Action from an employer may include, but is not limited to suspension, termination, or disciplinary counseling notice.
i. Enter "5" if there was any patient injury. This can include:
    - Mental injury that would require psychiatric, psychological or any type of counseling provided by a bona fide health care professional.
    - Physical injury includes requiring medical care ranging from first-aid treatment to hospitalization.
    - Death which resulted from an action, or inaction, by the respondent.
j. Enter "5" if the case involved a violation of the Drug Control Act (DCA) which may include dispensing/prescribing for non-medicinal purposes, not in accordance with dosage, without a relationship or prescription forgery.

Step 3: Combine Case Type Score and Offense and Respondent Factor Scores for a Total Worksheet Score

Step 4: Identify the Sanctioning Recommendation on the Sanctioning Table
The Total Worksheet Score corresponds to the sanctioning recommendation(s) located at the bottom of the worksheet. To determine the appropriate recommended sanction, find the range on the left that contains the Total Worksheet Score. These points correspond to the recommended sanction in the right column. For instance, a Total Worksheet Score of 40 is recommended for "No Sanction/Reprimand/ Monetary Penalty/Educational Terms."

Step 5: Coversheet
Complete the coversheet, including the recommended sanction, imposed sanction, and reason for departure if applicable.

- Next Meeting Date of the Full Board is February 19-21, 2026. Please check your calendars and advise staff of any known conflicts that may affect your attendance.

- 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). If you submit your reimbursement after the 30-day deadline, please be aware that it cannot be approved.

- In order for the agency to be in compliance with the travel regulations, please submit your request for today's meeting no later than

November 30, 2025