Board Members:

Brent Taylor, MD
(Chair)

David Barnes, DO

Matt Heilala, DPM

David Paulson, MD

David Wilson
Public Member

Upcoming Meetings:

Sept. 18 at 4:00 p.m.
Oct. 16 at 4:00 p.m.
Nov. 21 at 8:30 a.m.

ALASKA STATE MEDICAL BOARD

QUARTERLY MEETING

FRIDAY, AUGUST 22, 2025

DRAFT – AGENDA

Discussion of the following topics may require executive session. Only authorized members will be permitted to remain in the Board/Zoom room during executive session.

Location: Zoom, register at:
https://us02web.zoom.us/meeting/register/4uGONUOGTzGsCH8H4mozNg

Agenda

8:30 a.m. 1. Call to Order / Roll Call

8:32 a.m. 2. Review / Approval of Agenda

8:35 a.m. 3. Review / Approval of Minutes

- May 16, 2025
- June 5, 2025
- June 26, 2025

8:40 a.m. 4. Ethics Disclosure

8:45 a.m. 5. Public Comments & Board Correspondence

8:55 a.m. 6. Old Business

a. Medical Spa Work Group Update
   - FAQ's
   - Letter to Board of Chiropractors
   - Proposal concerning Medical Assistants

b. Board Statement/New Regulation Project
   - Late Term Abortion
   - Treatment of Gender Dysphoria in Minors

9:30 a.m. 7.New Business

- Definition of Written Prescriptions
- Request for Record Expungement

10:00 a.m. 8. Break

10:15 a.m. 9. Full Board Review
Michael Fruchter, MD
Jeffrey Graham, MD

Sheryar Khan, DO
Anita Powell, PA

10:45 a.m. 10. Malpractice Cases – Executive Session

Alfonso Urdaneta-Moncada, MD
Amit Sanghi, DO)
Beatrice Brooks, MD
Timothy Peterson, MD
David Marks, MD
Edward Prince, MD
Emily Lampe, MD
John Keitz, DO
Marius Pakalniskis, MD
Muneer Desai, MD

11:45 a.m. 11. Lunch Break

12:30 p.m. 12. Interview

- Jacob Stephenson, DO

1:00 p.m. 13. Investigations Update – Executive Session – Closed to the Public

- Case# 2024-000373, K.C.
- Case# 2024-000768, D.I.
- Case# 2024-000220, N.V.
- Case# 2024-001176, R.C.
- N.P., Request for Probation Reconsideration

2:30 p.m. 15. Wrap Up / Adjourn

Tentative date for the next meeting: Sept. 18, 2025, at 4:00 p.m.

STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS, AND PROFESSIONAL LICENSING

STATE MEDICAL BOARD
MINUTES OF MEETING
Friday, May 16, 2025

These are DRAFT minutes prepared by staff of the Division of Corporations, Business and Professional Licensing. They have not been reviewed or approved by the Board.

By authority of AS 08.01.070(2) and in compliance with the provisions of AS 44.62, a quarterly meeting of the Alaska State Medical Board was held Friday, May 16, 2025.

1. Call to Order/ Roll Call
The meeting was called to order by Chair Taylor at 8:31 a.m.

Roll Call
Board members present:

David Barnes, DO
Matt Heilala, DPM
Lydia Mielke, Public Member (Secretary)
David Paulson, MD
Brent Taylor, MD (Chair)
David Wilson, Public Member

It was noted by Ms. Mielke that the new appointee to the Board, Samantha Smith, Physician Assistant, failed to be confirmed by the legislature and will no longer be serving on the Board.

Staff present: Kendra Wardlaw, Senior Investigator, Aaron Poland, Investigator, Karina Medina, Probation Monitor, Charley Larson, Investigator, Shelley Irons, Investigator, Natalie Norberg, Executive Administrator; Jason Kaeser, Licensing Supervisor, Jacob Olsen, Licensing Examiner, Alisa Perkins, Licensing Examiner

2. **Review / Approval of Agenda**

On a motion duly made by Ms. Mielke, seconded by Dr. Barnes, and approved by roll call vote, the Alaska State Medical Board approved the agenda as presented.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

3. **Review/Approval of Minutes**

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor, and approved by roll call vote, the Alaska State Medical Board approved the minutes for the February 21, 2025, March 20, 2025, March 28, 2025, and April 17, 2025, meetings.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

4. Ethics Disclosures

Ms. Norberg queried each board member. There were no ethical disclosures made by board members.

5. Deliberative Session

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor and approved by a roll call vote, the Alaska State Medical Board entered a deliberative session under AS 44.62.310(d) solely to make a decision concerning the Office of Administrative Hearing's proposed decision

In the Matter of C.D.
Office of Administrative Hearings Case Number 23-0112-MED
Board Case Numbers: 2022-001189

with Administrative Judges Chris Kennedy or Cheryl Mandala or special counsel to the Board, AAG Robert Bacaj to join the Board if invited, and others to be excluded during the deliberative session.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The Reviewing Board Member, Dr. Heilala was also excluded from the deliberative session.

The Board entered a deliberative session at 8:36 a.m. and returned on the record at 8:49 a.m.

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor and approved by a roll call vote, the Alaska State Medical Board adopted the decision as proposed to revoke Alaska license #199122 issued to Dr. C.D. and affirm the summary suspension of license #199122 on February 10, 2023.

Roll Call: Yeas, Dr. Barnes, Ms. Mielke, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Abstained: Dr. Heilala

Ms. Mielke stated, "It is the Board's position in the interest of public safety and transparency that all information related to this case should be released publicly." Ms. Mielke put forth a motion for all information related to this case to be released. The motion was seconded by Dr. Paulson. During the discussion, ALJ Judge Mandala was recognized to address the Board. ALJ Mandala questioned how the Board is defining "all the information" in the case. It was suggested by Ms. Norberg that the Board may want to delay a decision on this matter to consider a more nuanced position. Several board members voiced their support for delaying a decision on this matter. In a roll call vote, the Board did not approve the motion.

Roll Call: Nays, Dr. Barnes, Ms. Mielke, Dr. Paulson, Dr. Taylor, and Mr. Wilson.
Abstained: Dr. Heilala

6. Public Comments & Board Correspondence

Chair Taylor opened the floor for members of the public to address the Board.

- **Michael Kramer** advised he wanted to address a procedural issue concerning the "confidentiality issue." He stated, "The state statute is clear that the Medical Board is a Peer Review Organization, subject to the same confidentiality rules as hospital peer review organizations, there is no exception. We briefed it extensively in front of ALJ Kennedy, and he said that the law applies." Mr. Kramer noted that the AAG's office disagreed with ALJ's determination and appealed it to the superior court. Mr. Kramer stated several times that he found it distressing that the Board would act so quickly to determine that all records should be released, given the ALJ's ruling that the confidentiality rules apply to the Board. He opined that the Board may have acted quickly because they were influenced during the executive session by the AG. Mr. Kramer disputed the notion that public safety is an issue in this case since there was "no finding that this surgeon was dangerous to the public regarding his surgical skills." Mr. Kramer asserted that the only public safety matter in this case would have to relate to the doctor's failure to disclose a prior investigation. Mr. Kramer also observed that Dr. Heilala was in the executive session with the Board although he abstained from voting because he was a Reviewing Board Member.

Ms**.** Norberg requested that the Board identify for the record who was present in the deliberative session. Chair Taylor clarified that Dr. Heilala was asked to leave the room shortly after the Board went into the deliberative session and returned only after the meeting was opened. Board members present during the session included Mr. Wilson, Dr. Barnes, Dr. Paulson, Ms. Mielke and Dr. Taylor. AAG Bacaj was invited in for a procedural question as well.

- **Harriet Dinegar Milks** thanked the board for pausing on making a decision related to the confidentiality issue, affirming that it is a complex issue. She stated that the Peer Review Statute does not shield everything from public disclosure, rather "it was written specifically to enable hospitals and other review organizations to conduct an investigation without interference or without fear of liability." Ms. Milks affirmed that she believes the Board is a review organization and encouraged the Board to read the statute carefully, and the pleadings, and consult with your AG. Ms. Milks asserted that once the Board received the case, there is no longer a need to protect the information from disclosure. She stated that it is the division's opinion, that "the public needs to know not only what you decide, but how you decide it." Ms. Milks stated that the basis for the decision, including the evidence and testimony considered, are all things that historically have been made available to the public. Ms. Milks acknowledged that this issue is on appeal to the Superior Court, and that "it's probably time to let a court decide." Finally, Ms. Milks asserted that it is not true that Judge Kennedy found no negligence in the case. Ms. Milks stated that Judge Kennedy found in his proposed decision, that the Board has now adopted, that the negligence was in selecting this particular patient for this particular operation which related to the fact that the patient died.

- **Dr. Cosmin Dobrescu** advised that he was calling in to "request or ask if the Board wishes to ask me any questions or to speak to me."

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Chair Taylor queried the Board to see if there were any questions for Dr. Dobrescu. There were no questions or comments raised by board members to Dr. Dobrescu.

Chair Taylor asked board members if they had reviewed this quarter's correspondence to the Board.

Ms. Norberg highlighted the Psychedelic Medicine Task Force recommendations, noting that if the FDA does approve the use of psychedelic medications, and if they are approved in Alaska, there will be implications for the Medical Board to update its Guidelines for Prescribing Controlled Substance. Board members opined on the likelihood of psychedelic medications being approved and the legalization and public consumption process being similar to cannabis.

Acknowledging the 3rd Quarter Budget Report, Dr. Taylor observed that legal expenses for the Board have increased since last year. Ms. Norberg explained that legal expenses have increased due to the number of litigated cases coming before the Board. Questions regarding the Governor's Administrative Order's halt on regulation projects and how that will impact the Board were also addressed.

The Prescription Drug Monitoring Program 3rd Quarter Report was briefly discussed. Board members were reminded that technical violations, cases involving a licensee's failure to register for the PDMP in a timely manner, have been delegated to the Executive Administrator for resolution.

7. Full Board Review

- **Harold Hollander, D.O.**

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor and approved by a roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions for the purpose of discussing doctors Hollander and Stephenson's applications for licensure with Board staff remaining during the session.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

The Board went off the record at 9:18 a.m. and returned on the record at 9:29 a.m.

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor and approved by a roll call vote, the Alaska State Medical Board approved Harold Hollander, D.O. for a full medical license.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor and approved by a roll call vote, the Alaska State Medical Board decided to postpone a decision regarding licensure for Dr. Jacob Stephenson until further information is gathered.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

8. Break

The Board went off the record for a break at 9:30 a.m. and returned on the record at 9:47 a.m.

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9. Interviews

- **Adam Fitzgerald, M.D.**

Dr. Fitzgerald requested to have his interview conducted in an executive session.

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor and approved by a roll call vote, Alaska State Medical Board entered into an executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions for the purpose of discussing Dr. Adam Fitzgerald's application for licensure with Dr. Fitzgerald remaining for part of the session and Board staff remaining during the entire session.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

The Board went off the record at 9:49 a.m. and returned on the record at 10:13 a.m.

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor and approved by a roll call vote, Alaska State Medical Board decided to table a decision regarding whether to grant Dr. Fitzgerald a license pending further information to be gathered.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

- **Justin Sterett, M.D.**

Dr. Sterett requested to have his interview conducted in an executive session.

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(2), and the Alaska Constitutional Right to Privacy Provisions for the purpose of discussing Dr. Justin Sterett's application for licensure with Dr. Sterett remaining for part of the session and Board staff remaining during the entire session.

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

The Board went off the record at 10:16 a.m. and returned on the record at 10:38 a.m.

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor and approved by roll call vote, the Alaska State Medical Board approved Dr. Justin Sterett for a full medical license.

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

10. New Business

- **Notice regarding Industrial Hemp.** Sara Chambers, Boards and Regulations Advisor for the Commissioner's Office, was invited to address the Board to introduce the topic. Ms. Chambers explained the Department of Commerce is helping to ensure that licensees of health care related boards are notified of the recent announcement regarding the State's laws regarding industrial hemp. The notice is that industrial hemp is regulated by the Division of Agriculture and requires that all hemp derived products and any retailers of industrial hemp products to be

registered by the division. Intoxicating hemp products that are sometimes used in the healthcare context such as CBD oil and other hemp seed products all require registration. Registration is considered a straightforward process, and the department is wanting to ensure all medical board licensees are aware of the requirement. Board members expressed no concerns or comments.

- **Medical Spa Workgroup Update.** Ms. Chambers was invited to introduce this topic. It was explained that the Medical Spa Workgroup is a non-statutory body comprised of representatives from six boards. Dr. Paulson represents the Medical Board on the group. The purpose of the group is to learn about, discuss and propose potential board actions related to ensuring that the various and numerous aesthetic procedures, which are frequently changing due to new technology, are safely administered in Alaska. A key consideration right now from the Medical Board's perspective is clarifying the existing statutes and regulations regarding the role of the medical director, this includes the oversight, delegation and supervision of unlicensed assistants in the administration of some of these procedures. Alaska's department of law has weighed in on this question and provided a response in the memo provided to the Board.

  Dr. Paulson affirmed that the issues under consideration in the workgroup are complex. He alluded to business models in Alaska which are embracing a crossover between medicine, wellness and cosmetics where we are "discovering vulnerabilities" and he believes this is "dangerous territory." Dr. Paulson asserted that part of the solution may be to resurrect a concept introduced in the legislature in 2017, in SB 108, which would have created a pathway to certify medical assistants. Dr. Paulson endorses creating a tiered level of certified medical assistants that could have training with minimum standards in aesthetics. He believes physicians or advanced practitioners would need to evaluate the patient and develop the treatment plan and then certain treatments can be administered by the certified medical assistant by protocols. Dr. Paulson suggested that nurses could have jurisdiction over medical assistants.

  Board members discussed and agreed that there are frequently questions and gray areas in the aesthetic arena as they relate to the practice of medicine. Laser tattoo removal, deep facial peels, IV hydration and compounding issues were examples identified where questions are often raised. It was acknowledged that there are many variables to consider, such as a practitioner's training and industry specific devices that are being used, when determining whether a procedure requires complex medical judgement to administer.

  Ms. Chambers offered to work with Dr. Paulson and the Board to make a recommendation for the Board to consider whether a solution requires statutory or regulatory change and to possibly engage with the Board of Nursing on a solution.

Malpractice Case Reviews

Acknowledging that the meeting was ahead of schedule it was suggested to and then agreed to by Chair Taylor to address item # 15, "Malpractice Case Reviews" at this point in the agenda.

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor and approved by a roll call vote, the Alaska State Medical Board entered into an executive session in accordance with AS 44.62.310 (c)(3), and Alaska Constitutional Right to Privacy Provisions, with board staff remaining in the session for the purpose of discussing malpractice cases involving the following practitioners:

- **Daniel Bade, MD**
- **David Christianson, MD**
- **James Cagle, DO**
- **Kara Perrelli, MD**
- **Ravi Patel, DO**
- **Scott Boruchov, MD**
- **Stephen Kujansuu, MD**
- **Thomas Kelley, DO**

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

The Board went off the record at 11:06 a.m. and returned on the record at 11:26 a.m.

On a motion duly made by Ms. Mielke, and seconded by Dr. Taylor, the Alaska State Medical Board decided to take no further action with respect to malpractice cases related to the following physicians:

- **Daniel Bade, MD**
- **David Christianson, MD**
- **James Cagle, DO**
- **Kara Perrelli, MD**
- **Scott Boruchov, MD**
- **Stephen Kujansuu, MD**
- **Thomas Kelley, DO**

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

On a motion duly made by Ms. Mielke, and seconded by Dr. Taylor, the Alaska State Medical Board decided to refer the malpractice case involving Ravi Patel, D.O. to the Investigations Unit for the purpose of gathering additional information.

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

Old Business

Noting the meeting was still ahead of schedule, Chair Taylor decided to address item # 13, "Old Business" at this point in the agenda.

- **2025-2026 Board Priorities and Goals**

Chair Taylor invited board members to introduce ideas for board priorities to be addressed in the upcoming fiscal year.

Mr. Wilson stated he had two priorities for the Board to consider. First, he would like to revisit the "Reviewing Board Member" matter. Mr. Wilson asserted that the Reviewing Board Members are subject matter experts, and the most knowledgeable about investigative cases yet he is concerned that their recommendations are not consistently presented to the Board by the investigators, because on occasion it has been revealed that the opinion or recommendation of the RBM was not supported by the Dept. of Law. Mr. Wilson is concerned that the Board is only getting the perspective of the investigators because they do not have access to the RBM during deliberations. Mr. Wilson would like the Board to explore a better solution.

Second, Mr. Wilson suggested that the Board should issue a statement in opposition to the MRNA vaccines for COVID, especially as they are part of the childhood vaccine schedule in the State of Alaska from the Department of Health. Mr. Wilson stated that there is an overwhelming amount of evidence that now shows that the MRNA vaccines are not safe. He is concerned that the MRNA Covid Vaccine is considered a part of the childhood vaccine schedule in Alaska. Other board members voiced support for reviewing vaccine recommendations and to possibly issue a statement that is narrow in focus or that encourages pediatricians to practice prudential judgement when considering the CDC guidelines. Opposing restrictions placed on people if they do not follow the CDC guidelines was also suggested.

Ms. Mielke reminded the Board regarding a loophole in the licensing regulations, whereas if someone lies on their application, and the falsehood is not discovered until after the license is issued, there is not a simple process for the board to rescind the license. It was agreed that this priority should be added to the list for exploring.

Dr. Heilala stated that he strongly feels that it is important for Alaskans to understand that there is no limit on abortion of any kind in Alaska. Other board members agreed that transparency and knowledge is important, and an important role of the State Medical Board is to communicate information to the public. Additional board members supported discussing a statement that informs the public that there are zero limits to abortion in Alaska.

- **Annual Board Report**

Chair Taylor suggested that the draft annual report presented for the Board's review was straightforward. There were no questions or comments from board members.

On a motion duly made by Mr. Wilson, and seconded by Dr. Barnes, the State Medical Board approved the FY2025 Annual Board Report as presented.

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

- **Reauthorization – Delegation of Authority**

Chair Taylor confirmed that it is a requirement for delegated authority to be annually confirmed by the Board. There were no questions or comments from board members.

In accordance with 12 AAC 40.910, in a motion duly made by Ms. Mielke and seconded by Dr. Taylor, the State Medical Board approved to reauthorize Natalie Norberg, Executive Administrator, to execute the following duties:

1) **To issue full license or temporary permits to applicants who meet the requirements for licensure and have no professional fitness concerns or findings on their FSMB or NPDB Clearance reports.**
2) **To review technical violations related to the Prescription Drug Monitoring Program for review and recommendations.**

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

In accordance with 12 AAC 40.910, in a motion duly made by Ms. Mielke and seconded by Dr. Taylor, the State Medical Board approved to reauthorize Jason Kaeser, Licensing Supervisor, to issue temporary permits to applicants who meet the requirements for a

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temporary permit and have no professional fitness concerns or findings on their FSMB or NPDB Clearance reports.

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

11. Lunch Break – The Board recessed for lunch at 11:45 a.m. and returned on the record at 12:45 p.m.

12. Investigation Updates

- **Probation Quarterly Report.**

Karina Medina, Probation Monitor for the State Medical Board, provided an overview of the quarterly probation report, advising that all licensees are in compliance unless otherwise noted, and one licensee was released since the last Board meeting. There is one request for the Board today, which will be addressed in executive session.

- **Case #2023-001023**

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case# 2023--001023, with Board and Investigative staff remaining during the session and the Reviewing Board Member or the Board's designee excluded from the session.

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

The Board entered executive session at 12:47 p.m. The Board returned on the record at 12:49 p.m.

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor, and decided by roll call vote, the Alaska State Medical Board decided to impose a civil fine as presented in Case# 2023--001023

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

- **Case #2024-001176**

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor, and approved by roll call vote, the Alaska State Medical Board entered an executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case# 2024-001176, with Board and Investigative staff remaining during the session and the Reviewing Board Members excluded from the session.

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

The Board entered executive session at 12:50 p.m. The Board returned on the record at 12:58 p.m.

On a motion duly made by Ms. Mielke, seconded by Dr. Barnes, and decided by roll call vote, the Alaska State Medical Board decided not to approve a license reinstatement in Case# 2024-001176.

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Mr. Wilson noted that the Board is concerned about the numerous allegations that R.C. engaged in acts of deceit; fraud; intentional or negligent performance of patient care by persons under the licensee's supervision; professional incompetence; and unprofessional conduct that resulted in his criminal conviction in 2024 of a misdemeanor offense related to Attempted Medicaid Fraud. These allegations are in violation of AS 08.64.326(a)(2), (4) (6), (8), (9), 12 AAC 40.967(10), 12 AAC 40.976(2) and 12 AAC 40.920(f)(6).

Yeas, Dr. Barnes, Ms. Mielke, Dr. Paulson, and Mr. Wilson
Abstained: Dr. Heilala and Dr. Taylor

- **Case #2024-001224**

On a motion duly made by Ms. Mielke, seconded by Dr. Barnes, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case# 2024-001224, with Board and Investigative staff remaining during the session and the Reviewing Board Member excluded from the session.

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

The Board entered executive session at 1:01 p.m. The Board returned on the record at 1:04 p.m.

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor, and approved by roll call vote, the Alaska State Medical Board decided to impose a consent agreement as presented in Case# 2024-001224.

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

- **Case #2023-000549**

On a motion duly made by Ms. Mielke, seconded by Taylor, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case# 2023-000549, with Board and Investigative staff remaining during the session.

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

The Board entered executive session at 1:05 p.m. The Board returned on the record at 1:15 p.m.

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor, and approved by roll call vote, the Alaska State Medical Board decided to make no change to the consent agreement in case# 2023-000549.

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Taylor and Mr. Wilson
Abstained: Dr. Paulson

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- **Case #2024-000094**

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor, and approved by roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case# 2024-000094, with Board and Investigative staff remaining during the session and the Reviewing Board Member excluded from the session.

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

The Board entered executive session at 1:16 p.m. The Board returned on the record at 1:24 p.m.

On a motion duly made by Ms. Mielke, seconded by Dr. Taylor, and approved by roll call vote, the Alaska State Medical Board decided to impose a consent agreement as presented in Case# 2024-000094.

Yeas, Dr. Barnes, Dr. Heilala, Ms. Mielke, Dr. Paulson, Dr. Taylor and Mr. Wilson

16. Wrap up/Adjourn

Board members agreed to move the meeting scheduled for June 19 to June 18, 2025, at 4:00 p.m.

The meeting was adjourned by unanimous consent at 1:27 p.m.

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STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS, AND PROFESSIONAL LICENSING

STATE MEDICAL BOARD
MINUTES OF MEETING
Thursday June 5, 2025

These are DRAFT minutes prepared by staff of the Division of Corporations, Business and Professional Licensing. They have not been reviewed or approved by the Board.

By authority of AS 08.01.070(2) and in compliance with the provisions of AS 44.62, a meeting of the Alaska State Medical Board was held Thursday, June 5, 2025.

1. Call to Order/ Roll Call
The meeting was called to order by Chair Taylor at 4:04 p.m.

Roll Call
Board members present:
Brent Taylor, MD, Chair
David Barnes, DO
Matt Heilala, DPM
Dave Paulson, MD
David Wilson, Public Member

State employees present: Sylvan Robb, Director, Erika Prieksat, Chief Investigator, Robert Bacaj, Assistant Attorney General, Jason Kaeser, Licensing Supervisor; and Natalie Norberg, Executive Administrator

2. Review / Approval of Agenda

On a motion duly made by Mr. Wilson and seconded by Dr. Heilala, the Alaska State Medical Board approved the agenda as presented.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Dr. Paulson, Dr. Taylor and Mr. Wilson

3. Deliberative Session

On a motion duly made by David Wilson, seconded by Dr. Taylor and approved by a roll call vote, the Alaska State Medical Board entered a deliberative session under AS 44.62.310(d) solely to make a decision on the confidentiality issue presented for Board resolution *In the Matter of C.D.*, Office of Administrative Hearings Case Number 23-0112-MED, Board Case Number 2022-001189, with special counsel to the Board, Assistant Attorney General Robert Bacaj joining the Board and all others excluded during the deliberative session.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The Board entered a deliberative session at 4:06 p.m. and returned on the record at 4:15 p.m.

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On a motion duly made by David Wilson, seconded by Dr. Taylor and approved by a roll call vote, the Alaska State Medical Board decided that the hearing record, including pleadings, exhibits, and proposed and adopted decisions and the Board's Order should be made public in OAH Case No 23-0112-MED, Board Case No. 2022-001189. The Board also determined that this decision does not override any protective orders or confidentiality protections for information redacted from the hearing record, including Personal Health Information.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

4. Investigations Update

On a motion duly made by Mr. Wilson, seconded by Dr. Taylor and approved by a roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case number 2024-001176 with Division staff remaining during the session and the reviewing board members excluded from the session.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The board entered the executive session at 4:17 p.m. and returned on the record at 4:27 p.m.

On a motion duly made by Mr. Wilson, seconded by Dr. Barnes and approved by roll call vote, the Alaska State Medical Board decided to rescind the decision it made on May 16, 2025, concerning Case # 2024-001176 and refer the case back to Investigations and Department of Law to request a hearing.

Roll Call: Yeas, Dr. Barnes, Dr. Paulson, and Mr. Wilson.
Abstained: Dr. Heilala and Dr. Taylor

8. Wrap up / Adjourn

Dr. Taylor opened the floor to Dr. Heilala, inviting him to briefly discuss a few things. Dr. Heilala suggested that since the legislature did not take any action on the Board's statement regarding the transgender care of minors, the Board may want to explore drafting a resolution which identifies the treatment of transgender care of minors as constituting unprofessional conduct. Dr. Heilala volunteered to help draft a statement or resolution for the Board's consideration. Similarly, Dr. Heilala suggested that the Board issue a statement to educate the public about the expansive nature and lack of regulation of abortion in Alaska and to explore what else the Board can do about this. Dr. Heilala also volunteered to help draft a statement about abortion for the Board's consideration. Several members voiced their support for these ideas.

On a motion duly made by Mr. Wilson, seconded by Dr. Barnes, and approved by roll call vote, the Alaska State Medical Board designated Dr. Heilala to work with the Board Chair to draft a statement for the Board's consideration at a future meeting for the purpose of raising public awareness regarding Alaska's expansive laws allowing abortion.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

DRAFT

On a motion duly made by Mr. Wilson, seconded by Dr. Barnes and approved by roll call vote, the Alaska State Medical Board designated Dr. Heilala to work with the Board Chair to draft a statement for the Board's consideration at a future meeting related to declaring practitioners who utilize hormonal and surgical treatments for gender dysphoria in minors as being grossly negligent and therefore subject to disciplinary sanctions by the Medical Board.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

Ms. Norberg announced that the next monthly meeting is tentatively scheduled for July 17. However, if no emergent issues are identified in the next couple of weeks, this meeting will be cancelled to give board members a summer break. Dr. Barnes advised that he has a conflict with the August 15 date, set for the next quarterly meeting. Chair Taylor requested the Executive Administrator to poll board members to determine a workable date for all.

The meeting was adjourned by unanimous consent at 4:34 p.m.

DRAFT

STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF CORPORATIONS, BUSINESS, AND PROFESSIONAL LICENSING

STATE MEDICAL BOARD
MINUTES OF MEETING
Thursday June 26, 2025

These are DRAFT minutes prepared by staff of the Division of Corporations, Business and Professional Licensing. They have not been reviewed or approved by the Board.

By authority of AS 08.01.070(2) and in compliance with the provisions of AS 44.62, a meeting of the Alaska State Medical Board was held Thursday, June 26, 2025.

1. Call to Order/ Roll Call
The meeting was called to order by Chair Taylor at 4:02 p.m.

Roll Call
Board members present:

Brent Taylor, MD, Chair
David Barnes, DO
Matt Heilala, DPM
Dave Paulson, MD
David Wilson, Public Member

State employees present: Glenn Saviers, Deputy Director; Kendra Wardlaw, Senior Investigator; Jenni Summers, Senior Investigator; Shelley Irons, Investigator; Dannie Kerfeld, Probation Monitor; and Jason Kaeser, Licensing Supervisor

2. Review / Approval of Agenda

On a motion duly made by Dr. Heilala and seconded by Dr. Barnes, the Alaska State Medical Board approved the agenda as presented.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Dr. Paulson, Dr. Taylor and Mr. Wilson

3. Ethics Disclosures
Mr. Kaeser queried each board member. There were no ethical disclosures made by board members.

4. Investigations Update

On a motion duly made by Mr. Wilson, seconded by Dr. Taylor and approved by a roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case number 2025-000496, with Division staff remaining during the session and the reviewing board member excluded from the session.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The board entered the executive session at 4:05 p.m. and returned on the record at 4:09 p.m.

On a motion duly made by Mr. Wilson, seconded by Dr. Taylor and approved by roll call vote, the Alaska State Medical Board approved the order for a summary suspension in Case Number 2025-000496 as presented

Roll Call: Yeas, Dr. Heilala, Dr. Taylor, Dr. Paulson, and Mr. Wilson.
Abstained: Dr. Barnes

On a motion duly made by Mr. Wilson, seconded by Dr. Taylor and approved by a roll call vote, the Alaska State Medical Board entered executive session in accordance with AS 44.62.310(c)(4), for the purpose of discussing Case numbers 2023-000934 & 2024-000056, with Division staff remaining during the session and the reviewing board members excluded from the session.

Roll Call: Yeas, Dr. Barnes, Dr. Heilala, Dr. Paulson, Dr. Taylor, and Mr. Wilson.

The board entered the executive session at 4:12 p.m. and returned on the record at 4:17 p.m.

On a motion duly made by Mr. Wilson, seconded by Dr. Taylor and approved by roll call vote, the Alaska State Medical Board approved the consent agreement as presented in Case numbers 2023-000934 & 2024-000056.

Roll Call: Yeas, Dr. Taylor, Dr. Paulson, and Mr. Wilson.
Abstained: Dr. Barnes & Dr. Heilala

8. Wrap up / Adjourn

The meeting was adjourned by unanimous consent at 4:19 p.m.

DRAFT

FEDERATION OF
STATE MEDICAL BOARDS

2025 ANNUAL REPORT

MESSAGE TO OUR STAKEHOLDERS

KATIE L. TEMPLETON, JD
Chair, Board of Directors

HUMAYUN J. CHAUDHRY, DO, MACP
President & CEO

We are pleased to share with you the Federation of State Medical Boards' 2024-2025 Annual Report. Much of FSMB's success has been the result of well-established partnerships with individuals such as yourself — we are grateful for your ongoing support.

We hope you will take a few moments to explore our Annual Report to learn more about FSMB's activities and accomplishments during the past year and read about our shared achievements.

During the past year, we have attempted to emphasize the closely intertwined issues of the physician workforce and physician well-being. An often-overlooked aspect of public protection has been the negative impact burnout has on the physician workforce - both from a quantity and quality perspective.

FSMB continued our support of promoting the importance of physician well-being with medical boards, physician health programs, and organizations such as the Dr. Lorna Breen Heroes Foundation. Over the last several years, many medical boards have partnered with the Foundation to reduce the stigma associated with physicians seeking mental health care by revising or eliminating questions about impairment from licensing applications.

The growth of the international medical graduate (IMG) physician population in recent decades — to nearly one quarter of the more than one million physicians in the U.S. — has helped address increasing healthcare demands across the country. The appropriate licensing of IMG physicians will continue to contribute to access to quality healthcare.

The past year saw the continued rapid increase in states adopting legislation to improve access to care for underserved communities in their jurisdictions by provisionally licensing internationally-trained physicians (ITPs) who already completed their training overseas.

To guide best practices for regulating physicians licensed through these streamlined pathways, FSMB is co-chairing the Advisory Commission on Additional Licensing Models, working alongside the Accreditation Council for Graduate Medical Education (ACGME) and Intealth, which administers the Educational Commission for Foreign Medical Graduates (ECFMG). The Advisory Commission's first set of recommendations, released in February 2025, drew widespread interest from media and policymakers.

FSMB's Washington, D.C., advocacy team worked on many fronts to help state medical boards achieve their individual legislative and policy priorities. At the federal level, FSMB helped to introduce the bipartisan States Handling Access to Reciprocity for Employment (SHARE) Act. Introduced in March 2025, the SHARE Act (H.R. 2332 / S. 1101) adds a technical amendment to existing federal law to clearly authorize the FBI to conduct criminal background checks for state medical boards and other licensing agencies for the purpose of interstate licensure compacts. FSMB endorses this legislation.

FSMB continues to make major investments in technology and explore ways to leverage data capabilities to better serve state medical boards. The organization has undertaken a comprehensive reorganization of its customer support model, centralizing support services under a single team to position FSMB to better meet the evolving needs of the USMLE program, Federation Credentials Verification Service (FCVS), credentialing customers, and state medical boards.

FSMB's future is bright, driven by collaboration, engagement and partnership. It is a privilege to have worked closely with you.

This year, FSMB remained committed to delivering exceptional value to our members. Guided by your evolving needs, we expanded educational opportunities, strengthened our professional community through collaboration, and advanced our advocacy efforts. At the same time, we invested in technology upgrades to enhance services, streamline access to data, and ensure a more responsive and connected member experience. The pages that follow highlight the progress we've made and the collective impact of our shared commitment.

BUILDING COLLABORATION AND COMMUNITY

FSMB continues to foster collaboration among regulatory bodies through several key initiatives.

In response to increasing interest among state policy makers to improve patient access and reduce workforce shortages by modifying licensure requirements for physicians who have completed training outside the United States, FSMB partnered with the Accreditation Council for Graduate Medical Education (ACGME) and Intealth to establish the Advisory Commission on Additional Licensing Models.

In June 2024, the Advisory Commission hosted a one-day symposium with 175 representatives from state medical boards and organizations involved in medical education, accreditation, and certification. This forum facilitated the exchange of ideas and discussions on how to best guide and advise state medical boards and other stakeholders on the development and implementation of additional pathways for medical licensure. In February 2025, the Commission released its first set of recommendations focusing on eligibility requirements for internationally trained physicians entering into additional licensure pathways. The Commission is continuing its work and will be releasing a second set of recommendations focused on assessment and supervision of internationally trained physicians in Summer 2025.

In March 2025, FSMB co-hosted the latest Tri-Regulator Symposium with the National Association of Boards of Pharmacy (NABP) and the National Council of State Boards of Nursing (NCSBN). This collaborative event addressed interprofessional cooperation and challenges facing state regulatory boards, with discussions covering FDA updates, recent Supreme Court cases, artificial intelligence applications, and workforce issues.

Following the symposium, members of the FSMB, NABP, NCSBN, and the American Association of Dental Boards joined together to hold the second Opioid Regulatory Collaborative Summit. The meeting provided attendees with updates on opioid treatment and prescribing policies, insights into administration policy impacts on regulatory efforts, and approaches to managing substance use disorders among licensees. The summit also explored emerging treatments such as ketamine, stimulants, and psychedelics, and how they are regulated.

STRENGTHENING MEMBER ENGAGEMENT

FSMB continues to enhance support for state medical boards through the Office of Engagement and Member Services. This year, we provided:

PERSONALIZED ORIENTATIONS for new state medical board executive directors.

A NEW BOARD MEMBER ORIENTATION, consisting of three virtual sessions on the licensing and disciplinary processes, administrative law, roles and responsibilities of board members, professionalism, and important adjuncts to the medical regulatory system, such as Physician Health Programs.

CUSTOMIZED PRESENTATIONS and visits to state medical boards, including the Maryland Board of Physicians, Mississippi State Board of Medical Licensure, New Jersey State Board of Medical Examiners, New York State Office of Professional Medical Conduct, and New York State Board for Medicine.

To facilitate knowledge sharing and collaboration, FSMB established a bi-monthly virtual forum for medical directors, modeled on the successful board attorneys' forum launched in 2022, to discuss critical regulatory topics, enhance support and advance shared goals.

The Certified Medical Board Licensing Specialists Program, developed in partnership with Administrators in Medicine (AIM), successfully concluded its inaugural cohort in July 2024. This comprehensive training program for licensing specialists was made possible through FSMB's $30,000 grant to AIM. A second cohort launched in January 2025.

> I was thoroughly impressed with the workshop and will recommend my board members to consider attending these presentations. It is valuable for both new and seasoned members.
>
> **PARTICIPANT**
> BOARD MEMBER TRAINING

ENHANCING TECHNOLOGY FOR BETTER SERVICE

FSMB has made significant investments in technology and system-wide integration to improve services to member boards.

All state medical boards have been incorporated into the new Services Portal, providing centralized access to documents from FSMB services. FSMB also enhanced customer support by implementing Zendesk, a customer service platform, initially on the Physician Data Center and Docinfo physician information website. Work is underway to evaluate personnel needs and implement Zendesk as FSMB's customer service platform for all departments.

In response to emerging technologies, FSMB has also created an Office of AI Innovation to coordinate efforts in harnessing artificial intelligence to support internal operations and provide applications for state medical boards. Two AI-related platforms have been made available to senior staff and board members: Perplexity, an AI-powered search engine that prioritizes accuracy with cited responses, and Microsoft Copilot, which combines AI language models with contextual code analysis.

IMPROVED CUSTOMER SERVICE AND EFFICIENCY

FSMB is reorganizing its customer support model from a product-focused to a user-focused approach, centralizing common support services under a single team to better serve the USMLE program, FCVS, credentialing customers, and state medical boards.

All state medical boards transitioned to FSMB's new Services Portal, streamlining access to key documents in one central location.

The Physician Data Center (PDC) serves as a central hub for state medical board data sharing, integrating licensure, discipline, and specialty certification information. In 2024, PDC delivered 229,084 detailed reports (up from 167,897 in 2023) and increased distribution of disciplinary alerts to 24,325 compared to 17,123 the previous year. The team processed an average of 148 license files monthly, matching over 20 million records.

The Federation Credentials Verification Service (FCVS) delivered 73,060 profiles to state medical boards in 2024, and improved cycle times to 14 days. Overall cycle time improved by three-and-a-half days compared to 2023, while initial cycle time improved by five days.

The Uniform Application for Medical Licensure (UA) has been adopted by 27 state boards, with 19,811 applications processed in 2024.

UA

19,811
APPLICATIONS PROCESSED

27
TOTAL STATE BOARDS USING UA

PDC

DETAILED REPORTS DELIVERED BY PDC IN 2024

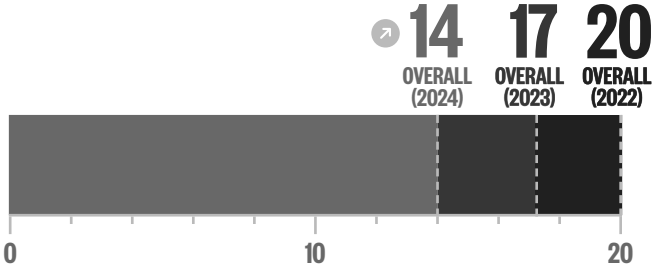
DISCIPLINARY ALERTS DISTRIBUTED BY PDC

148
LICENSE FILES PROCESSED MONTHLY

20M
RECORDS MATCHED

FCVS

73,060
PROFILES DELIVERED TO STATE MEDICAL BOARDS BY FCVS IN 2024



CYCLE TIMES IN DAYS

DELIVERING TARGETED EDUCATIONAL PROGRAMMING

FSMB's Education Department develops innovative programming that directly responds to the needs of state medical boards. Through surveys, site visits, and analysis of board materials, the Education Committee identifies key topics for educational opportunities and appropriate learning formats.

The 2025 FSMB Annual Meeting (FSMB AM25) in Seattle, themed "Innovating Together," welcomed more than 600 attendees and featured over two dozen sessions, including keynote presentations from healthcare thought leaders:

ERIC TOPOL, MD, on artificial intelligence's impact on healthcare delivery and medical regulation

TIMOTHY CAULFIELD, LLM, on evidence-based decision-making in health policy

ALI INGERSOLL, who shared her perspective on navigating the healthcare system as a patient and disability advocate during the FSMB Foundation Luncheon

The meeting also offered role-specific forums addressing unique responsibilities within state medical boards and lunch-and-learn sessions on professional competency, capacity, and the changing political landscape's impact on healthcare policy.

The 16th annual Board Attorneys Workshop held in November 2024 hosted 70 attendees representing 26 state medical boards. The workshop covered legislative updates relevant to state medical boards, implications of recent Supreme Court rulings, the PA Licensure Compact, and the regulatory landscape of IV hydration therapies.

In addition to offering workshops and courses to member boards, FSMB collaborated with individual boards to deliver CME courses to their licensees. In Fall 2024, FSMB accredited live webinars for the Washington Medical Commission, titled "Addressing Vaccine Hesitancy in Rural Communities." During these webinars, rural healthcare providers were introduced to motivational interviewing, a way to help patients choose trustworthy sources of information about vaccines. More than 550 physician and non-physician learners participated in this two-part series.

FSMB joined the FSMB Foundation and the AIM Foundation in developing and launching a CME-accredited educational video series on physician professional boundaries. This innovative series features concise, scenario-based videos depicting real-world challenges physicians may face in maintaining appropriate boundaries with patients. The educational activity is intended for a wide audience, including medical students, practicing physicians, and patients. It is available for free to all state medical and osteopathic boards to offer their licensees as an opportunity for CME.

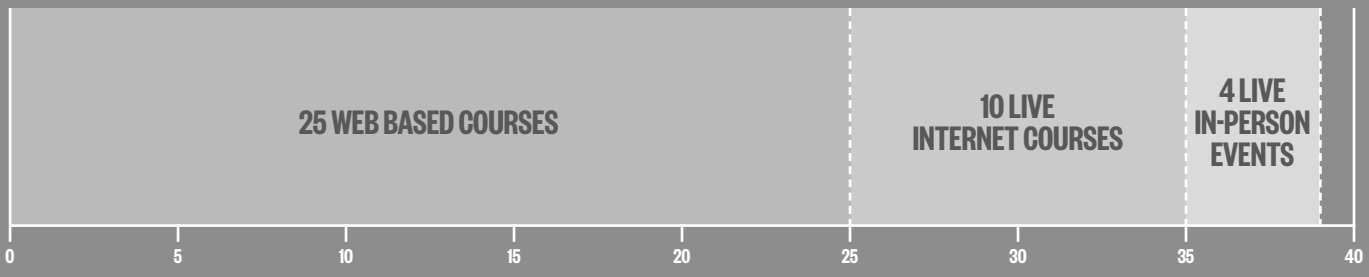
Is there a better word beyond “excellent” to describe this phenomenal Annual Meeting? This has truly been the best conference I have ever attended in all my years as a practicing physician attending conferences all my career. FSMB is truly led by the membership and it shows when you present the topics and presenters that you had this year. Wow!

PARTICIPANT
FSMB AM25

CME BY THE NUMBERS

FSMB, an accredited CME provider through the Accreditation Council for Continuing Medical Education (ACCME), regularly assists state medical boards with accredited educational program development and management. In 2024, FSMB's CME program:

3,500+ LEARNERS
PARTICIPATED IN EDUCATION PROGRAMS



39 ACTIVITIES DELIVERED

AWARDED 61.25
AMA PRA CATEGORY 1 CREDIT HOURS

INCREASED BY 48%
PARTICIPATION IN EDUCATIONAL PROGRAMMING

IMPROVING COMMUNICATION AND ADVOCACY

This fiscal year, FSMB finalized its visual branding and messaging to better communicate available products and services to member medical boards, and to better articulate how FSMB assists boards in their mandate to protect the public.

A public awareness campaign has launched using video and social media to direct viewers to CareMatters.org, a website educating the public about state medical boards, physician licensing, physician information search tools, and how to contact their state medical boards.

On the advocacy front, FSMB's Board of Directors participated in the annual Hill Day in Washington, DC, meeting with 30 Congressional offices to advocate for the States Handling Access to Reciprocity for Employment (SHARE) Act (H.R. 2332 / S. 1101), which proposes a vital update to the licensing process by authorizing the FBI to conduct criminal background checks for state licensing agencies for interstate licensure compacts. FSMB also worked closely with federal agencies to provide input on policies affecting medical regulation and endorsed key federal legislation supporting healthcare provider wellness and telehealth service expansion. FSMB continued to track major legislation passed by Congress, providing updates to state medical boards on relevant developments.

FSMB's official public policies are intended to give guidance and encourage consistency among state medical boards to protect the public and improve the quality, safety and integrity of health care. During the 2025 House of Delegates meeting in Seattle, FSMB adopted several significant reports and best-practice recommendations:

RECOMMENDATIONS from FSMB's Ethics and Professionalism Committee on professionalism related to examinations due to their importance in the licensing process.

UPDATED GUIDANCE for state medical boards when considering potential reentry to practice requirements for physicians seeking to resume active practice following a significant absence.

Learn more about these and other policy recommendations at **FSMB.ORG/ADVOCACY/POLICIES-AND-REGULATORY-RESOURCES/.**

SUPPORTING THE USMLE PROGRAM

The United States Medical Licensing Examination (USMLE) program continues to benefit from state board participation.

In 2024, 44 individuals from 26 boards participated in USMLE activities, including representatives from Alabama-Medical Licensure Commission, District of Columbia, Florida-Medical, Hawaii, Idaho, Illinois, Indiana, Iowa, Maine-Medical, Massachusetts, Michigan-Medical, Minnesota, Mississippi, Missouri, Montana, New Hampshire, New Jersey, New York-Licensure, North Carolina, Oklahoma-Osteopathic, Pennsylvania-Medical, Texas, Vermont-Medical, Washington-Medical, Washington-Osteopathic, and West Virginia-Medical.

FSMB and the National Board of Medical Examiners (NBME) co-hosted the 18th annual USMLE orientation for state medical board members and staff. The State Board Advisory Panel to USMLE, consisting of representatives from nine state boards, provided guidance on issues impacting the program.

The USMLE program continued to enhance its communications efforts by hiring a Communications Manager responsible for creating and executing communications plans and social media efforts in coordination with NBME's marketing team. The program continues to see growth in its social media following, strengthening communication and outreach to the more than 130,000 examinees taking the USMLE each year, as well as medical educators and state medical board members and staff.

2024-2025 BOARD OF DIRECTORS

Leadership

KATIE L. TEMPLETON, JD, CHAIR
Oklahoma State Board of Osteopathic Examiners

GEORGE M. ABRAHAM, MD, MPH, CHAIR-ELECT
Massachusetts Board of Registration in Medicine

SHAWN P. PARKER, JD, MPA, TREASURER
North Carolina Medical Board

HUMAYUN J. CHAUDHRY, DO, MACP, SECRETARY
FSMB President and CEO

JEFFREY D. CARTER, MD, IMMEDIATE PAST CHAIR
Missouri Board of Registration for the Healing Arts

Directors

ANDREA A. ANDERSON, MD, MED
District of Columbia Board of Medicine

ALEXIOS G. CARAYANNOPOULOS, DO, MPH
Rhode Island Board of Medical Licensure and Discipline

KENNETH E. CLEVELAND, MD
Mississippi State Board of Medical Licensure

EDWARD O. COUSINEAU, JD
Nevada State Board of Medical Examiners

MAROULLA S. GLEATON, MD
Maine Board of Licensure in Medicine

DENISE PINES, MBA
Osteopathic Medical Board of California

CHRISTY L. VALENTINE THEARD, MD, MBA
Louisiana State Board of Medical Examiners

J. MICHAEL WIETING, DO, MED
Tennessee Board of Osteopathic Examination

JOSEPH R. WILLETT, DO
Minnesota Board of Medical Practice

MARK B. WOODLAND, MS, MD
Pennsylvania State Board of Medicine

SHERIF Z. ZAAFRAN, MD
Texas Medical Board

2024-2025 AWARD WINNERS

The Leadership Award

Presented in recognition of outstanding and exemplary leadership, commitment, and contribution in advancing the public good at the medical board level.

CRAIG H. CHRISTOPHER, MD
Commission Member
Medical Licensure Commission of Alabama

Dr. Christopher served Alabama with distinction for 45 years as a respected obstetrician and gynecologist. After retiring from his private practice, he mentored OB/GYN students and residents for over 10 years as a volunteer faculty member at UAB Hospital. Along with his contributions to medicine as a highly respected physician and teacher, Dr. Christopher also protected and advocated for Alabama patients as a member of Alabama's State Committee on Public Health, which he chaired from 2005-2006. In recognition of his exceptional leadership skills, Dr. Christopher's peers elected him to serve as president of Alabama's largest county medical society and the Medical Association of the State of Alabama. Dr. Christopher's 23 years in medical regulation began when he was elected to the Alabama State Board of Medical Examiners (ALBME) in 1995. His 11 years on the ALBME included service as Vice Chairman and Chairman. Dr. Christopher was first appointed to the Alabama Medical Licensure Commission by Governor Robert Bentley in 2012, and he was reappointed to serve additional five-year terms in 2017 and 2022. He served as the Commission's Vice Chairman from 2019 until his election as Chairman in 2022. Before stepping down as Chairman in June 2024, Dr. Christopher directed significant updates to the Commission's policies and procedures, which have improved the agency's ability to fulfill its mission to protect Alabama's patients.

The Award of Merit

Presented in recognition of an activity or contribution that has positively impacted and strengthened medical licensure and discipline and helped enhance public protection.

MARSCHALL SMITH, MPA
Executive Director
Interstate Medical Licensure Compact Commission

Mr. Smith is a dynamic leader with over 35 years of experience in government and health administration. He has led the Interstate Medical Licensure Compact Commission (IMLCC) for the last eight years, transforming it from a startup to a streamlined process for licensing physicians across state lines. Under his leadership, the IMLCC has expanded from 17 member states in 2017 to 42 in 2025, with a projected 2025 gross revenue exceeding $40 million. Before joining IMLCC, Mr. Smith served as the Professional Standards Manager with the Colorado Department of Health and as the Program Director for the Colorado Medical Board. His focus on efficiency and stakeholder engagement has strengthened operations, increased revenues, and ensured sustainable services. Mr. Smith holds an M.A. in Public Administration from the University of Colorado and a B.A. in Political Science and History from Drake University.

2024-2025 AWARD WINNERS

The Distinguished Service Award

Presented in recognition of the highest level of service, commitment, and contribution to FSMB; the advancement of the profession of medical licensure and discipline; and the strengthening and enhancement of public protection.

GERALDINE T. O' SHEA, DO
Past Chair
Osteopathic Medical Board of California

Dr. O'Shea is an Osteopathic Internist in private practice who has served in the licensing community for over 20 years. In 2005, California Governor Arnold Schwarzenegger appointed her to the Osteopathic Medical Board of California. Within a year she became Chair, a position she held until July 2012. Within this time, she served as a delegate to the Federation of State Medical Boards and participated in its Audit and Finance Committees. Joining her fellow Osteopathic delegates, she served the American Association of Osteopathic Examiners sequentially as Secretary, Vice President, President and Immediate Past President between 2009 to 2017. Dr. O'Shea was also a member of the Practicing Physician's Advisory Council for CMS between 2004 to 2008. In 2011 she was elected to serve on the FSMB Nominating Committee. Elected in 2013, Dr. O'Shea is currently a member of the American Osteopathic Association's Board of Trustees. In 2022, the AOA recommended her for membership on the FSMB's Physician Reentry Task Force which recently concluded their assigned duties.

LAWRENCE JAY EPSTEIN, MD
Past Chair
New York State Board for Medicine

Dr. Epstein is a lifelong New Yorker, born in New York City and raised in Queens. He attended the University of Delaware and later completed medical school through the New York State Physician Shortage Program at Tel Aviv University. He completed his residency and fellowship at SUNY Downstate in 1987 and has practiced in New York ever since. He is a Professor of Anesthesiology and Neurology at the Icahn School of Medicine at Mount Sinai. Dr. Epstein served on the Board of Medicine from 2014 to 2024, completing his second five-year term. The Board selected him as Chair in his second year and reappointed him every year thereafter. He will continue to serve on the "Extended Board" and will soon join the New York State Board for Professional Medical Conduct. He has also served on multiple FSMB committees, beginning with the Committee on Emergency Preparedness during the first year of the COVID-19 pandemic. Dr. Epstein has more than 25 years of leadership experience in the profession, including serving as President of the New York State Society of Anesthesiologists and Chair of the American Society of Anesthesiologists Committee on Bylaws.

DANNY TAKANISHI, JR, MD
Chair
Hawaii Medical Board

Dr. Takanishi is a Professor and Associate Chair for Academic Affairs in the Department of Surgery at the John A. Burns School of Medicine in Hawaii. A graduate of the same institution, he completed his General Surgery Residency and Surgical Critical Care Fellowship in Hawaii, followed by a Surgical Oncology Fellowship at the University of Chicago, where he later held leadership roles in surgical education and clinical programs. Dr. Takanishi has been a member of the Hawaii Medical Board since 2006, serving as Chair for multiple terms, including his current tenure. He has been actively involved with the Federation of State Medical Boards, contributing to various committees and task forces, including chairing the Workgroup on Physician Impairment. He also serves on the Advisory Commission on Additional Licensing Models. Beyond medical regulation, Dr. Takanishi has played a significant role in medical education, serving in leadership positions with the United States Medical Licensing Examination and the Accreditation Council for Graduate Medical Education. He is also an oral examiner for the American Board of Surgery and has held leadership roles in multiple national surgical organizations.

2024-2025 AWARD WINNERS

The JMR Award for Distinguished Scholarship

Presented in recognition of an outstanding objective, scholarly contribution to the FSMB's *Journal of Medical Regulation*.

SIDNEY ZISOOK, MD
Professor of Psychiatry
University of California San Diego Department of Education, Development and Research

Dr. Zisook is a University of California San Diego (UCSD) Distinguished Professor of Psychiatry. He completed medical school at the Stitch-Loyola School of Medicine, residency at Massachusetts General Hospital and a clinical fellowship in psychiatry at Harvard University. Dr. Zisook was the founding Director of the UCSD Healer Education, Assessment and Referral (HEAR) program, dedicated to preventing/reducing nurse and physician mental health stigma, burnout, and suicide. He currently directs the UCSD Physician Peer Support Program and serves on the Scientific Council of the American Foundation for Suicide Prevention, Scientific Advisory Board of the Depression and Bipolar Support Alliance, Board of Directors of the American College of Psychiatry, and Editorial Board of *FOCUS: The Journal of Lifelong Learning in Psychiatry*. Dr. Zisook's key academic interests include suicide prevention with a special focus on healthcare workforce suicide, grief and prolonged grief disorder, treatment resistant depression, and medical education. He has published over 400 scientific articles, chapters and books in these areas.

The JMR Award for Excellence in Editorial Writing

Presented in recognition of an outstanding editorial contribution to the *Journal of Medical Regulation*.

JUSTIN L. BULLOCK, MD, MPH
Clinical Researcher
University of Washington School of Medicine

Dr. Bullock is a clinician researcher in Nephrology at the University of Washington School of Medicine and the Co-director of the Docs with Disabilities Initiative. He is passionate about creating safe environments in medicine where everyone in the hospital can bring their authentic selves to work in the spirit of healing. His primary research centers on how educators can foster identity safety in the learning environment, where all members of the healthcare team can be their authentic selves in the workplace. In addition to his education scholarship, Dr. Bullock is outspoken about his lived experience as a gay Black bipolar physician. Drawing on his dual identities as a patient and provider with serious illness, he believes deeply that medicine is a lifelong journey of healing as much for providers as it is for patients.

IN MEMORIAM

As we reflect on the past year, we mourn the loss of extraordinary individuals whose lasting influence shaped our field. Their vision, dedication, and impact will be remembered, and we honor their enduring legacies.

SUSAN E. WERNICK
1949-2024
Connecticut Medical Examining Board

ROBERT E. PORTER, JR., MD
1934-2024
New Hampshire Board of Medicine

JOHN F. GADDIS, DO
1946-2024
Maine Board of Osteopathic Licensure

REV. DANIEL W. MORRISSEY, OP
1936-2024
New Hampshire Board of Medicine & New York State Office of Professional Medical Conduct

DONALD L. LEBRUN
1936-2025
New Hampshire Board of Medicine

BURTON T. MARK, DO
1938-2025
Pennsylvania State Board of Osteopathic Medicine

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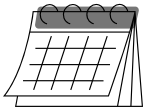
May 2025 CPME Report

General Updates	Accreditation Actions	Continuing Education	Residencies and Fellowships	Collaborative Residency Evaluator Committee (CREC)	Publication Updates





The Council on Podiatric Medical Education (CPME or Council) held its spring meeting on May 3, 2025. The recommendations emanating from council committees, which completed their deliberations at meetings and conference calls held from February–May, constitute the majority of each CPME agenda and include the review of site visit reports and progress reports from the colleges of podiatric medicine. The Specialty Board Recognition Committee (SBRC) held its meeting in February. The Continuing Education Committee (CEC) and the Residency Review Committee (RRC) held their meetings in March, and the Accreditation Committee, Budget Planning Committee, and Executive Committee met in May.



Future CPME Meeting Dates:

2025: October 17-18

2026: April 25 and October 16-17

2027: April 17 and October 29-30

2028: April 29 and October 27-28

CPME has begun offering virtual options for non-executive sessions of CPME and committee meetings. Registration links will be posted on the CPME website 6 weeks prior to a meeting for guests and/or observers to register in advance and indicate whether attendance will be in-person or virtual.

Council Elections and Appointments

The council elected its officers to be effective at the close of its October 2025 meeting. Dr. Alyssa Stephenson of Phoenix, AZ was elected chair, and Dr. Steven Vyce of New Haven, CT was elected vice chair.

- Alyssa Stephenson, DPM is a podiatrist at the Carl T. Hayden Veterans Affairs Medical Center in Phoenix, AZ. Dr. Stephenson serves as a college site visit, residency, and fellowship evaluator, and as chair of the CEC and SBRC.
- Steven Vyce, DPM serves as chief, Department of Podiatric Surgery and Medicine, Yale-New Haven Medical Center in New Haven, CT. Dr. Vyce serves as a CPME residency and fellowship evaluator and as chair of the RRC.

After 11 years of service on various committees and the council, including the past four years as chair of the Accreditation Committee, Dr. Eric Stamps retired from the council on May 3, 2025. In the interim, Dr. Jonathan Labovitz will serve in his place as an administrator representative until elections are held at the council's October 2025 meeting. Additionally, Dr. Melanie Violand has been appointed as the new chair of the Accreditation Committee.

- Jonathan Labovitz, DPM, serves as dean at the Western University of Health Sciences, College of Podiatric Medicine in Pomona, CA.
- Melanie Violand, DPM, serves as the associate dean at the Midwestern University Arizona College of Podiatric Medicine in Glendale, AZ.

At-large Member Positions Open on the Council

The Council on Podiatric Medical Education's Nominating Committee is seeking applications for the at-large and public member positions on the council. CPME will hold a closed-ballot election to fill the positions at its October 2025 meeting. The positions are for a three-year term renewable up to three consecutive terms.

Individuals seeking election to the at-large positions on the council **must describe in writing how they satisfy at least two of the following criteria:**

- Have been active for a period of at least two years as a director of an approved podiatric residency, fellowship, or provider of continuing education.
- Have been active for a period of at least two years as an academic administrator or a fulltime faculty member at a CPME-accredited college of podiatric medicine.
- Have demonstrated leadership within the profession or distinguished himself/herself/themself as a practitioner.
- Have served actively on one of the council's committees for a minimum of one full term.
- Have served on at least one CPME onsite evaluation team to a college of podiatric medicine, or three CPME on-site evaluation teams to residency programs, fellowship programs, or continuing education providers.

The applicant must **demonstrate qualifications and experience in at least one of the following areas of need:**

- Academic—someone currently or recently directly engaged in a significant manner in postsecondary education and/or research.
- Administrator—someone currently or recently directly engaged in a significant manner in a postsecondary podiatric medical program or institutional administration.
- Educator—someone currently or recently directly engaged in a significant manner in an academic capacity at an accredited college of podiatric medicine who may not be an academic dean.
- Practitioner—someone directly engaged in a significant manner in the practice of podiatric medicine.
- Public Member—public members must not have a significant relationship (either direct or indirect) with podiatric medical organizations or podiatric medical educational institutions. These individuals shall have no vested interest in or financial relationship to the podiatric medical profession.

In addition to the requirements outlined above, the candidate is encouraged to describe other podiatric and non-podiatric experiences they have that strengthen the submission.

Individuals seeking election to the council must submit a curriculum vitae and an application letter **that addresses both the requirements and the area of need** to hstagliano@cpme.org. Applications received after **June 15** will not be considered.

CPME Mission

The mission of the council is to promote the quality of graduate education, postgraduate education, certification, and continuing education. By confirming these programs meet established standards and requirements, the council serves to protect the public, podiatric medical students, and doctors of podiatric medicine.

Guiding Principles

The success of CPME is based on the following guiding principles. A commitment to:

- the CPME mission;
- the engagement in continuous quality improvement and learning;
- the contribution of CPME to the profession; and
- the cultivation and support of an environment that reflects a commitment to a broad representation and respect within its member institutions, board and staff, representatives, and all who are served by these groups.

GENERAL UPDATES

Release of the CPME Conflicts of Interest List

As part of its commitment to transparency and integrity, CPME requires all council members, committee members, evaluators, consultants, and staff to annually disclose any potential conflicts of interest. These disclosures help ensure that decisions related to the accreditation and oversight of programs, institutions, and organizations are made objectively and without bias.

A conflict of interest may arise when an individual has a personal, professional, or financial relationship, current or within the past five years, with an entity under CPME's jurisdiction. Conflicts include serving in a leadership position within the past five years within the profession as defined as one holding a position on the board of directors, serving as a committee chair, employment, or any other position that calls into question the council member's ability to fairly perform their duties. In such cases, individuals must recuse themselves from all related discussions, decisions, and voting activities.

Serving as a volunteer within the profession, such as serving on a committee of an organization such as APMA, COTH, ACFAS, ACPM, ABPM, ABFAS, NBPME, as a part of case review, or as an exam writer, would not be considered conflicts.

The list of conflicts of interest can be found here.

Terminology Changes

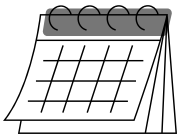
The council officially updated the terminology used for committee activities, changing "CPME-approved" to "CPME-accredited" for the RRC and the CEC, while retaining "CPME-recognized" for the SBRC. This change will take effect on July 1, 2025. The Accreditation Committee will continue to use the "CPME-accredited" terminology.

ACCREDITATION ACTIONS

For greater detail concerning the council's May 2025 accreditation actions, click on the "Accreditation Actions" link under each college's listing at www.cpme.org/cpme100. CPME took the following accreditation actions at its May 2025 meeting:

- **Kent State University College of Podiatric Medicine—**At its May 2025 meeting, CPME elected, based on an on-site evaluation, to extend accreditation through April 2033.
- **LECOM School of Podiatric Medicine—**At its May 2025 meeting, CPME elected, based on an on-site evaluation, to grant preaccreditation status to the LECOM School of Podiatric Medicine as there are no identified concerns or areas of noncompliance with accreditation standards or requirements.

- **New York College of Podiatric Medicine of Touro University—**At its May 2025 meeting, CPME elected, based on a focused evaluation visit, to affirm that the substantive change in ownership procedures has been completed for the New York College of Podiatric Medicine of Touro University. NYCPM of Touro University is scheduled for a required site visit by the Middle States Commission on Higher Education in June 2025 before the acquisition is finalized.
- **Temple University School of Podiatric Medicine—**At its May 2025 meeting, CPME voted to extend accreditation through April 2031 as the school is in compliance with all accreditation standards and demonstrated full compliance within one year of the comprehensive evaluation decision.



Future Meetings of the Accreditation Committee

2025: October 15-16

2026: April 23-24 and October 14-15

2027: April 15-16 and October 27-28

2028: April 27-28 and October 25-26

CONTINUING EDUCATION

Approval as a Provider

California Podiatric Medical Association
Cine-Med
Midwest Podiatry Conference
Temple University School of Podiatric Medicine
The University of Texas Health San Antonio, Joe R. & Teresa Lozano Long School of Medicine
West Penn Hospital
Western University of Health Sciences College of Podiatric Medicine

Approval with report as a Provider

Alabama Podiatric Medical Association
American Board of Podiatric Medicine
American College of Foot & Ankle Surgeons
American Podiatric Medical Association
Midwestern University Arizona College of Podiatric Medicine
Barry University School of Podiatric Medicine
Biomechanical Institute
Civic Hospital Resident Alumni Association
Data Trace Publishing Company
Florida Podiatric Medical Association
Massachusetts Foot & Ankle Society
Missouri Podiatric Medical Association

New Jersey Podiatric Medical Society
Ohio Foot and Ankle Medical Foundation

Probationary Approval *(Candidate for withdrawal, effective October 2025)*

American Society of Podiatric Surgeons

Voluntarily Terminated

American Association of Colleges of Podiatric Medicine
Foot and Ankle Surgery Academy

CEC Recommendations Approved by CPME

The council *approved* the following changes to the petition schedule.

- Move Georgia Podiatric Medical Association from September 2026 to March 2027
- Move the National Board of Podiatric Medical Examiners from September 2027 to March 2028
- Move William L. Goldfarb Foundation and Wisconsin Podiatric Medical Association from March 2028 to September 2028
- Move PRESENT e-learning Systems and Tennessee Podiatric Medical Association from September 2028 to March 2029

The council *approved* a change to requirement 5.2.

Former language for requirement 5.2: If the provider designates funds from a commercial interest for an individual lecture and/or workshop, no CECH or CME credit may be awarded, and the following stipulations apply:

- The schedule must state that no CECH or CME credit will be awarded for the individual component
- The commercial interest may be named if no logo is used and the name is in the same font style, point size, and color as the rest of the educational program publication(s)

Updated language for requirement 5.2: If the provider designates funds from a commercial interest for a lecture, workshop, and/or track, no CECH or CME credit may be awarded, unless it is disclosed to learners that the provider has made the decision to support that aspect of the activity using those funds.

- The provider must maintain a verifiable mechanism of the disclosure to the learner.

The council *approved* the changes to Appendix C - Sources of Gap Analysis (bullet point 5).
Former language for Appendix C - Sources of Gap Analysis (bullet point 5): Gaps can be identified using the following tools:

- Expert opinions from university or physician leaders who are not involved in the planning of the activity

Updated language for Appendix C - Sources of Gap Analysis (bullet point 5): Gaps can be identified using the following suggested tools:

- Expert opinions from hospital, university, or physician leaders

The council *did not approve* the committee's recommendations to leave requirement 6.4 unchanged.

Current 6.4 requirement: The provider shall perform a minimum of one attendance verification every four hours of the continuing education activity.

How to meet this requirement:
The council does not designate the method used for attendance verification. Attendance verification of the learners must be completed on the day of the activity by the provider. The provider must validate attendance prior to issuing documentation of attendance.

The council *approved* the following new language for requirement 6.4:
New requirement 6.4: The provider shall have a method to record attendance or verify participation.

How to meet this requirement:
The council does not designate the specific method used to record attendance or verify participation. Suggested methods include:

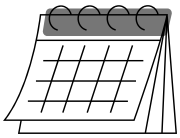
- Attestation
- Sign-In/Sign-Out Sheets
- QR Code Scanning
- Electronic Attendance Systems
- Surveys/Quizzes: Pre/post-session assessments to confirm engagement
- Staff Monitoring: In-person staff verify attendance during the session
- Video/Audio Tracking
- Manual Verification

Tiered Fees for Small Providers of Continuing Education: Following the APMA 2025 House of Delegates meeting, providers of continuing education provided feedback concerning the possibility of a tiered fees system for small providers of continuing education (defined as providers that only offer one CE activity per year). The committee reviewed the current fee schedule and the 2024 list of providers, activities, and joint providers and decided not to make a recommendation to the council at this time. Currently, small state associations and/or organizations have the option of becoming a joint provider with an approved provider of continuing education. The council asked the committee to continue to monitor this issue.

The council approved the implementation of training for continuing education providers. With the newly revised documents set to take effect on July 1, 2025, and considering recent feedback received from the APMA HOD meeting, the committee discussed plans to offer provider workshop(s) multiple times per year. The goal is to establish a structured training approach that supports the long-term objective of enabling participation by providers preparing for an upcoming petition review. The workshops would be open to directors and provider coordinators.

The first Zoom CE Provider Training: *New Continuing Education Documents* is scheduled for June 2, 2025, from 8:00–9:00 pm ET.

The council approved the committee's recommendation of adding attendance at poster abstract presentations to the list in Appendix A.



Future Meetings of the CEC

2025: September 12-13

2026: March 6-7 and September 18-19

2027: March 12-13 and September 17-18

RESIDENCIES AND FELLOWSHIPS

Approval as PMSR and/or PMSR/RRA

Adventist Health White Memorial
Charlie Norwood
Chino Valley Medical Center
Christus Saint Patrick Hospital
Gundersen Clinic, Ltd. – Gundersen Health System and Gundersen Lutheran Medical Center, Inc. – Gundersen Medical Foundation
Hackensack Meridian Health Palisades Medical Center
HCA Florida Westside Hospital RESIDENCY
HealthAlliance Hospital
HealthPartners Institute/Regions Hospital
Henry Ford Health – Henry Ford Wyandotte Hospital
Heritage Valley Beaver
Jefferson Health
Lenox Hill Hospital at Northwell Health
Mohawk Valley - Interim progress report
Roger Williams Medical Center
The Jewish Hospital - Mercy Health
UnityPoint Health – Trinity Regional Medical Center

Approval as a Fellowship

HCA Florida Westside Hospital

Approval with Report as a PMSR/RRA

Ascension St. Vincent Evansville
Atrium Health Wake Forest Baptist
Aultman Alliance Community Hospital
Brookdale Hospital Medical Center

Carl T. Hayden Veterans Affairs Medical Center
Central Alabama DVA
Christiana Care Health Services
Detroit Medical Center
HCA Houston Healthcare Kingwood
Inspira Medical Center Vineland
Jackson South Medical Center
James A. Haley Veterans' Hospital
Jefferson Health Northeast - Progress Report
John Peter Smith Hospital
Main Line Health Bryn Mawr Hospital Residency
Montefiore Mount Vernon Hospital
Mount Sinai Medical Center
Norton Audubon Hospital
NYU Grossman Long Island School of Medicine
Ochsner Clinic Foundation
OSF HealthCare Saint Anthony Medical Center
Rush University Medical Center
Saint Vincent Hospital
Salem Veterans Affairs Medical Center
Sanford Medical Center - Fargo
St. Francis Hospital
The Christ Hospital
UCI Health Fountain Valley
University Hospital Community Consortium
Veterans Affairs Puget Sound Health Care System

Approval with Report as a Fellowship

The University of Texas Health Science Center at San Antonio

Probation as PMSR and/or PMSR/RRA *(Candidate for withdrawal, effective July 1, 2026)*

Virtua Health
Bellevue Hospital
Corewell Health – Wayne
Department of Veterans Affairs Medical Center - Lebanon
James H. Quillen Veterans Affairs Medical Center
Keralty Hospital
Long Beach Memorial Medical Center

Richmond University Medical Center
Trinitas Regional Medical Center
UCI Health Lakewood
Weiss Memorial Hospital

Increase in Positions

Christiana Care Health Services
Reading Hospital

Voluntary Withdrawal of Approval of PMSR and/or PMSR/RRA *(effective July 1, 2025)*

Crozier-Chester Hospital (effective immediately)
Grant Medical Center OhioHealth
LA Downtown Medical Center
The Heights Hospital
Tucson Medical Center and Arizona College of Podiatric Medicine at Midwestern University
VA New York Harbor Health Care System
West Covina Medical Center

Withdrawal of Approval of PMSR/RRA *(effective July 1, 2025)*

Larkin Community Hospital – Palm Springs Campus

RRC Recommendations Approved by CPME

- The council reviewed the new substantive change forms for programs to submit to CPME as notification of resident resignation, termination or leave of absence, changes in program administration, changes in hospital name, and other substantive changes.
- The council approved the Milestones and the Supplemental Guide for the Use of Milestones. The council determined that training materials should be created related to the use of these Milestones, and that the Milestones will be available concurrently with the training materials.
- Sixty people attended the May 10, 2025 training workshop for program directors and residency coordinators: *Understanding CPME 320 and Getting Ready for the On-site Evaluation*. Twenty-three program directors and 37 coordinators attended this full-day training workshop.
- The council approved a policy to clarify when affiliation agreements are needed within different hospitals owned by the same entity:

  For the sake of consistency, the RRC has determined that if the sponsoring institution is a hospital (not a health-care system), the hospital must have an affiliation agreement with all affiliated training sites regardless of the hospital system. If the sponsoring institution is a health-care system, affiliation agreements are not needed with hospitals within the system.

- The council approved an FAQ document related to work hours that has been posted at www.cpme.org/logging-guidance. The RRC continues to work on memos related to proper logging and is currently working on a memo related to biomechanical examinations. Memos will be posted online and

emails will be sent to all program directors, coordinators, and evaluators when new guidance memos are available.
- The council approved posting suggested competencies for various podiatric fellowships on the CPME website for fellowship program directors to use as a resource.

Appointment of Committee Members

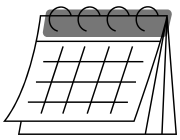
Dr. Harry Schneider was reappointed to the RRC as the CPME representative.

Residency and Fellowship Visits – Invitation for Comments

As part of the residency and fellowship approval process, CPME conducts evaluations of new programs and re-evaluations of approved programs. Each fall and spring, CPME meets to determine approval decisions. At its fall meeting, the council reviews programs visited during the previous spring on-site evaluation cycle, and at its spring meeting, the council reviews programs visited during the previous fall on-site evaluation cycle. To review the programs currently scheduled for on-site evaluation, visit www.cpme.org/onsiteschedule. The council updates the list as evaluation dates are confirmed.

The council's residency and fellowship approval process includes consideration of third-party comments concerning an institution's qualifications for either provisional or continued approval. Comments must be received 15 days prior to the program's scheduled site visit date. All third-party comments must be signed. Comments are forwarded to the evaluation team, and anonymously to the program director for response, if appropriate, prior to the visit.

Please submit third-party comments for programs to be reviewed to: Bertus Tempelhoff, CPME assistant director, at btempelhoff@cpme.org.



Future Meetings of the RRC

2025: September 19-20

2026: March 19-21 and September 24-26

An extra day was added to each meeting for the interim review of CPME 320, 330, 820, and 830.

CREC UPDATES

CREC held the *New Evaluator Training Workshop* on May 10, 2025, in Chicago for newly approved residency and fellowship on-site evaluators. Ten evaluators representing ABFAS and ABPM participated in the training.

Become a CPME Residency Program Evaluator

One of the most important components of the CPME residency approval process is the site visit. The site visit is a peer-review process that helps to enhance the quality of education by assessing a program's compliance with CPME standards and requirements. CPME is committed to ensuring each evaluator possesses appropriate

experience and skills essential to the evaluation process. CPME residency evaluators must be certified by one or both of the specialty boards recognized by the CPME and should be either program directors or active faculty members of CPME-approved residencies.

Prior to participating as a member of a team, evaluators complete a training program and are assigned to a team as trainees under the tutelage of the team chair and the specialty board representatives. The council pays all expenses incurred during the site visit and a per diem for each travel and on-site visit day.

Individuals interested in becoming residency evaluators should submit a letter of interest and current curriculum vitae to their certifying board(s). Contact information for the American Board of Foot and Ankle Surgery (ABFAS) or the American Board of Podiatric Medicine (ABPM), as well as a description of the ABFAS- and ABPM-certified evaluator criteria, can be found at www.cpme.org/residencyevaluators.

Please feel free to provide this information to interested and qualified individuals within and outside of your institution or organization.

PUBLICATION UPDATES

CPME PUBLICATIONS 120 AND 130: DOCUMENTS UNDER REVISION (COLLEGES OF PODIATRIC MEDICINE)

Every six years, the council conducts a comprehensive review of its standards, requirements, and procedures related to its evaluation activities. The Accreditation Ad Hoc Committee held its first meeting on April 3, 2025, followed by a meeting on May 14, 2025, where members reviewed input from communities of interest submitted via surveys and comment letters. The committee will now begin drafting the first version of the revised CPME 120, Standards and Requirements for Accrediting Colleges of Podiatric Medicine, and CPME 130, Procedures for Accrediting Colleges of Podiatric Medicine. The committee plans to meet monthly to complete this work.

CPME PUBLICATIONS 220 AND 230: DOCUMENTS ADOPTED (SPECIALTY BOARDS)

In March 2021, the APMA House of Delegates approved a resolution to designate the Joint Committee on the Recognition of Specialty Boards (JCRSB) as a standing committee of the council. In response, CPME adopted amendments to its Bylaws at its October 2021 and April 2022 meetings to align with the APMA action. These changes officially established the JCRSB as a standing committee and restructured its representation.

To reflect this change, CPME renamed the JCRSB to the Specialty Board Recognition Committee (SBRC). As part of the transition, the committee's governing documents—CPME 220 (Criteria and Guidelines for Recognition of a Specialty Board for Podiatric Medical Practice) and CPME 230 (Procedures for Recognition of a Specialty Board for Podiatric Medical Practice)—required revision to reflect the new structure.

An Ad Hoc Advisory Committee began reviewing these documents in fall 2022. Over the course of 18 months, the committee held 13 meetings. In April 2024, the committee submitted Draft I of CPME 220 and 230, along with new supporting documents: CPME 209a and 209b (Eligibility Requirements and Initial Recognition Applications)

and CPME 209c (Subspecialty Certification Proposal). CPME approved Draft I of all five documents during a special meeting on May 13, 2024, and opened a 60-day public comment period ending July 15, 2024.

At its October 2024 meeting, the council reviewed initial feedback from the community of interest. Due to the volume of responses, CPME extended its review into the fall and scheduled a follow-up videoconference for December 11, 2024, to determine next steps.

Following a thorough review of the submitted comments, the council adopted the finalized versions of CPME 220, 230, 209a, 209b, and 209c at its May 3, 2025, meeting. These documents are now in effect.

If you have any questions, please contact Heather Stagliano, CPME's executive director, at hstagliano@cpme.org.

CPME extends its sincere thanks to the Ad Hoc Advisory Committee members for their dedication, hard work, and invaluable contributions throughout this process. Their efforts have played a critical role in advancing the standards for specialty board certification in podiatric medicine.

CPME PUBLICATIONS 720 AND 730: FINAL DOCUMENTS PUBLISHED (CONTINUING EDUCATION)

CPME adopted the revised CPME 720, Standards and Requirements for Approval of Providers of Continuing Education in Podiatric Medicine, and CPME 730, Procedures for Approval of Providers of Continuing Education in Podiatric Medicine, at its October 2024 meeting. The newly approved documents were disseminated and posted to the CPME website on March 12, 2025, and will take effect on July 1, 2025. If you have any questions, please contact Sandy Saylor, CPME associate director, at ssaylor@cpme.org.

The council extends its sincere appreciation and heartfelt gratitude to the CE Ad Hoc Advisory Committee members for their hard work, dedication, and outstanding contributions throughout this lengthy process. Their commitment to excellence and the advancement of continuing education in podiatric medicine has been invaluable.

SBRC Ad Hoc Committee

Kieran Mahan, DPM (chair)

Kathy Kreiter (ABFAS representative)

Gina Painter, DPM (ABPM representative)

Lawrence Ramunno, MD, MPH, MBA (health-care representative)

James Sang, DPM (double-boarded practitioner)

Kara Schmitt, PhD (psychometrician member)

Harry Schneider, DPM (representing CPME)

Melanie Violand, DPM (representing CPME)

James Christina, DPM (ex-officio member)

Keith Cook, DPM (ex-officio member)

Alyssa Stephenson, DPM (ex-officio member)

Continuing Education Ad Hoc Committee

Oleg Petrov, DPM (Chair)

Lara Beer-Caulfield

Michael Brody, DPM

Lori DeBlasi, DPM

Jay LeBow, DPM

Rodney Peele, JD

CONTACT US

Council on Podiatric Medical Education

Address: 11400 Rockville Pike, Suite 220, Rockville, MD 20852

Email: cpmestaff@cpme.org

Website: Council on Podiatric Medical Education

From: Beverly Shelton on behalf of Humayun Chaudhry
Subject: FDA Letter to FSMB on Cagrilintide
Date: Tuesday, June 3, 2025 10:08:03 AM
Attachments: image001.png

CAUTION: This email originated from outside the State of Alaska mail system. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Dear Executive Directors,

I wanted to alert you to a letter sent to the FSMB from the U.S. Food and Drug Administration (FDA) with information related to compounded drug products containing cagrilintide, some of which claim to treat obesity and other conditions. The FDA has asked us to share this letter with our member boards to make licensees aware of the current regulatory status of compounded cagrilintide. The FDA shared a similar letter with FSMB in early April about a compounded drug called retatrutide.

If you have questions about any issues related to drug compounding, the FDA encourages you to reach out to the Office of Compounding Quality and Compliance at compounding@fda.hhs.gov.

Sincerely,
Hank

Humayun "Hank" Chaudhry , DO, MACP, FRCP
President and Chief Executive Officer

Federation of State Medical Boards
1775 Eye Street, N.W. | Suite 410
Washington, DC 20006
817-868-4044 direct | 817-259-2856 fax
hchaudhry@fsmb.org www.fsmb.org

June 2, 2025

Humayun J. Chaudhry, DO, MACP
President and CEO
Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, TX 76309

Dear Dr. Chaudhry:

The purpose of this letter is to bring to the attention of the Federation of State Medical Boards information related to compounded drug products containing cagrilintide, some of which claim to treat obesity and other conditions. FDA believes that health care professionals should be advised about the current regulatory status of compounded cagrilintide.

Sections 503A and 503B of the Federal Food, Drug, and Cosmetic Act (FD&C Act) describe the conditions that must be satisfied for compounded human drug products to be exempt from certain sections of the FD&C Act, including the requirements of premarket approval and labeling with adequate directions for use. Among the conditions of sections 503A and 503B are restrictions on the bulk drug substances (active pharmaceutical ingredients or APIs) that may be used to compound human drug products.

One of the conditions that must be met for a compounded drug product to qualify for the exemptions under section 503A of the FD&C Act is that a licensed pharmacist in a State licensed pharmacy or a Federal facility, or a licensed physician, compounds the drug product using bulk drug substances that: (1) comply with the standards of an applicable United States Pharmacopeia (USP) or National Formulary (NF) monograph, if a monograph exists, and the USP chapter on pharmacy compounding; (2) if such a monograph does not exist, are drug substances that are components of drugs approved by the Secretary; or (3) if such a monograph does not exist and the bulk drug substance is not a component of a drug approved by FDA, appear on a list developed by FDA through regulation ("503A Bulks List") (section 503A(b)(1)(A)(i) of the FD&C Act). Cagrilintide is not the subject of an applicable USP or NF monograph, is not a component of an FDA-approved drug product, and does not appear on the 503A Bulks List. Therefore, compounded cagrilintide products would not at this time qualify for the exemptions under section 503A of the FD&C Act.

One of the conditions that must be met for a drug product compounded by an outsourcing facility to qualify for the exemptions under section 503B of the FD&C Act, is that the outsourcing facility does not compound drug products using a bulk drug substance unless: (1) the bulk drug substance appears on a list established by the Secretary identifying bulk drug substances for

which there is a clinical need ("503B Bulks List"), or (2) the drug product compounded from such bulk drug substance appears on FDA's drug shortage list in effect under section 506E at the time of compounding, distribution and dispensing (section 503B(a)(2)(A)(i) and (ii) of the FD&C Act). Cagrilintide does not appear on the 503B Bulks List, nor does it appear on FDA's drug shortage list. Therefore, compounded cagrilintide products would not at this time qualify for the exemptions under section 503B of the FD&C Act.

Additionally, FDA has warned companies that have illegally sold unapproved drugs that are falsely labeled "for research purposes" or "not for human consumption."[1] The agency recommends that consumers not purchase products, such as cagrilintide, that do not meet the exemptions of sections 503A or 503B of the FD&C Act, are of unknown quality, and may be harmful to their health. FDA also encourages health care providers to discuss this issue with their patients.

We are also sending this letter to the National Association of Boards of Pharmacy and National Council of State Boards of Nursing to facilitate communication among associations with shared goals regarding these matters.

We look forward to continuing to work with you on matters related to drug compounding. If you have additional questions, please contact the Office of Compounding Quality and Compliance at compounding@fda.hhs.gov.

Sincerely,

Maria Edisa Gozun, PharmD
Division Director, Division of Compounding II
Office of Compounding Quality and Compliance
Office of Compliance
Center for Drug Evaluation and Research

From: Federation of Podiatric Medical Boards <fpmb@fpmb.org>
Sent: Monday, June 30, 2025 9:04 AM
To: FPMB FPMB <fpmb@fpmb.org>
Subject: FPMB - [UPDATES] Board Attends FSMB Annual Meeting / CPME Report and Revisions / AACPM Residency Placement Update

Dear Member Podiatric Medical Board:

Please find below several updates from the Federation of Podiatric Medical Boards (FPMB) and our allied organizations. Highlights include the FPMB Board's participation in the Federation of State Medical Boards (FSMB) Annual Meeting, key actions recently adopted by the Council on Podiatric Medical Education (CPME), and updated residency placement information from the American Association of Colleges of Podiatric Medicine (AACPM). These developments underscore our shared commitment to public protection and to advancing the integrity of podiatric medicine. Kindly review the summaries and share any pertinent details with your Board Members and staff.

FPMB Board Attends the FSMB Annual Meeting
April 23, 2025

Every year, the Federation of Podiatric Medical Boards (FPMB) attends the Federation of State Medical Boards (FSMB) Annual Meeting and House of Delegates (HOD) as their invited guest. FPMB's Board Members and staff are individually recognized by the FSMB CEO at the HOD.

FSMB's conference topics are always of a wide range relative to healthcare in general and medical boards specifically. Highlights this year included building influence in state and federal policy, AI's role as it transforms medicine, increasing the use of telemedicine, disciplinary issues including promoting quality of care through collaboration and working through issues of sexual misconduct, physician competency and physician well-being.

Legislative hot topics included other healthcare professionals increasing their scopes, the eighteen (18) professional healthcare interstate compacts, off label use of prescriptions, mRNA vaccines and ketamine treatments. One other issue of interest was the trend of CME requirements becoming less restrictive and less specific.

The FPMB Board of Directors also holds its in-person meeting while in attendance at their meeting. Like the FSMB for MDs/DOs, the FPMB represents all state boards licensing DPMs and guides individual boards on procedural issues while providing support where needed.

However, that is only one role of the FPMB. FPMB provides NBPME score reporting to states to support licensee applications across the country and prides itself on near immediate score releases once requested.

One focus of the FPMB Board Meeting this year was the progress of the Interstate Podiatric Medical Licensure Compact initiative. Once established, the benefits will include expedited licensure, improved mobility and increased opportunities for Podiatric physicians across state borders. The FPMB has taken on this role for the Podiatric profession.

-Marlene Reid, DPM, FPMB President (FY 2024-2025)

Council on Podiatric Medical Education

The Council on Podiatric Medical Education (CPME / Council) promotes the quality of **graduate education, postgraduate education, certification, and continuing education**. By confirming these programs meet established standards and requirements, the Council serves to protect the public, podiatric medical students, and doctors of podiatric medicine. FPMB represents its Member Boards and their mission to protect the public on CPME's Continuing Education Committee.

Please note the following two updates:

REPORT - Minutes of the May 2025 CPME Meeting
Following the spring and fall meetings of the Council on Podiatric Medical Education, a Report of the Council is created to provide a summary of the Council's actions and notices. You will find the May 2025 Report of the Council, from the Council's spring 2025 meeting, as well as previous Reports of the Council, on the www.cpme.org homepage.

Revised CPME Specialty Board Documents Adopted
After more than two years of review, 13 committee meetings, two surveys to the community of interest, and one listening session, CPME has finalized revisions to two key documents: CPME 220 and CPME 230. As part of this process, CPME created three new application documents: two for applicant specialty boards seeking recognition (CPME 209a and CPME 209b) and one for recognized specialty boards applying for subspecialty certification (CPME 209c). Drafts were first approved in May 2024 and shared for public comment through July 15. Based on feedback, the council conducted further review and officially adopted the finalized versions at its May 3, 2025, meeting. These documents are now in effect and published on the CPME webpage.

American Association of Colleges of Podiatric Medicine

The American Association of Colleges of Podiatric Medicine (AACPM) is a nationally recognized education association that serves as a resource to students, residents and practitioners by providing direct access to **academic institutions**; highlighting opportunities for clerkships and **residencies**; and linking students to mentors that guide their career development.

Please see attached for the updated 2025 Residency Placement Status press release.

Thank you for your continued partnership. If FPMB can support your Board in any way, please let us know. Have a wonderful week!

Best,
Russ

Russell J. Stoner, CAE
Executive Director
Federation of Podiatric Medical Boards
12116 Flag Harbor Drive | Germantown, MD 20874-1979
202-810-3762 direct | 202-318-0091 fax
fpmb@fpmb.org | www.fpmb.org

aacpm
American Association of Colleges of Podiatric Medicine
15850 Crabbs Branch Way, Suite 320
Rockville, Maryland 20855-2622
301-948-9760
www.aacpm.org

PRESS RELEASE
For release ***May 31, 2025***

Updated 2025 Residency Placement Status

The AACPM provides periodic status reports on residency placements from Match Week through the end of June. The May report reflects the applicants that became eligible with the May administration of APMLE Part II.

Match Week placement results were released at 12:00 pm Eastern on Friday, March 21. The following is residency placement data as of May 31, 2025:

RESIDENCY APPLICANTS: Class of 2025

Placed in Residencies	516 (96.6%)
To Be Placed	18 (3.4%)
TOTAL	534 (100.0%)

RESIDENCY POSITIONS:

CPME Approved Positions as of March 21, 2025	625
Positions not filling for this training year	53
Total Active Positions Available for this year	572

Prior Year Applicants:	**Class of 2024**	**Class of 2023**	**Prior Classes**
Placed in Residencies	8 (100.0%)	3 (100.0%)	1 (100.0%)
To Be Placed	0 (0.0%)	0 (0.0%)	0 (0.0%)
TOTAL	8 (100.0%)	3 (100.0%)	1 (100.0%)

When taking overall placements into consideration, 528 (96.7%) of the 546 residency applicants have found residency positions thus far this year. There are 18 (3.3%) applicants that have yet to find a residency position for the 2025-2026 training year.

There are currently thirty-seven (37) unfilled approved entry-level positions listed on the Open Positions page of the Association's website.

About AACPM

*Established in 1967, **the American Association of Colleges of Podiatric Medicine** (AACPM) represents the eleven accredited schools and colleges of podiatric medicine and more than 200 hospitals and institutions that offer postdoctoral training in podiatric medicine. AACPM's mission is to serve as the leader in facilitating and promoting excellence in podiatric medical education leading to the delivery of the highest quality lower extremity healthcare to the public. The Association serves as a national forum to exchange ideas and information regarding undergraduate and graduate podiatric medical education.*

For additional information, contact:
Moraith G. North
AACPM Executive Director
301-948-9760

FEDERATION OF STATE MEDICAL BOARDS

Board of Directors Meeting
April 23 and April 27, 2025

HIGHLIGHTS

The FSMB Board of Directors met in Seattle, WA on April 23 and 27, 2025. The following is a summary of those meetings.

April 23, 2025

2025 House of Delegates (HOD) Meeting

The Board of Directors discussed the reports going before the 2025 HOD for consideration. See page three for a complete list of the actions taken by the HOD.

Informational Reports

Informational reports were provided on the activities/work of the FSMB Chair, President-CEO, Chief Advocacy Officer, Chief Assessment Officer, Chief Learning Officer, Chief Legal Officer, and Chief Operating Officer. Additionally, an updated Financial/Investment Report was presented. The Board received a report from the Board's Planning Committee. Updates were also provided on USMLE operations and the work of the Advisory Commission on Additional Licensing Models.

April 27, 2025

New Directors of the Board

Newly installed FSMB Chair George M. Abraham, MD, MPH welcomed the Board of Directors' newly elected Directors-at-Large Jorge A. Alsip, MD, MBA; Christine M. Khandelwal, DO, MHPE; and Ramanathan Raju, MD, MB. Dr. Abraham also congratulated Christy L. Valentine Theard, MD, MBA on her election as Chair-elect, and Maroulla S. Gleaton, MD on her re-election as a Directors-at-Large and Edward O. Cousineau, JD on his re-election as Staff Fellow.

Election of Directors-at-Large to the Executive Committee

The Board of Directors elected Directors-at-Large Andrea Anderson, MD, MEd, Mark B. Woodland, MS, MD, and Sherif Z. Zaafran, MD to the Board's Executive Committee for a one-year term.

Committee and Workgroup Appointments

The Board of Directors approved the Chair's recommendations for FSMB standing committee appointments for the coming year. The Board also authorized the Chair to finalize any outstanding committee appointments that might need to be made following the Board's meeting to ensure the work of the groups can proceed in a timely manner.

Informational Report and Resources

The Board received a presentation and discussions of the legal and fiduciary responsibilities of the Board from counsel. Additionally, the Board was provided with the schedule of Board meetings for the upcoming year and the FY 2026 FSMB Bylaws as approved by the 2025 House of Delegates.

Actions by the FSMB House of Delegates
April 26, 2025

1. The Agenda for the April 26, 2025, annual meeting of the House of Delegates was **APPROVED**.

2. The Report of the Rules Committee was **ADOPTED**.

3. The Consent Agenda for the April 26, 2025, annual meeting of the House of Delegates was **APPROVED**.

4. The Minutes of the April 20, 2024, annual meeting of the House of Delegates were **APPROVED**.

5. The FY 2026 Proposed Budget was **ADOPTED.**

6. Elections

Chair-elect: **Christy L. Valentine Theard, MD, MBA (2025-2026) (elected by acclamation)**

Directors-at-Large: **Jorge A. Alsip, MD, MBA (2025-2028)**
Maroulla S. Gleaton, MD (2025-2026)
Christine M. Khandelwal, DO (2025-2028)
Ramanathan Raju, MD, MBA (2025-2028)

Nominating Committee: **Naveed Razzaque, MD (2025-2027)**
Andy R. Tanner, DO (2025-2027)
Dondre D. Young (2025-2027)

1. Proposed Amendment #1 to the Bylaws

The House of Delegates APPROVED the recommendation Bylaws Committee to REFER to the Bylaws Committee for further discussion of Article II, Sec. B, determining the length of eligibility as a Fellow.

Amend **Bylaws Article III. Officers: Election and Duties and Article IV: Board of Directors** as follows:

ARTICLE III. OFFICERS: ELECTION AND DUTIES
SECTION A. OFFICERS OF THE FSMB

2. Only an individual who is currently or has been a Fellow as defined in Article II, Section B, paragraph 1 ~~at the time of the individual's election or appointment~~ shall be eligible for election or appointment as an Officer of the FSMB, except for the position of Secretary.

ARTICLE IV. BOARD OF DIRECTORS

SECTION C. ELECTION OF DIRECTORS-AT-LARGE

6. Only an individual who is currently or has been a Board Member Fellow at the time of the individual's election shall be eligible for election as a Director of the FSMB.

2. Proposed Amendment #2 to the Bylaws contained in the Report of the Bylaws Committee was **NOT ADOPTED**:

ARTICLE VI. PRESIDENT

The Board of Directors may, by a two-thirds majority vote of the full Board, appoint a President of the FSMB~~, who shall be a physician,~~ to serve without term. The President shall administer the affairs of the FSMB and shall have such duties and responsibilities as the Board of Directors and the FSMB shall direct. The President shall serve as Secretary of the FSMB and shall be an ex-officio member, without vote, of the Board of Directors.

3. Proposed Amendment #3 to the Bylaws contained in the Report of the Bylaws Committee was **ADOPTED**:

ARTICLE VIII: STANDING AND SPECIAL COMMITTEES
SECTION E. ETHICS AND PROFESSIONALISM COMMITTEE

The Ethics and Professionalism Committee shall be composed of up to eight Fellows. ~~**and up to two subject matter experts.**~~ **In addition, the Chair may appoint additional individuals as subject matter experts to serve on the committee**. The Ethics and Professionalism Committee shall address ethical and professional issues pertinent to medical regulation.

4. The recommendations from the FSMB Ethics and Professionalism Committee, contained in BRD RPT 25-1: *Professionalism in the Context of Assessment for Licensure* were **ADOPTED** and the remainder of the report filed.

5. The recommendations from the FSMB Reentry to Practice Working Group, contained in BRD RPT 25-2: *Reentry to Practice* were **ADOPTED** and the remainder of the report filed.

VINCENT L. DICIANNI
VDICIANNI@AFFILIATEDMONITORS.COM

BY E-MAIL

June 2025

The Growing Use of Independent Monitoring

For twenty years, Affiliated Monitors has been a regular exhibitor at the Federation of State Medical Boards' events, and we again had a wonderful opportunity to connect with many attendees at this year's Annual Meeting in Seattle. Thank you to those who stopped by our exhibitor's table to visit and learn more about independent monitoring. Over the years, we have met Board members, executive staff, and counsel from across the country. We recognize the significant role the FSMB plays in the practice of medicine, both from educational and best practice standards, as well as in its innovation.

To those we have worked with over the years, we thank you and appreciate the opportunities to work with your boards. We are proud to have earned your trust through the dedication, professionalism, and excellence of our team and services.

For those who have not yet utilized our services, this letter will serve to introduce you to Affiliated Monitors and perhaps give you reason to consider utilizing a third party monitor in those matters where a probationary sanction option might be considered as an opportunity to 1) allow a healthcare professional to address the deficiencies that led to board action, 2) remediate errors, and 3) become a stronger provider, as validated by a professional, independent third party monitor.

When Affiliated Monitors started in 2004, the use of independent monitoring as a probationary sanction was a novel idea embraced by a few boards; since then, many more boards have incorporated it into their disciplinary process. We have worked closely with board staff to support their efforts, recognizing the realities of busy schedules and staff budgets. Importantly, independent practice monitoring has allowed boards the ability to follow their licensees' compliance activities and provided valuable insight into the clinical setting.

Affiliated Monitors has become a trusted resource for medical, osteopathic and many other healthcare boards across the country, and has helped hundreds of physicians meet their practice and regulatory standards. Because many of our team members formerly worked for regulatory boards, we understand how important it is to provide solutions tailored to the requirements of individual boards.

AFFILIATED MONITORS, INC.™
INTEGRITY THROUGH COMPLIANCE

Affiliated Monitors is committed to providing professional independent monitoring services that allow:

- Physicians to continue to practice during their probation, while demonstrating effective and sustainable practice improvements.
- Boards and staff to receive timely and actionable information about monitored licensees.
- Practitioners to receive specific insights and helpful recommendations and mentoring from peers in a manner conducive to learning.
- Well-tailored, remedial monitoring programs to address practice deficiencies effectively and as an adjunct to standard probation, reprimands, or fines.

In parallel with our monitoring services, Affiliated Monitors highlights our proactive *compliance risk management tools,* such as clinical competency assessments, billing audits, and evaluation of policies and processes for compliance risks. In some cases, we help practices develop or update their compliance programs, train their staff, and improve their compliance with statutes and regulations governing the practice of medicine.

It was interesting to hear the FSMB panel on boundary matters, including consideration of the use of practice monitors. We have been providing monitoring in boundary cases for many years, with excellent results and at no cost to the boards.

Affiliated Monitors is proud to promote the use of independent monitoring as an accepted tool utilized by many government agencies to make effective improvements to the practice of medicine. We would also welcome the opportunity to present to your board to give members a fuller understanding of our services and the benefits of independent monitoring.

We appreciate the opportunity to serve your board, your licensees, and your constituents.

Sincerely,

Vincent L. DiCianni
President

AFFILIATED MONITORS, INC.™
INTEGRITY THROUGH COMPLIANCE

The Independent Monitoring and Assessment Experts for Healthcare Practices

Services

- Practice-based Monitoring
- Record Reviews
- Oversight of Prescription and Dispensing Practices
- Billing and Coding Audits
- Boundaries Oversight
- Clinical Competence Assessments
- Return-to-Practice Evaluations/Oversight
- System Reviews and Compliance Programs
- Tracking Compliance with Board Orders and Medicaid Fraud Prosecution Agreements

Clients

- Hospitals
- Nursing Homes
- Home Care Agencies
- Ambulatory Surgery Centers
- Clinical Laboratories
- Pharmacies
- Individuals and Group Practices
  - MDs & DOs
  - Dentists
  - Chiropractors
  - PTs & OTs
  - Advanced Practice Nurses
  - Physician Assistants

Affiliated Monitors, Inc.
Headquartered in Boston, MA
866-201-0903
affiliatedmonitors.com

Affiliated Monitors, Inc. (AMI) was the first company in the U.S. to focus on providing independent integrity monitoring in healthcare. Since 2004, regulatory authorities from 42 states have trusted AMI to oversee nearly 850 healthcare matters involving hospitals, surgical centers, pharmacies, labs, practice groups, and individual practitioners.

AMI's monitoring is based on current federal, state, and local laws. Our approach is practical: we recommend improvements and share best practices to enhance public protection and address areas of concern. AMI's monitoring provides practitioners with the information and guidance needed to achieve and demonstrate sustainable compliance.

integrity: AMI is a trusted resource for professionals, practices, legal counsel, state boards and regulators.

independence: Providing objective, third-party monitors to assess clinical, operational, and administrative practice functions.

experience: With years of experience in healthcare, government, compliance, risk management, and law, AMI is unmatched in assessing and monitoring providers and practices. We address clinical knowledge, reasoning and application; record-keeping; billing; boundary issues; and compliance with state and federal laws.

Benefits of Independent Monitoring

- Regulatory agencies receive comprehensive reports on the compliance of practitioners.
- Providers continue to practice while demonstrating remediation.
- Specialty-specific, flexible oversight is tailored for each practitioner.
- Local monitors provide recommendations that reflect community expectations.
- Evidence-based practices are shared to facilitate sustained improvements.

Costs of Independent Monitoring

- Affiliated Monitors bills for its services on an hourly basis.
- Factors affecting cost include the scope, frequency and duration of the monitoring.
- Affiliated Monitors encourages efficiency in its reviews to contain costs.

The Independent Monitoring and Assessment Experts for Healthcare Practices

Meet some of AMI's team members, who represent a variety of backgrounds and talents, and a singular commitment to the value of independent assessment and monitoring.

Denise L. Moran, JD dmoran@affiliatedmonitors.com

Director of Healthcare Monitoring Services—Nashville, TN

- Lead designer of healthcare practice monitoring and compliance programs, clinical competence assessments, and applied education programs
- Former Senior Attorney for the Tennessee Department of Health, serving as legal counsel for all departmental programs, including the enforcement of regulations governing 39 healthcare professions and facilities

Deann Conroy, JD dconroy@affiliatedmonitors.com

Compliance Solutions Manager—Des Moines, IA

- Attorney and educator of healthcare legal issues
- Former Division Deputy Director, Colorado Department of Public Health & Environment; Program Director, Colorado Department of Regulatory Agencies for five healthcare professional programs that oversaw regulation and discipline for more than 25,000 professionals

Alan Van Tassel avtassel@affiliatedmonitors.com

Compliance and Monitoring Associate—Boston, MA

- Healthcare compliance professional with expertise in regulatory standards
- Former Investigations Supervisor at Massachusetts Division of Professional Licensure for 20 professional regulatory boards; oversaw investigations and enforcement for over 130,000 licensed professionals and businesses

Kia D. Johnson, MSN, APRN, FNP-C kjohnson@affiliatedmonitors.com

Compliance Solutions Manager—Houston, TX

- Advanced practice nurse with extensive experience in clinical practice, healthcare management, and regulatory compliance in hospital and clinic environments
- Clinical expertise in providing evidence-based care to diverse patient populations with emphasis on family and geriatric medicine and oversight of healthcare teams
- Management-level experience in audits, performance evaluations, resource allocation, and staff education

Erin LeBel, LICSW elebel@affiliatedmonitors.com

Compliance Solutions Manager—Boston, MA

- Healthcare compliance professional with expertise in professional regulatory standards
- Former Executive Director at the Massachusetts Division of Professional Licensure for several mental health professional regulatory boards, including Social Workers, Psychologists, Mental Health Counselors,and Behavior Analysts; oversaw the regulatory implementation and compliance protocol for over 50,000 mental health professionals

Val Peake vpeake@affiliatedmonitors.com

Compliance Solutions Manager—Oklahoma City, OK

- Healthcare compliance professional with expertise in training and development
- Former Training Development Specialist, HRDT Learning Office, Maryland Department of Human Services; State Training Coordinator, Centers for Medicare and Medicaid Services (CMS); Medication Administration Program Coordinator, Health Facilities & Emergency Medical Services Division, Colorado Department of Public Health & Environment (CDPHE)

Susan Dvorak sdvorak@affiliatedmonitors.com

Compliance Solutions Manager—Sacramento, CA

- Healthcare compliance professional with expertise in medical board matters including compliance tracking and investigations
- Former Probation compliance monitor, Medical Board of California; Program representative handling claims adjudication, California Employment Development Department Disability Program; and Technician, California Health Benefit Exchange

100 Daingerfield Road, Suite 100
Alexandria, VA 22314

www.a4pc.org

Alliance for Pharmacy Compounding

June 17, 2025

Natalie Norberg
Alaska State Medical Board
333 Willoughby Ave., 9th Fl
State Office Building
Juneau, AK 99801

Subject: Clarifying the Legality, Safety, and Necessity of Compounded Medications Amid Industry Misinformation

Dear Executive Administrator Norberg and Members of the Alaska State Medical Board:

On behalf of the Alliance for Pharmacy Compounding, we write to address misleading and inaccurate claims by drugmakers and others about compounded medications. These claims are not only misinformed but are increasingly being used to pressure health professional boards and regulators to adopt positions that contradict federal and state law and could inappropriately interfere with patient access to necessary, individualized therapy.

I. Compounding Is a Legal, Regulated, and Necessary Component of the U.S. Drug Supply Chain

In our healthcare system, FDA-approved drugs are supreme. If an FDA-approved drug is accessible and judged by a prescriber to be appropriate for a particular patient, the FDA-approved drug is what should be prescribed and dispensed. But FDA-approved drugs are sometimes not accessible, the result of shortages with a variety of causes. Likewise, FDA-approved drugs don't come in strengths and dosage forms that are right for everyone, and prescribers need to be able to prescribe customized medications when, in their judgment, a manufactured drug is not the best course of therapy for a human or animal patient.

Compounding plays a vital role in filling therapeutic gaps when no FDA-approved, commercially available medication is suitable or available. In that way, compounding fills essential gaps in the drug supply chain — not as competition for the makers of FDA-approved drugs, but rather filling gaps in drugs supply that drugmakers cannot or do not fill.

Federal law — the Food, Drug, and Cosmetic Act (FDCA) — permits the compounding of medications by state-licensed pharmacies (503A) and FDA-registered outsourcing facilities (503B). These compounded medications are not FDA-approved because they are not mass manufactured for a general population. Instead, they are prepared based on a prescriber's medical judgment for a specific patient or, in the case of 503Bs, in anticipation of need within a health system.

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Alexandria, VA 22314

www.a4pc.org

Alliance for Pharmacy Compounding

Importantly, the law recognizes that compounded medications are essential medical therapies. Pharmacies are held to rigorous standards including United States Pharmacopeia (USP) chapters <795>, <797>, and <800>, and current good manufacturing practices (cGMP) for 503Bs. Outsourcing facilities must adhere to current good manufacturing practices, just like drug manufacturers. These standards address sterility, potency, beyond-use dating, labeling, and more. State boards of pharmacy and FDA conduct regular inspections of pharmacies and facilities to ensure compliance.

II. Manufacturer Misinformation: Conflating Compounding with Counterfeiting

We are increasingly concerned by the dissemination of misinformation by drug manufacturers Eli Lilly and Novo Nordisk, which have launched campaigns targeting compounded GLP-1 medications like semaglutide and tirzepatide. Their efforts include:

- Implying that all compounded GLP-1s are unsafe or unregulated;
- Suggesting that the active pharmaceutical ingredients (APIs) used are substandard or counterfeit;
- Mischaracterizing outsourcing facility distribution as unlawful wholesaling; and
- Inappropriately citing unverified adverse event reports from the FDA Adverse Event Reporting System (FAERS) as evidence of harm.

These efforts appear aimed at preserving market exclusivity rather than protecting public health. They are also legally and factually incorrect.

III. GLP-1 APIs Are Lawfully Sourced and Tested

Federal law requires pharmacies and outsourcing facilities to use APIs from FDA-registered manufacturers. These substances must be accompanied by Certificates of Analysis verifying identity, purity, and potency. While some of these manufacturers are based overseas, this is consistent with FDA policy. Most APIs used in the US supply chain are manufactured overseas. FDA-registered facilities are subject to inspection and enforcement. Importantly, FDA has raised no concerns about the quality of the API used by compounding pharmacies and outsourcing facilities. The drugmaker misrepresentations are simply not rooted in fact.

Assertions that compounders are using “counterfeit” or “unapproved” APIs reflect a fundamental misunderstanding of regulatory definitions. FDA does not "approve" APIs, it approves finished drug products. The claim that synthetic GLP-1 APIs are inherently inferior to recombinant versions is unsupported and, in fact, contradicted by the synthetic nature of many commercial APIs, including those used by Eli Lilly.

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IV. Adverse Event Reports Are Misused and Misleading

FAERS data has been repeatedly misrepresented to suggest that compounded GLP-1s carry extraordinary risks. In truth:

- Reports in FAERS are unverified, voluntary, and often duplicative.
- They do not confirm causation and are skewed against compounded drugs because those lack formal labeling, making nearly all adverse events "unexpected" by default.
- The FDA itself has publicly stated that using FAERS to compare the safety of compounded and commercial drugs is "highly misleading."

Moreover, the adverse events attributed to compounded GLP-1s largely reflect known and labeled side effects of the brand-name drugs. There is no credible evidence that the act of compounding these medications introduces new or greater risks.

V. Outsourcing Facilities Are Permitted to Dispense Through Pharmacies

One persistent mischaracterization is the claim that 503B outsourcing facilities are unlawfully wholesaling medications to 503A pharmacies. Section 503B explicitly permits outsourcing facilities to distribute compounded medications to healthcare providers, including pharmacies, for dispensing pursuant to patient-specific prescriptions. FDA guidance confirms this interpretation. Transfers from a 503B to a 503A pharmacy are lawful so long as the 503A pharmacy dispenses the medication pursuant to a valid prescription and the 503B facility is the one that compounded it. No provision of federal law prohibits this practice.

VI. Compounding Is Critical in Emergencies and Shortages

During the 2022–2023 respiratory "tripledemic," many pharmacies compounded acetaminophen, ibuprofen, and amoxicillin suspensions to treat sick children amid national shortages. Following the flooding of Baxter's North Carolina plant in 2024, 503B facilities rapidly supplied sterile IV solutions like sodium chloride and dextrose nationwide at a time when they are in severe shortage. These efforts highlight the indispensable role compounding plays in maintaining patient care during supply disruptions.

This is not an abuse of regulatory flexibility, it is intentional policy, a feature Congress explicitly built into the FDCA. When FDA-approved drugs are unavailable or unsuitable, compounders are permitted to step in — again, preparing drugs based on the order of a prescriber for a particular patient. This capacity is essential to health system resilience.

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VII. Prescribers' Medical Judgment Must Be Protected

Prescribers have the right and responsibility to determine the best treatment for their patients. That includes choosing compounded medications when they offer a clinically significant difference. FDA guidance explicitly respects prescriber judgment in such situations, even when the commercial version is not in shortage.

Health professional boards should resist pressure to limit or second-guess prescriber decisions based on misleading narratives. Forwarding or endorsing industry-sponsored letters without legal review may create confusion or chill lawful prescribing.

VIII. Conclusion and Request

We urge the Alaska State Medical Board to:

- Refrain from disseminating manufacturer-originated materials without independent validation.
- Affirm the legality and regulatory rigor of compounded medications under federal and state law.
- Support the authority of licensed prescribers to determine when compounding is medically appropriate.
- Encourage balanced, fact-based education on compounding among licensees.

We appreciate your leadership in protecting patient access and supporting sound clinical judgment. APC stands ready to provide further information, technical expertise, or educational resources at your request.

Sincerely,

Scott Brunner, CAE
Chief Executive Officer
scott@a4pc.org

Quarterly FSMB Update on USMLE®
June 2025, Vol. 6, No. 2

USMLE Volunteer Spotlight

Lois Krahn, M.D.
Arizona Medical Board
& USMLE Composite Committee

Brief Bio

I am delighted to serve on the USMLE Composite Committee that builds on my previous experience of being a member of the USMLE Management Committee. I am originally from Winnipeg in Manitoba, Canada and came to the US to attend college at Bryn Mawr College, followed by medical school at the Mayo Clinic Alix School of Medicine and graduate education at Georgetown University School of Medicine and the Mayo Clinic Graduate School of Medicine. My clinical interests have been most recently focused on sleep medicine, particularly for people with narcolepsy, idiopathic hypersomnia and similar conditions. My background is that I have served on the Arizona Medical Board for 11 years, a role that opened doors for me with the USMLE. My roles at Mayo Clinic have included teaching undergraduate and graduate medical education, giving me additional insight into the importance of the USMLE for newly graduated medical students and international medical graduates seeking licensure to independently practice medicine. In July 2025 after 31 years on staff I will retire from my role as Professor of Psychiatry to transition to emeritus status at the Mayo Clinic.

Reflection

My involvement with the USMLE has been particularly influential in my work as a member of the Arizona Medical Board as we seek to ensure that physicians have the needed knowledge and skills to serve the community. Like many US states, Arizona attracts physicians who have completed their medical studies at many different schools from the US and around the world. The USMLE program provides an invaluable common pathway to demonstrate the expected expertise required for the practice of medicine. Arizonans benefit from a group of doctors who hail from across the country and the world, but they first must have confidence that each licensed physician has the needed qualifications. The USMLE satisfies this critical part of the application for a medical license.

Value of the USMLE as a Member of a State Board

As a result of the many discussions and deliberations on USMLE committees, I have developed much more insight into the core requirements of a medical licensure application. I had familiarity with the USMLE program, but with active participation with several different committees of the USMLE I gained a deeper understanding into the overarching goals of the USMLE program and how it adapts over time. I have enjoyed developing relationships with the truly impressive staff of the USMLE who are deeply committed to use their impressive collective expertise to make the USMLE the premier medical licensure program in the world.

The USMLE program is grateful to Dr. Krahn for her service to the USMLE on behalf of the medical licensing board community. She is currently a member of the USMLE Composite Committee and has previously served on a USMLE Step 1 Standard Setting Panel; USMLE Step 3 Form Review; and the USMLE Management Committee.

USMLE Orientation for State Board Members and Staff

FSMB will host the 19th annual USMLE Orientation for State Board Members and Staff on **October 2, 2025,** at FSMB's offices in Euless, Texas.

The orientation, first held in 2007, provides members and staff from state medical and osteopathic boards with an opportunity to learn about the USMLE program and engage directly with program staff. The goals of the workshop remain: (1) to inform and educate the medical board/regulatory community on the USMLE program, including new developments and key issues; (2) to create and facilitate relationships with USMLE program staff to ensure that state boards have an immediate resource for any USMLE-related questions; and (3) to share opportunities for state board members and staff to participate directly with the USMLE program. To date, 229 individuals from 61 boards have participated in an orientation. Sixty-six participants (representing 35 boards) have served subsequently with the USMLE program on standard setting panels and advisory panels, the USMLE Management Committee, the USMLE Composite Committee, and/or item writing and item review committees.

Board members and staff interested in participating in this year's Orientation should contact Frances Cain, Director of Assessment Services at FSMB.

USMLE and NBME Parts Transcripts

FSMB now processes official transcripts for all NBME Parts examinees. This includes both physicians with only NBME Parts exam history and physicians with a combination of NBME Parts and USMLE history. The NBME Parts transcripts will be posted to the FSMB board portal, as is standard protocol for USMLE transcripts.

As previously communicated, as of August 2024 FSMB processes all official USMLE transcripts for all examinees. FSMB also processes transcripts for the FLEX and SPEX examinations.

We ask the state medical boards to reference FSMB's website as the source for obtaining USMLE, NBME Parts, FLEX and SPEX transcripts as part of their licensing application materials.

If you have any questions about USMLE or NBME Parts transcripts, please contact Frances Cain, Director of Assessment Services at FSMB, or Debbie Cusson, Manager of Assessment Services at FSMB.

Change to Step 2 CK Passing Standard Begins July 1, 2025

At its June 2025 meeting, the USMLE Management Committee conducted a review of the USMLE Step 2 CK passing standard. Management Committee members include individuals with experience on **state medical boards**, medical school and residency program faculty from across the U.S., practicing physicians, residents, and public members. The Committee decided that a four-point increase in the passing standard – used to determine a Pass or Fail outcome – will apply to Step 2 CK examinees testing on or after July 1, 2025. On the three-digit score scale, the passing standard will change from 214 to 218.

As part of the USMLE program's operational procedures and in alignment with best practices for licensing and certification exams, a scheduled comprehensive review and analysis of the passing standard for each Step exam typically occurs every three to four years. This ensures that the passing standard reflects current expectations concerning knowledge and skills needed to support effective medical practice and patient care.

The Management Committee determined this adjustment to the passing standard through the careful and thorough consideration of information from multiple sources, including:

- Recommendations from independent groups of physicians and educators unaffiliated with the USMLE who participated in content-based standard-setting panels in March and April 2025;
- Results of surveys of various groups (e.g., residency program directors, medical school faculty, **state licensing representatives**, examinees) concerning the appropriateness of the current passing standard for the Step 2 CK examination;
- Data on trends in examinee performance; and
- Score precision and its effect on the pass/fail outcome.

FSMB, on behalf of the USMLE program, would like to express our gratitude to the state medical board staff and members who participated in the Step 2 CK standard setting surveys and/or panels.

USMLE Examinee Newsletter

The USMLE program recently launched an electronic newsletter aimed at providing USMLE applicants and examinees with helpful information and key resources to help them along their journey to becoming a licensed physician. Updates about tools and services designed to help them track their progress and make the most of their study time are also provided.

Any interested individuals - not just USMLE applicants and examinees! - can sign up for the newsletter via the USMLE website.

Social Media

2025 USMLE Meetings

July: Committee for Individualized Review

August: Management Committee

September: Committee for Individualized Review
Composite Committee

Resources

USMLE.org
Bulletin of Information
FAQs

From: Habib, Elana L (DOH) <elana.habib@alaska.gov>
Sent: Thursday, July 17, 2025 4:19 PM
Subject: New Alaska-based MAT Guide Released: Clear, Evidence-Based Resource for Providers, Partners, and Communities

Please feel free to share the message below through any listservs you manage or with colleagues who may have an interest in this topic. Your help in spreading the word is greatly appreciated.

New Alaska-based MAT Guide Released: Clear, Evidence-Based Resource for Providers, Partners, and Communities
***Download this digital-only resource*:**
https://health.alaska.gov/media/jkmlmjlq/mat_guide.pdf

Medication for Addiction Treatment (MAT) is a foundation of evidence-based addiction treatment and the first-line treatment for opioid use disorder; significantly improving treatment retention, decreasing the risk of overdose and overdose death. MAT access can help close treatment gaps, which significantly impact Alaska's rural communities.

To enhance MAT across Alaska, a new *Medications for Addiction Treatment (MAT) Guide, 3rd Edition* is now available. The guide is designed to serve a broad professional audience including prescribers, care coordinators, social workers, peer support staff, and program administrators. It's also an accessible tool for patient education and community outreach.

The guide provides information on:

- **Clinical overviews of MAT options including mechanisms, access pathways, and considerations**
- **Screening, assessing, and referring individuals for MAT**
- **Best practices for integrating MAT into primary care practices**
- **Common myths and messaging guidance for patient and family communication**
- **Provider-specific FAQs and links to additional training opportunities**

A huge thank you to everyone who played a role in shaping the MAT Guide into such a valuable resource.

If you, your loved one, or your patient needs assistance with finding substance use disorder treatment, go to Findtreatment.gov.

Did you know that MAT and naloxone together can significantly reduce the risk of overdose and save lives? Make sure you're prepared—contact Project HOPE or visit iknowmine.org to get

naloxone and learn more. You can also email doh.projecthope.info@alaska.gov for assistance.

Explore, Expand, Engage: Upcoming MAT Learning Opportunities

Peaks to Coast: United Opioid & Polysubstance Response Summit

September 4–5, 2025 | Virtual

Learn more

Alaska MAT Conference 2025

October 21–23, 2025 | Anchorage, AK

Learn more

Project ECHO: Alaska MAT Series

August and September 2025 | Free virtual learning collaborative

Learn more

Funding Support: The MAT Guide, 3rd Edition, was made possible by Opioid Response Network and Grant Number 6H79TI085749-02M004 from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The contents are those of the author(s) and do not necessarily represent the official views of, nor does it imply endorsement by, SAMHSA, HHS, or the U.S. Government.

Best,

Elana Habib, MPH
State Opioid Treatment Authority (HPM III)
Alaska SUD Treatment Coordinator
Alaska Division of Behavioral Health
P: 907.269.3619|C: 907.720.3504
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Web: https://health.alaska.gov/dbh

From: State of Reform <info@stateofreform.com>
Sent: Monday, June 30, 2025 7:53 AM
To: Board, Medical (CED sponsored) <medicalboard@alaska.gov>
Subject: Just Announced: Agenda for the Alaska State of Reform Health Policy Conference

Join Us in Anchorage on September 11th for the Alaska State of Reform Health Policy Conference

Hi --

Join us for the **Alaska State of Reform Health Policy Conference** on September 11, 2025. This event brings together policymakers, healthcare leaders, and innovators to discuss and shape the future of health policy in the region.

Agenda highlights:

- Opening Plenary: Navigating the Changing Federal Landscape & What it Means for Alaska
- The State of Behavioral Health in Alaska
- AI in Alaska: Harnessing Artificial Intelligence to Transform Healthcare Delivery
- Strengthening Tribal Health in Alaska

View this year's schedule below:

7:30-8:30	Registration/Networking Breakfast		
8:30-9:15	Opening Plenary: Navigating the Changing Federal Landscape & What it Means for Alaska		
9:30-10:30	Advancing Broadband Infrastructure to Transform Healthcare in Alaska	The State of Behavioral Health in Alaska: Challenges, Gaps, & Pathways Forward	Navigating Pharmacy Pol Biosimilars, & High-Cost Dru Alaska's Evolving Healthc Landscape
10:45-11:45	AI in Alaska: Harnessing Artificial Intelligence to Transform Healthcare Delivery in the Last Frontier	Improving Primary Care & Value-Based Contracting in Alaska's Healthcare System	Housing Is Healthcare: Addr Homelessness Through Ala Health System
11:45-12:45	Networking Lunch		
1:00-2:00	Caring for Alaska's Elders: Improving Health Access & Medicare Policy for an Aging Population	Advancing Care for High-Needs Alaskans Through Collaboration & Innovation	Growing & Sustaining Alas Healthcare Workforce
2:15-3:15	Reforming Employer-Based & Self-Insured Health Insurance in Alaska	Strengthening Tribal Health in Alaska	
3:30-4:30	Closing Plenary: The Future of Alaska Medicaid		

Don't miss the opportunity to be part of the conversation. View our detailed agenda **here**. Stay tuned for more details on our session topics and evolving agenda in the coming weeks.

REGISTER NOW

We hope to see you in Anchorage. Please reach out to **info@stateofreform.com** if you have any input or questions. We have many exciting sponsorship opportunities

available at this year's conference. For more information, please feel free to email **sponsorship@stateofreform.com**. We would love to partner with you!

State of Reform

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From: J. Corey Feist, Co-Founder <corey@drbreenheroes.org>
Sent: Thursday, June 26, 2025 12:40 PM
To: Norberg, Natalie M (CED) <natalie.norberg@alaska.gov>
Subject: The Latest from the Dr. Lorna Breen Heroes' FoundationDear Natalie,

This month, we raised our voices for change—and the impact is undeniable.

Health workers and advocates took to Capitol Hill with FIGS, Noah Wyle, and the American Foundation for Suicide Prevention to push for the reauthorization and funding of the Dr. Lorna Breen Act and other laws designed to support health workers' wellbeing.

In Colorado, a major legislative victory is removing intrusive mental health questions from licensing applications. Meanwhile, University of Washington Medicine received its Wellbeing First Champion badge for revising its credentialing applications.

We amplified powerful stories from our ambassador community, brought fresh voices into the movement, and continued to grow a team committed to driving change.

Advocacy is working, culture is shifting, and your voice is helping lead the way.

With gratitude,

Corey Feist

CEO & Co-Founder of the Dr. Lorna Breen Heroes' Foundation

Health Workers and Advocates Raise Their Voices on Capitol Hill

Hundreds of health workers and advocates took to Capitol Hill in June to push for the reauthorization and funding of the Dr. Lorna Breen Health Care Provider Protection Act, including our partners at FIGS, The Pitt actor Noah Wyle, volunteers at the American Foundation for Suicide Prevention, and more!

Advocates conveyed to legislators that protecting our healthcare workforce's mental health requires reducing administrative burden, expanding access to mental health care, and helping clinicians feel safer in seeking help.

As Noah stated in USA Today, *"Without a supported, protected, and fairly treated workforce, there is no patient care."* Watch his interview in ABC News to learn more about his advocacy with FIGS.

We are honored to stand alongside our partners and so many of you in this growing call to action. **Join us—ask your representatives to reauthorize the Lorna Breen Act:**

Email Your Legislators

From: Osteopathic Medical Board of California Active Email List <OMBC-ACTIVE@SUBSCRIBE.DCALISTS.CA.GOV> On Behalf Of Osteopathic Medical Board of California
Sent: Sunday, June 15, 2025 11:27 PM
To: OMBC-ACTIVE@SUBSCRIBE.DCALISTS.CA.GOV
Subject: Osteopathic Medical Board of California - Rite Aid Closure

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

OMBC
EST. 1922
Osteopathic Medical Board of California

As you may be aware, Rite Aid filed for bankruptcy in October 2023, resulting in the closure of several locations nationwide. On May 5, 2025, Rite Aid filed for bankruptcy again and is in the process of selling assets, including prescriptions, to other pharmacies. In light of the ongoing Rite Aid bankruptcy proceedings and the resulting closures of numerous pharmacy locations across California, the Department of Consumer Affairs, the California State Board of Pharmacy, the Medical Board of California and the Osteopathic Medical Board of California urge all healthcare prescribers to work collaboratively with pharmacists to ensure uninterrupted access to necessary medications for patients.

These closures have the potential to significantly affect timely access to prescriptions in many communities, increasing the need for clear, timely, and cooperative communication between prescribers and pharmacists. We encourage prescribers to be responsive to pharmacists' outreach when validating or authorizing prescription refills. This cooperation is critical to facilitating safe transfers and the timely

dispensing of medications for patients who may be transitioning to new pharmacy providers.

Pharmacists are working diligently to minimize the impact of these disruptions and ensure patient care is not compromised. Your support, through prompt confirmation of prescription details and professional collaboration, is essential in maintaining continuity of care for Californians affected by these closures. Such confirmation can be provided by sending a new electronic prescription to a new pharmacy of the patient's choice if the prescriber or authorized agent is unavailable to speak directly with a pharmacist. Further, it is strongly recommended that prescribers work with their patients to identify a new pharmacy where electronic medical records indicate that a Rite Aid pharmacy is the current pharmacy on record.

We thank you for your patience during this transition period and note that the California State Board of Pharmacy is seeking changes in Pharmacy Law to remove prescriptive requirements that will mitigate future impacts on patients and prescribers alike.

We remain committed to California patients and thank you for your assistance with helping patients navigate this transition in pharmacy services.

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GOVERNOR MIKE DUNLEAVY

Department of Commerce, Community, and Economic Development

DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING
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Medical Spa Services Frequently Asked Questions
DRAFT 7-11-25

This document is intended to assist in interpretation of Alaska statutes and regulations regarding various medical spa services. This draft will be reviewed from time to time by the Medical Spa Services Work Group, then circulated to relevant professional licensing boards for final approval prior to publication. This work draft should not be relied upon as a final interpretation or alternative to the law. Certain regulations are included below; always review the entirety of statutes and regulations of the appropriate programs and seek attorney assistance when needed. Last Medical Spa Services Work Group review: June 11, 2025

MEDICAL DIRECTOR AND CLINIC OVERSIGHT

- **What is a medical spa?**
  A "medical spa" is not a term specifically recognized in Alaska law, though the services rendered and personnel performing them may be regulated by one or more professional licensing boards. For the purpose of this FAQ, a "medical spa" is a popular term of art describing a clinic where medical procedures and services may be delivered, albeit in a more casual or consumer-focused setting than a traditional clinic and potentially alongside nonmedical services. Medical spas themselves are not specifically regulated as a unique *entity* by the state, though licensees advertising or performing medical or esthetics services and procedures are. A medical facility regulated by the Department of Health that offers medical spa services may have additional requirements than those outlined in this FAQ.

  The term "medical spa services" is also not specifically defined in Alaska law. For the purpose of this analysis, examples of medical spa services include, but are not limited to, all aspects of oversight, diagnosis, prescription, administration, and follow-up care for elective cosmetic and wellness-related medical activities if performed outside a traditional medical setting. Some of the services reviewed by the Medical Spa Services Work Group are discussed below.

- **Who may serve as the "medical director"?**
  "Medical director" is not a term specifically found in Alaska law. Within this context, a medical director is considered anyone who has the legal authority to supervise or delegate medical or nursing activities: A physician or physician assistant licensed by the Alaska State Medical Board or an advanced practice registered nurse licensed by the Alaska Board of Nursing and operating within a population focus with a lifespan scope. An APRN may not practice outside of their designated population focus.

  A person serving as the medical director of a spa or clinic providing services requiring professional licensure takes on the responsibility of ensuring delegation is appropriate under state law and within their own scope of practice, including ensuring the appropriateness of any licensing, training, and education of persons to whom they are delegating.

  A registered nurse, licensed practical nurse, chiropractor, dentist, physical therapist, massage therapist, EMT, paramedic, or other licensed health care provider may not evaluate, diagnose, determine, or

delegate treatment for a patient in a general medical spa or IV hydration clinic setting. Refer to the individual scopes of practice for these licenses and certifications.

- **What services may a physician or physician assistant delegate, and what are those requirements?** 12 AAC 40.967(32) prohibits a Medical Board licensee from permitting patient care that includes administering a botulinum toxin or dermal filler, autotransplanting biological materials, or treating with chemical peels below the dermal layer, or hot lasers, by a person who is not an appropriate health care provider trained and licensed under AS 08 to perform the treatment.

  Otherwise, if a licensee with the ability to delegate determines the procedure can be delegated and the licensee and the person to whom they are delegating meet the qualifications--both of which as determined within reason by the licensee under statute or regulation--then the delegation is permissible.

  What procedures are *permissible and not permissible* to be delegated are spelled out at 12 AAC 40.920(e) and (f):

  (e) Routine medical duties that may be delegated to another person under the standards set out in this section means duties that

  (1) occur frequently in the daily care of a patient or group of patients;
  (2) do not require the person to whom the duty is delegated to exercise professional medical knowledge or judgment;
  (3) do not require the exercise of complex medical skills;
  (4) have a standard procedure and predictable results; and
  (5) present minimal potential risk to the patient.

  (f) Duties that require the exercise of professional medical knowledge or judgment or complex medical skills may not be delegated. Duties that may not be delegated include

  (1) the assessment of the patient's medical condition, and referral and follow-up;
  (2) formulation of the plan of medical care and evaluation of the patient's response to the care provided;
  (3) counseling of the patient and the patient's family or significant others regarding the patient's health;
  (4) transmitting verbal prescription orders, without written documentation, from the patient's health care provider;
  (5) duties related to pain management and opioid use and addiction;
  (6) the initiation, administration, and monitoring of intravenous therapy, including blood or blood products;
  (7) the initiation administration, and monitoring of procedural sedation;
  (8) assessing sterile wound or decubitus ulcer care;
  (9) managing and monitoring home dialysis therapy;
  (10) oral tracheal suction;
  (11) medication management for unstable medical conditions requiring ongoing assessment and adjustment of dosage or timing of administration;
  (12) placement and administration of nasogastric tubes and fluids;
  (13) initial assessment and management of newly-placed gastrostomy tubes and the patient's nutrition; and
  (14) the administration of injectable medications, unless

  (A) it is a single intramuscular, intradermal, or subcutaneous injection, not otherwise prohibited under 12 AAC 40.967(33); and
  (B) all other provisions of this section are met; and
  (C) the delegating physician, podiatrist, osteopath, or physician assistant is immediately available on site.

  The circumstances under which delegable procedures may be delegated, how the unlicensed practice must be supervised, and how a medical director makes those assessments are substantially addressed for medicine at 12 AAC 40.920(a) – (d):

DRAFT

(a) A physician, podiatrist, osteopath, or physician assistant licensed under AS 08.64 may delegate the performance of routine medical duties to an agent of the physician, podiatrist, osteopath, or physician assistant, if the following conditions are met:

(1) the duty to be delegated must be within the scope of practice of the delegating physician, podiatrist, osteopath, or physician assistant;
(2) a licensed physician, podiatrist, osteopath, or physician assistant must assess the patient's medical condition and needs to determine if a duty for that patient may be safely delegated;
(3) the patient's medical condition must be stable and predictable;
(4) the person to whom the duty is to be delegated has received the training needed to safely perform the delegated duty, and this training has been documented;
(5) the delegating physician, podiatrist, osteopath, or physician assistant determines that the person to whom a duty is to be delegated is competent to perform the delegated duty correctly and safely and accepts the delegation of the duty and the accountability for carrying out the duty correctly;
(6) performance of the delegated duty would not require the person to whom it is delegated to exercise professional medical judgment or have knowledge of complex medical skills;
(7) the delegating physician, podiatrist, osteopath, or physician assistant provides to the person, with a copy maintained on record, written instructions that include

(A) a clear description of the procedure to follow to perform each task in the delegated duty;
(B) the predicted outcomes of the delegated task;
(C) procedures for observing, reporting, and responding to side effects, complications, or unexpected outcomes in the patient; and
(D) the procedure to document the performance of the duty in the patient's record.

(b) A physician, podiatrist, osteopath, or physician assistant who has delegated a routine duty to another person shall provide appropriate direction and supervision of the person, including the evaluation of patient outcomes. Another physician, podiatrist, osteopath, or physician assistant may assume delegating responsibilities from the delegating physician, podiatrist, osteopath, or physician assistant if the substitute physician, podiatrist, osteopath, or physician assistant has assessed the patient, the skills of the person to whom the delegation was made, and the plan of care. Either the original or substitute delegating physician, podiatrist, osteopath, or physician assistant shall remain readily available for consultation by the person to whom the duty is delegated, either in person or by telecommunication.
(c) The delegation of a routine duty to another person under this section is specific to that person and for that patient, and does not authorize any other person to perform the delegated duty.
(d) The physician, podiatrist, osteopath, or physician assistant who delegated the routine duty to another person remains responsible for the quality of the medical care provided to the patient.

In every consideration of delegation, the delegating physician or physician assistant must decide what constitutes appropriate professional judgment as it pertains to their interpretation of these cited regulations. The AMA Code of Ethics adopted by reference by the Medical Board at 12 AAC 40.955 provides useful guidance as to what appropriate professional judgment looks like in a medical director who is licensed under AS 08.64.

- **What services may an advanced practice registered nurse delegate, and what are those requirements?**

If a licensee with the ability to delegate determines the procedure can be delegated and the licensee and the person to whom they are delegating meet the qualifications--both of which as determined within reason by the licensee under statute or regulation--then the delegation is permissible.

The board has formally adopted a regulation regarding scope of practice that generally refers to activities allowable by an APRN, in addition to other requirements pertaining to licensure in the APRN's population focus, prescriptive authority, etc.:

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12 AAC 44.430. SCOPE OF PRACTICE. The board recognizes advanced and specialized acts of nursing practice as those described in the scope of practice statements published by national professional nursing associations recognized by the board for advanced practice registered nurses certified by the national certification bodies recognized by the board.

The procedures that are *permissible* to be delegated to unlicensed persons are fairly well spelled out in 12 AAC 44.955, .960, .965, .966, .970, .975.

The circumstances under which delegable procedures may be delegated, how the unlicensed practice must be supervised, and how an APRN makes those assessments are substantially addressed for nursing at 12 AAC 44.950 and .975.

12 AAC 44.950. Standards for delegation of nursing duties to other persons

(a) A nurse licensed under AS 08.68 may delegate the performance of nursing duties to other persons, including unlicensed assistive personnel, if the following conditions are met:

(1) the nursing duty to be delegated must be within the scope of practice of the delegating nurse;

(2) a registered nurse must assess the patient's medical condition and needs to determine if a nursing duty for that patient may be safely delegated to another person;

(3) the patient's medical condition must be stable and predictable;

(4) the person to whom the nursing duty is to be delegated has received the training needed to safely perform the delegated duty, and this training has been documented;

(5) the nurse determines that the person to whom a nursing duty is to be delegated is competent to perform the delegated duty correctly and safely and accepts the delegation of the duty and the accountability for carrying out the duty correctly;

(6) performance of the delegated nursing duty would not require the person to whom it was delegated to exercise professional nursing judgment or knowledge or complex nursing skills;

(7) the nurse provides to the person, with a copy maintained on record, written instructions that include

(A) a clear description of the procedure to follow to perform each task in the delegated duty;

(B) the predicted outcomes of the delegated nursing task;

(C) how the person is to observe and report side effects, complications, or unexpected outcomes in the patient, and the actions appropriate to respond to any of these; and

(D) the procedure to document the performance of the nursing duty in the patient's record.

(b) A nurse who has delegated a nursing duty to another person shall provide appropriate direction and supervision of the person, including the evaluation of patient outcomes. Another nurse may assume delegating responsibilities from the delegating nurse if the substitute nurse has assessed the patient, the skills of the person to whom the delegation was made, and the plan of care. Either the original delegating nurse or the substitute nurse shall remain readily available for consultation by the person, either in person or by telecommunication.

(c) The delegation of a nursing duty to another person under this section is specific to that person and for that patient, and does not authorize any other person to perform the delegated duty.

(d) The nurse who delegated the nursing duty to another person remains responsible for the quality of the nursing care provided to the patient.

12 AAC 44.955 Delegation of routine nursing duties

(a) Routine nursing duties may be delegated to another person under the standards set out in 12 AAC 44.950. Routine nursing duties are those that

(1) occur frequently in the daily care of a patient or group of patients;

(2) do not require the person to whom the duty is delegated to exercise professional nursing knowledge or judgment;

(3) do not require the exercise of complex nursing skills;

(4) have a standard procedure and predictable results; and

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(5) present minimal potential risk to the patient.

(b) Routine nursing duties that may be delegated include

(1) monitoring bodily functions;

(2) taking and recording vital signs;

(3) transporting patients;

(4) non-invasive collection and testing of physical specimens;

(5) measuring and recording fluid and food intake and output; and

(6) personal care tasks such as bathing, oral hygiene, dressing, toileting, assisting with eating, hydrating, and skin care.

12 AAC 44.960 Delegation of specialized nursing duties

(a) Specialized nursing duties are those duties that do not require professional nursing education to correctly perform, but require more training and skill than routine nursing duties. Specialized nursing duties may be delegated to another person under the standards set out in 12 AAC 44.950.

(b) Specialized nursing tasks that may be delegated include

(1) changing simple, nonsterile dressings using aseptic technique when no wound debridement or packing is involved;

(2) assisting patients with self-medication;

(3) obtaining blood glucose levels;

(4) suctioning of the oral pharynx;

(5) providing tracheostomy care in established, stable patients;

(6) removal of internal or external urinary catheters;

(7) adding fluid to established gastrostomy tube feedings and changing established tube feeding bags; and

(8) placing electrodes and leads for electrocardiogram, cardiac monitoring, and telemetry.

(c) A nurse who delegates a nursing duty to another person under this section shall develop a nursing delegation plan that describes the frequency and methods of evaluation of the performance of the delegated duty by the other person. The delegating nurse shall evaluate a continuing delegation as appropriate, but must perform an evaluation on-site at least once every 90 days after the delegation was made. The delegating nurse shall keep a record of the evaluations conducted.

12 AAC 44.970. Nursing duties that may not be delegated.

Nursing duties that require the exercise of professional nursing knowledge or judgment or complex nursing skills may not be delegated. Nursing duties that may not be delegated include

(1) the comprehensive assessment of the patient by a registered nurse, and referral and follow-up;

(2) the focused assessment of the patient by a licensed practical nurse;

(3) formulation of the plan of nursing care and evaluation of the patient's response to the care provided;

(4) health education and health counseling of the patient and the patient's family or significant others in promoting the patient's health;

(5) receiving or transmitting verbal, telephone, or written orders from the patient's health care provider;

(6) the initiation, administration, and monitoring of intravenous therapy, including blood or blood products;

(7) providing and assessing sterile wound or decubitus ulcer care;

(8) managing and monitoring home dialysis therapy;

(9) oral tracheal suction;

(10) medication management for unstable medical conditions requiring ongoing assessment and adjustment of dosage or timing of administration;

(11) placement and administration of nasogastric tubes and fluids;

(12) initial assessment and management of newly-placed gastrostomy tubes and the patient's nutrition;

(13) except as provided in 12 AAC 44.966, the administration of injectable medications.

12 AAC 44.975. Exclusions

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The provisions of 12 AAC 44.950 – 12 AAC 44.970 apply only to the delegation of nursing duties by a nurse licensed under AS 08.68; they do not apply when nursing duties have not been delegated, including when a person is acting
(1) within the scope of the person's own license;
(2) under other legal authority; or
(3) under the supervision of another licensed health care provider.

In every consideration of delegation, the delegating physician or physician assistant must decide what constitutes appropriate professional judgment as it pertains to their interpretation of these cited regulations. In addition to the statutes and regulations of the board, we can usually turn to the code of ethics adopted by the board in regulation as an additional standard. The Board of Nursing has not officially adopted a code of ethics in regulation; however, nurses informally lean on codes published by national nursing associations that generally echo the same principles.

Note that 12 AAC 44.770 spells out unprofessional conduct, including a list of examples. Nursing conduct that could adversely affect the health and welfare of the public constitutes unprofessional conduct under AS 08.68.270(7).

- **Does the medical director need to be onsite? When is telemedicine allowed?**
  The medical director must remain readily available for consultation by the person to whom the duty is delegated, either in person or by telecommunication. An initial consultation with a patient may happen via telecommunication. During medical procedures, a person with the appropriate level of licensure to perform the procedure and manage emergencies according to established facility protocols should always be onsite. Medical director should be immediately available (by phone or text) in case of complications.

- **Who can perform patient evaluations, diagnose conditions requiring treatment, and make treatment recommendations?**
  A physician, physician assistant, or advanced practice registered nurse may evaluate patients, perform diagnoses, and make recommendations for treatment. Registered nurses, licensed practical nurses, medical assistants, and other persons with appropriate training may be delegated certain functions relating to patient intake, such as performing an interview regarding symptoms and medical history and taking vital signs. This information helps inform the physician, physician assistant, or advanced practice registered nurse in performing their patient evaluation.

  Although medical spas may offer services that are not medically necessary, or they may consider themselves "wellness"—rather than medical—institutions, the medical cosmetic procedures and hydration services they provide fall under the delivery of medical or nursing services and are regulated by the State Medical Board and Board of Nursing.

- **Who can obtain, prescribe, administer, or dispense prescription medicines and products?**
  A licensee with prescriptive authority and who is practicing within their scope, such as a physician, physician assistant, or advanced practice registered nurse. Delegation requirements are spelled out in the statutes and regulations of each board. A dentist may do so within the practice of dentistry, which does not include most esthetics procedures.

  Standing orders are unique to each patient. They may not be generally given for a class or group of patients. Any changes to an individual's standing orders must include evaluation and written changes by the medical director or other provider in the practice who is an Alaska-licensed physician, physician assistant, or advanced practice registered nurse.

- **What are the requirements for medical recordkeeping, HIPAA, etc.?**

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Medical spas and hydration clinics must adhere to all recordkeeping standards relevant to the practitioner's license, state and federal laws, and other standards that may apply to their individual situations, such as insurance requirements. Each facility should have a written protocol for recordkeeping.

- **What is the legal risk for a medical director?**
  The risk is the same as it would be for any practitioner within any other medical practice. If a licensee delegates authority to another person, they also assume the risk associated with actions by that individual. If the medical director is also the owner of the facility, additional liabilities regarding the workplace or public access may apply.

  Any facility where medical services are provided should have written emergency protocols, both to address general crises and those specific to the potential risks of the procedures performed. Providers should be trained on monitoring patients for adverse outcomes and how to respond in case of an emergency. The medical director should always be available onsite or by telecommunication.

EMTs AND PARAMEDICS

The State EMS Medical Director and State EMS Medical Direction Committee are solely responsible for the scope of practice and medical direction for EMS and Paramedics in the state. The scope of practice for these individuals is limited to procedures authorized in regulation or by the EMS Medical Director.

The activities of these personnel are contemplated within the context of basic or advanced life support (ALS) and only under the supervision of a sponsoring physician. There is currently no authorization for certified EMS personnel or Paramedics to practice advanced procedures outside of ALS activities, such as performing procedures authorized within their certification while employed at a medical spa. Doing so can constitute a breach of the EMS regulations, placing an ALS EMS clinician at professional risk.

ESTHETICS

1. **What services may an Alaska-licensed esthetician provide under their own license?**
   A person providing esthetics services must be licensed as an esthetician by the Alaska Board of Barbers and Hairdressers or be licensed in Alaska as a health care professional. Certain limited exceptions may apply; please refer to AS 08.13.160(d). Holding a "license" or "certification" by the manufacturer of an esthetics device does not in itself authorize the individual to legally use that device on another person. With limited exception, estheticians must practice in a shop licensed by the board.

   Per AS 08.13.220, "esthetics" means the use of the hands, appliances, cosmetic preparations, antiseptics, or lotions in massaging, cleansing, stimulating, or similar work on the scalp, face or neck, including skin care, make-up, and temporary removal of superfluous hair, for cosmetic purposes for a fee.

   12 AAC 09.990(b) clarifies the definition of "appliances":

   > (1) "appliances" in the field of esthetics means only those devices used to stimulate natural physiological processes intended to improve the health and appearance of a person's skin; a device
   >
   > (A) operates within the manufacturer's guidelines;
   > (B) does not directly ablate or destroy live tissue;
   > (C) does not involve an incision into skin beyond the epidermis; and
   > (D) is not defined as a Class III or Class IV laser device under 21 C.F.R. 1040.10, revised as of April 2, 2018, and adopted by reference;

2. **What esthetics services may an Alaska-licensed hairdresser provide under their own license?**
   A person licensed by the Alaska Board of Barbers and Hairdressers to practice hairdressing is considered to be licensed to practice manicuring, hair braiding, and limited esthetics under the same license. Per AS 08.13.220, "limited esthetics" means to perform for a fee for cosmetic purposes temporary removal of superfluous hair on the face or neck, including eyebrow arching by use of wax; or application of makeup or false eyelashes. With limited exception, hairdressers must practice in a shop licensed by the board.

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3. **What are "advanced esthetics services" and who may provide them?**
The term "advanced esthetics services" is not defined under Alaska law. For the purposes of the Medical Spa Services Work Group and related boards, the term refers to any procedure or service that falls outside of the scope of an Alaska-licensed esthetician, above.

Licenses or certifications in other jurisdictions, by private companies, or by manufacturers of beauty or health care products do not qualify individuals to practice esthetics, nursing, or medicine in Alaska. Persons who do not hold an Alaska license and persons who are licensed and considering performing services outside of their scope should review whether the services or procedures—or the promotion of such services or procedures—qualifies as the practice of medicine under AS 08.64.380 or nursing under AS 08.68.850.

As noted above, the Medical Board has specifically opined that the treatment with chemical peels below the dermal layer or use of hot (ablative) lasers is the practice of medicine and can only be delegated by a physician to a health care provider appropriately trained and licensed to perform the procedure.

AS 08.64.380 (6) "practice of medicine" or "practice of osteopathy" means:

(A) for a fee, donation or other consideration, to diagnose, treat, operate on, prescribe for, or administer to, any human ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition; or to attempt to perform or represent that a person is authorized to perform any of the acts set out in this subparagraph;

(B) to use or publicly display a title in connection with a person's name including "doctor of medicine," "physician," "M.D.," or "doctor of osteopathic medicine" or "D.O." or a specialist designation including "surgeon," "dermatologist," or a similar title in such a manner as to show that the person is willing or qualified to diagnose or treat the sick or injured;

AS 08.68.850 (9) "practice of advanced practice registered nursing" includes, in addition to the practice of registered nursing, the performance of acts of medical diagnosis and the prescription and dispensing of medical, therapeutic, or corrective measures under regulations adopted by the board;

AS 08.68.850 (10) "practice of practical nursing" means the performance for compensation or personal profit of nursing functions that do not require the substantial specialized skill, judgment, and knowledge of a registered nurse;

AS 08.68.850 (11) "practice of registered nursing" means the performance for compensation or personal profit of acts of professional service that requires substantial specialized knowledge, judgment, and skill based on the principles of biological, physiological, behavioral, and sociological sciences in assessing and responding to the health needs of individuals, families, or communities through services that include

(A) assessment of problems, counseling, and teaching

(i) clients to maintain health or prevent illness; and

(ii) in the care of the ill, injured, or infirm;

(B) administration, supervision, delegation, and evaluation of nursing practice;

(C) teaching others the skills of nursing;

(D) execution of a medical regimen as prescribed by a person authorized by the state to practice medicine;

(E) performance of other acts that require education and training that are recognized by the nursing profession as properly performed by registered nurses;

(F) performance of acts of medical diagnosis and the prescription of medical therapeutic or corrective measures under regulations adopted by the board;

<u>IV HYDRATION</u>

1. **What are the general practice requirements for an IV hydration clinic?**
An IV hydration clinic in any form and in any location is considered a medical clinic and must follow all state and federal standards applicable to any other general health care facility.

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2. **Who may evaluate, diagnose, and determine treatment for a patient?**
   As noted above, a physician, physician assistant, or advanced practice registered nurse may evaluate patients, perform diagnoses, and make recommendations for treatment. A chiropractor, dentist, physical therapist, EMT, paramedic, or other licensed health care provider may not evaluate, diagnose, and determine treatment for a patient in a general medical spa setting. Refer to the individual scopes of practice for these licenses and certifications.

   Registered nurses, licensed practical nurses, medical assistants, and other unlicensed persons with appropriate training may be delegated certain functions relating to patient intake, such as performing an interview regarding symptoms and medical history and taking vital signs. This information helps inform the physician, physician assistant, or advanced practice registered nurse who will personally assess the patient's condition and determine a treatment plan. This assessment may be performed in person or through telecommunication but may not be delegated.

   Although medical spas may offer services that are not medically necessary or consider themselves "wellness"—rather than medical—institutions, the medical cosmetic procedures and hydration services they provide fall under the delivery of medical or nursing services and are regulated by the State Medical Board and Board of Nursing.

3. **Who may order, and administer substances delivered intravenously?**
   Substances administered intravenously, including but not limited to saline and vitamins, require a prescription under federal law. A physician, physician assistant, or advanced practice registered nurse may order prescription medications if authorized under their Alaska license. A dentist may only order and administer prescription substances for use within the practice of dentistry. A chiropractor, physical therapist, massage therapist, or other licensed or certified health care provider without prescriptive authority may not order or administer prescription medication. Refer to the statutes and regulations for each license type for details about each scope of practice.

   12 AAC 40.920(f) and (g) prevents a physician or physician assistant from delegating the initiation, administration, and monitoring of intravenous therapy, including blood or blood products. A person with the authority to perform these procedures under the scope of their own license is not restricted from doing so as long as these duties have not been delegated.

   A medical director may delegate placing and starting an IV to a registered nurse or licensed practical nurse with an appropriate course of training on administering intravenous medication.

4. **What are the compounding requirements for IV hydration clinics?**
   USP <797> governs sterile compounding within the United States. Conditions for sterile compounding are outlined in this federal guidance, including standards for sterile "immediate use" (mixing and using within four hours) and use of a clean room if prepared outside of the immediate use window.

   A registered nurse may add an appropriate substance to an IV bag per the medical director order for a specific patient, following USP standards.

BOTOX, FILLERS, and OTHER COSMETIC INJECTABLES

1. **Who may evaluate, diagnose, and determine treatment for a patient?**
   As noted above, a physician, physician assistant, or advanced practice registered nurse may evaluate patients, perform diagnoses, and make recommendations for treatment. A chiropractor, dentist, physical therapist, EMT, paramedic, or other licensed health care provider may not evaluate, diagnose, and determine treatment for a patient in a general medical spa setting. Refer to the individual scopes of practice for these licenses and certifications.

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Registered nurses, licensed practical nurses, medical assistants, and other unlicensed persons with appropriate training may be delegated certain functions relating to patient intake, such as performing an interview regarding symptoms and medical history and taking vital signs. This information helps inform the physician, physician assistant, or advanced practice registered nurse who will personally assess the patient's condition and determine a treatment plan. This assessment may be performed in person or through telecommunication but may not be delegated.

2. Who may order and administer cosmetic injectables?

A physician, physician assistant, or advanced practice registered nurse may order prescription medications if authorized under their Alaska license. A dentists may order and administer Botox within the scope of practice of dentistry, such as to treat symptoms of TMJ. A dental hygienist is not allowed to administer Botox, fillers, or other cosmetic injectables.

12 AAC 40.967(32) prohibits a Medical Board licensee from permitting patient care that includes administering a botulinum toxin or dermal filler by a person who is not an appropriate health care provider trained and licensed under AS 08 to perform the treatment.

The Board of Nursing has issued an advisory opinion on cosmetic injectables;
https://www.commerce.alaska.gov/web/Portals/5/pub/NUR_AO_Medical_Aesthetic_2024.pdf

An esthetician, chiropractor, physical therapist, massage therapist, or other licensed or certified health care provider without prescriptive authority may not order prescription medication. They may not administer prescription medication without proper delegation. Refer to the statutes and regulations for each license type for details about each scope of practice.

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Medical Spa Services Work Group

Alaska Division of Corporations, Business and Professional Licensing
Minutes for Wednesday, June 11, 2025, at 4:00 PM AKDT
Held via Teams videoconfererence

Work group members present: April Erickson, Board of Nursing; Ramsey Bell for Ashley Schaber, Board of Pharmacy; Shannon Thompson, Board of Barbers and Hairdressers; John Lloyd, Board of Chiropractic Examiners; David Paulson, State Medical Board

Work group members excused: Kenley Michaud, Board of Dental Examiners

Staff present: Sara Chambers, facilitator; Sylvan Robb, Reid Bowman, Natalie Norberg, Patty Wolf
Members of affiliated boards present: Kevin McKinley and Mae Canady, Board of Barbers and Hairdressers
Public: Approximately half a dozen members of the public were present.

CALL TO ORDER
As facilitator, Ms. Chambers called the Work Group to order at 4:00 p.m. by calling the roll. She noted that a quorum was present and welcomed staff and members of the public who were present. She mentioned that Dr. Michaud could not attend the meeting due to a work commitment, which he had shared with the group when the meeting was scheduled.

She clarified the purpose of the Work Group:

- Identify “lifestyle enhancement” services that have a medical nexus and are currently performed or likely to be performed outside of a medical clinic or without appropriate supervision.
- Identify existing statutes and regulations that govern current requirements for training, licensure, and supervision of these procedures.
- Clarify how licensing boards could—jointly or in part—explain existing statutes and regulations that would help the public and licensees understand how these procedures should be safely administered according to the current laws of the state.
- Suggest changes in statute that would allow defensible and transparent pathways forward for appropriately trained and supervised individuals to provide these services without imposing undue economic or regulatory barriers.
- Carry forward Work Group updates and work products to the member boards for their subsequent review and action.

AGENDA OVERVIEW
Ms. Chambers outlined the meeting agenda, which included a review of an FAQ summarizing the group's work and a discussion on Botox, fillers, and cosmetic injectables. She emphasized the importance of staying on task and invited public comments.

REVIEW CORRESPONDENCE and PUBLIC COMMENT
No public comment or correspondence was received for review.

BOTOX AND COSMETIC INJECTABLES DISCUSSION
Ms. Chambers led a discussion on Botox, fillers, and cosmetic injectables, focusing on who can evaluate, diagnose, and administer these treatments. The group agreed that physicians, physician assistants, and APRNs are qualified to perform these tasks. Dr. Paulson raised a question about dentists' ability to use Botox for cosmetic procedures. Ms. Chambers clarified that the Board of Dental Examiners had explored this topic within the last year and determined dentists, but not dental hygienists, can use Botox within the scope of dentistry, such as for TMJ treatment, but not for general cosmetic purposes. Dr. Erickson supported this clarification.

Delegation and Certification: The group discussed the delegation of tasks to medical assistants and the certification requirements for administering injectables. Ms. Wolf provided information on a specific regulation (12 AAC 44.966) that allows APRNs to delegate injectable medication administration to certified medical assistants. However, upon discussion, it did not seem that the restriction to an "ambulatory care" setting was relevant to medical spas. There was also a question about whether this would be relevant to Botox placement since that is a different procedure than a typical injectable medication. Dr. Erickson will take this topic back to the Board of Nursing to see if additional definition or clarification would be helpful.

Dr. Paulson was interested in exploring licensure of medical assistants beyond the private certification currently addressed in Board of Nursing regulations. Ms. Chambers recounted the proposed legislation attempting to license medical assistants in or around 2018, which was defeated by the medical industry. Dr. Erickson mentioned that medical assistant training was a topic the Board of Nursing was already discussing.

DRAFT MEDICAL SPA SERVICES FREQUENTLY ASKED QUESTIONS REVIEW

The group walked through most of the areas of the draft FAQ Ms. Chambers had provided, stating that for the most part, they thought it was well-written and was ready for further review by each board.

Medical Director and Clinic Oversight: Ms. Chambers explained the roles and responsibilities of a medical director, emphasizing that they must have the legal authority to supervise or delegate medical or nursing activities. She clarified that "medical spa" and "medical director" are not legally defined in the state. The group discussed the qualifications and scope of practice for medical directors, with concerns raised by Dr. Paulson and Dr. Erickson regarding whether a physician assistant could serve as a medical director since they cannot practice independently. Ms. Chambers said she would note that concern for the Medical Board to discuss, particularly whether that service could be included in the collaborative agreement and, if so, what the legal impact would be to the supervising physician.

Chiropractic Scope of Practice: Dr. Lloyd raised concerns about the inclusion of laser and tattoo removal services in the FAQ, arguing that these services fall within the scope of chiropractic practice. The group discussed who would be "an appropriate health care provider trained and licensed under AS 08 to perform the treatment" per the Medical Board's regulation 12 AAC 40.967(32). There was also discussion about whether chiropractic statutes and regulations permitted or prohibited these practices. They agreed to seek clarification from the Medical Board on this issue. Dr. Lloyd also asked how other practices that are not specifically called out in statute or regulation are regulated, such as acoustical soundwave therapy for treatment of erectile dysfunction. He said he did not agree that use of lasers is restricted to those who hold a medical license; it is part of the practice of chiropractic since it addresses whole body wellness. Ms. Chambers said she would request clarification on that and reiterated that the current goal of this work group is to clarify what the existing statutes and regulations say about common medical spa practices; proposed changes to current statutes and regulations can be addressed in the near future.

EMS Professionals and Work in Medical Spas

Ms. Chambers mentioned that she worked with the State EMS Medical Director to clarify that EMS professionals and paramedics may not work within a medical spa setting. It is not covered within their license and puts their certification at risk.

Future Meetings

Ms. Chambers encouraged work group members to provide feedback and announced plans to schedule a follow-up meeting in mid-July, pending feedback from the Department of Law on the questions raised at this meeting. The goal would be to perfect a draft for each board to review at their upcoming August meetings.

ADJOURN

Having no further business to come before it, the work group adjourned the meeting at approximately 5:00 p.m.

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Commerce, Community, and Economic Development

STATE MEDICAL BOARD

P.O. Box 110806
Juneau, Alaska 99811-0806
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Fax: 907.465.2974

August 22, 2025

Dear colleagues with the Board of Chiropractic Examiners,

During the June 11, 2025, Medical Spa Services Workgroup meeting, Dr. Lloyd advised that chiropractors are providing laser tattoo removal services in Alaska as part of an array of "wellness" services now being offered by some chiropractors.

The State Medical Board would like to reiterate that the use of lasers to treat or operate on any human physical condition is considered the practice of medicine as defined by Alaska state law (08.64.380(6)(A)). The practice of medicine is limited to practitioners who hold a medical license under the State Medical Board or to an Advanced Practice Nurse Practitioner. Unless appropriately delegated by one of these practitioners, a chiropractor providing laser tattoo removal services is practicing outside their scope of practice as defined by Alaska Statute 08.20.900(3).

The unlicensed practice of medicine is considered a class A misdemeanor and is a punishable offense (AS 08.64.360). Such cases come before the State Medical Board for review. The State Medical Board respectfully requests that you notify your licensees that their independent use of lasers outside of a legal delegation to treat any condition is unlawful.

The State Medical Board understands that there may be concerns and confusion regarding this matter and would welcome a discussion about this issue with representatives from the Board of Chiropractic Examiners at a future board meeting. Please reach out to our Executive Administrator, Natalie Norberg, at natalie.norberg@alaska.gov if you would like to schedule time on an upcoming meeting agenda to discuss further.

Sincerely,

David Paulson, M.D.
Member on behalf of the State Medical Board

cc. Sylvan Robb, Division Director
Sara Chambers, Boards and Regulations Advisor

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Commerce, Community, and Economic Development

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MEMORANDUM

TO: David Paulson, MD
Alaska State Medical Board

DATE: Wednesday, August 06, 2025

FROM: Sara Chambers
Boards and Regulations Advisor

RE: Medical Assistants and Medical Spa Services

At the May 16, 2025, meeting of the Alaska State Medical Board, you requested a review of the history of medical assistant licensure and additional information to help guide an expansive conversation regarding delegation of medical esthetic services to assistive personnel.

I. Executive Summary and Recommendation

Specifically, within this context, the Alaska State Medical Board informally requested assistance in reviewing the feasibility of (1) the regulation of medical assistants by the state, and (2) regulation of medical assistants by the Board of Nursing.

Based on the information set forth below, my recommendation to the Alaska State Medical Board is as follows:

a. **Licensure of medical assistants will not accomplish improvements in care or delivery of services among medical spa patients.** Creation of additional licensing systems for medical assistants would increase the burden on health care professionals and facilities without providing benefits to patient care or safety.
b. **The most efficient approach may be to evaluate 12 AAC 40.920 to determine any inadequacies in the current delegation regulation. The board should thoughtfully update language that may not meet the board's expectations for physician accountability, scrutiny of training and education of the delegating physician, and fitness of the person to whom they are delegating.** Attached is an example of how the state of Rhode Island approached this question, using language that is substantially similar to the Alaska board's existing regulation.
c. **Support the Medical Spa Services Work Group's recommendation to create an advanced esthetician license under the Board of Barbers and Hairdressers or a similar endorsement to an existing license.** Most of the individuals wishing to practice medical esthetics either hold an esthetician license, a license by another state to practice laser hair removal, or a private certification on a system with limited, specific, and repeatable usage steps. Codifying expectations with an existing trained market would elicit more support and create a natural pathway for safe practice.

It is my hope that the board will review right-touch regulation options and pursue a pathway to either clarify current statutes and regulations regarding delegation or expand them to encompass safe training and education models without imposing undue restrictions. This type of approach may also be looked upon more favorably by the current administration, which has recently issued two Administrative Orders to manage the growth of government. This type of approach will help meet the growing demand for medical spa services while maintaining the highest standards of public safety.

II. Statement of Issues

a. Alaska State Medical Board regulations on delegation to assistive personnel

In May 2025, the Department of Commerce, Community, and Economic Development provided a memo—crafted in consultation with the Department of Law—to the board to guide its conversation surrounding current standards for delegation to assistive personnel under AS 08.64.106 and 12 AAC 40.920. This memo flowed from several conversations held by the Medical Spa Services Work Group regarding delegation by licensees of the Alaska State Medical Board and Board of Nursing.

Medical esthetics, sometimes referred to as advanced esthetics, include services that are currently considered the practice of medicine and regulated by the Alaska State Medical Board and Board of Nursing. Examples include use of Class III lasers to resurface skin, remove tattoos, and remove hair.

The work group was provided with written information and testimony from individuals who proposed various solutions, including delegation to individuals with private laser hair removal certification or to individuals with private training and certification by the manufacturer of specific laser products. The legal memo suggests these are already options under AS 08.64.106 and 12 AAC 40.920, assuming the standards set forth in those rules are also present.

Pursuant to this conversation by the board, Dr. Paulson suggested that physician delegation to medical assistants might be an advisable pathway toward closing the gap in delivery of medical esthetics services while maintaining public safety standards. Two elements that Dr. Paulson wished to consider are (1) the regulation of medical assistants by the state, and (2) that regulation be carried out by the Board of Nursing.

b. Background

For context, the Medical Spa Services Work Group was convened in August 2024 to address the public's lack of comprehension of Alaska statutes and regulations relating to "medical spa services," defined for this purpose as all aspects of oversight, diagnosis, prescription, administration, and follow-up care for various medical services if performed outside a traditional medical setting:

The work group has concluded discussions regarding medical directorship, delegation to unlicensed personnel, advanced esthetics, and IV hydration services. At its July meeting, the work group voted to forward a draft FAQ to each respective participating board for additional scrutiny and, ultimately, endorsement of a document to help clarify these issues for the public.

III. Licensure of Medical Assistants to Perform Medical Esthetic Procedures

a. Details

Regulation of medical assistants in any form requires the Alaska State Legislature to adopt new statutes concerning the type of regulation, the scope of licensure, who would license and regulate this industry, and any exemptions to regulation.

Currently, medical assistants are not regulated by the state. They often receive training and certification through private colleges and educational institutions, frequently under accredited programs. Health care facilities determine what level of training and certification are required for employment, if any.

According to the American Association of Medical Assistants, the basic curriculum across accredited programs includes general skills that do not require the use of independent professional judgment. In addition to administrative skills, clinical duties may include the following:

- Taking medical histories
- Explaining treatment procedures to patients
- Preparing patients for examinations

- Assisting the physician during examinations
- Collecting and preparing laboratory specimens
- Performing basic laboratory tests
- Instructing patients about medication and special diets
- Preparing and administering medications, including by intramuscular, intradermal, and subcutaneous injections—including vaccinations/immunizations, as directed by a physician or other licensed provider (e.g., a nurse practitioner or physician assistant)
- Transmitting prescription refills as directed
- Phlebotomy
- Taking electrocardiograms
- Wound care and changing dressings

Medical assistants are not trained or certified to perform specialized skills, such as certification to perform laser skin resurfacing or hair removal, though graduates may elect to independently pursue various additional pathways to advance their careers.

The Board of Nursing has adopted regulations similar to the Alaska State Medical Board regarding delegation to unlicensed personnel; however, additional nursing regulations specifically allow licensees to delegate the injection of medication to "certified medical assistants" under certain conditions:

> 12 AAC 44.966: (1) "certified medical assistant" means a person who is currently nationally certified as a medical assistant by a national body accredited by the National Commission for Certifying Agencies (NCCA) and meets the requirements of this section;

This appears to be the only instance in statute or regulations where *medical assistants* are specifically referred to by an Alaska professional licensing board.

b. Potential Benefits

Regulating medical assistants who *independently* elect to receive training to provide advanced, specialized services may more transparently codify career options for qualified individuals to work in medical spas. Although this pathway is theoretically already available under AS 08.64.106 and 12 AAC 40.920, regulating the certification and the standards could provide clear and enforceable guidance for both the delegating physician and the assistant.

c. Potential Risks and Challenges

As mentioned above, appropriately delegating to medical assistants or others with specialized training and education is already allowable under Alaska State Medical Board statutes and regulations. There has been no demonstrated public need to add cost and bureaucracy to the existing system.

Requiring regulation of *all* medical assistants is likely to receive overwhelming negative feedback from the medical community. This assessment is based on the comments received during deliberation of legislator-driven amendments to SB108 in 2018 (sample attached). Because the current scope of medical assistants does not present a significant public risk, there is no demonstrated need to explore additional restrictions to practice this profession.

Regulating medical assistants (as an industry in whole or in part) through a requirement of licensure will require legislation. Licensure (or similar state-issued credential) will drive up the cost to the state, the licensing program, and the licensee. It may also create confusion if certain medical assistants and not others require this type of credential.

Revising statutes and regulations to include *only* medical assistants will reduce opportunities to those who may hold other qualifying training and education and the physicians who wish to employ them, unnecessarily restricting economic opportunities and services available to Alaskans.

d. Recommendations

Given the goals of this request, the cost-benefit analysis, and potential to overly restrict options for qualified individuals, I do not recommend licensure of medical assistants as an initial step toward improving delegation standards.

IV. Regulation of Medical Assistants by the Board of Nursing

a. Details

The reason for the request for the Board of Nursing to govern licensure of medical assistants is unclear. This analysis will explore this request within the context of feasibility to implement delegation of certain medical esthetic duties.

As discussed above, regulation of medical assistants in any form requires the Alaska State Legislature to adopt new statutes concerning the type of regulation, the scope of licensure, who would license and regulate this industry, and any exemptions to regulation. This argument is explored fully in the preceding paragraphs.

Also mentioned above, the Board of Nursing has evaluated the safe utilization of medical assistants within the practice of nursing—at least for the purpose of delegating injectable medication. Within that context, the board has found that certification by an accredited body is an adequate qualification.

Currently, within the context of medical spa services, the Board of Nursing is also discussing current and future governance regarding delegation of certain specialized medical esthetic duties by an Advanced Practice Registered Nurse. They have not yet determined whether certified medical assistants have a role in those activities, whether certification is an appropriate level of training and education, or whether state licensure would add any value.

How the Board of Nursing proceeds does not have bearing on the statutes and regulations of the Alaska State Medical Board. If legislation was passed to authorize the Board of Nursing to regulate and license medical assistants, the Medical Board would still be required to examine and potentially revise its delegation of authority regulation—otherwise, the point of urging a new licensing scheme forward is moot. Medical Board licensees who delegate to *licensed* medical assistants would be held to the same levels of scrutiny and accountability as they do under *today's* statutes and regulations, rendering no new net effect on these practices.

b. Potential Benefits

Like those under AS 08.64, delegation statutes give the Board of Nursing wide latitude to manage standards in regulation. AS 08.68.805 already permits the board to adopt regulations governing delegation to unlicensed assistive personnel, so the Board of Nursing would need to evaluate how licensing medical assistants would further benefit delegation of medical esthetic duties by Advanced Practice Registered Nurses.

c. Potential Risks and Challenges

The argument against licensing medical assistants is laid out in Part III. A change in regulator does not present any significant difference in those concerns.

d. Recommendations

If the Alaska State Medical Board wishes to recommend the Board of Nursing pursue legislation to govern the practice of medical assistants, it should present their problem statement and reasons for expanding the Board of Nursing to that board during a public meeting.

Rhode Island Department of Health
Guidance Document Regarding the Operation of Medical Spas and Intravenous (IV) Therapy Businesses

Background

The Rhode Island Department of Health (RIDOH) is charged with implementing and enforcing laws for the protection of the public's health; this expansive authority includes oversight of healthcare facilities and healthcare professionals. The statutory authority for this regulatory oversight is largely set forth in Title 5 ("Businesses and Professions") and Title 23 ("Health and Safety") of the R.I. General Laws.

In the past few years, RIDOH has seen a proliferation of two new healthcare business types – medical spas and intravenous (IV) therapy businesses.

Medical spas, sometimes referred to as medspas or medispas, offer an array of services from traditional esthetic services (e.g., hairdressing, manicures) to traditional medical procedures (e.g., Botox, fillers, laser hair removal). For the purpose of this document, the term "medical spa" means an entity that offers or performs esthetic procedures that (a) do not require sedation; and (b) are directed at improving the person's appearance; and (c) do not meaningfully promote the proper function of the body or prevent or treat illness or disease. The term also refers to an entity that offers or performs any other esthetic procedure or treatment requiring the participation of a licensed healthcare professional.

Intravenous (IV) therapy businesses provide patients with IV fluids with or without medications, vitamins, minerals and/or amino acids. Sometimes these services are offered within a medical spa, but more often are a standalone business.

The services offered in these settings are advertised as being of minimal risk and thus are treated more as spa treatments rather than medical procedures; many of which intersect the specialties of medicine, nursing, and pharmacy. This framing makes it confusing for healthcare professionals and the public to understand the responsibilities of each specialty.

Furthermore, RIDOH has discovered many of these businesses operating without proper healthcare facility licensure and/or providers performing procedures that are not within their scope of practice nor adhering to the proper standard of care. Thus, patients receiving these medical treatments in these settings are at a higher risk for complications, including inadequate results (requiring additional procedures), infections, burns, and in extreme cases, death.

Based upon the foregoing, RIDOH's Division of Healthcare Quality and Safety (DHQS) in consultation with the professional boards of licensure and discipline, issue this guidance to

provide clarity on the licensure, ownership, standard of care, and standard of practice for healthcare professionals in medical spas and intravenous (IV) therapy businesses[1].

Questions regarding this guidance should be directed to Lauren Gareau at lauren.gareau@health.ri.gov or 401-222-4525.

Medical Spa and IV Therapy Business Ownership and Licensure

As medical spas and IV therapy businesses are an agglomeration of medical disciplines, the ownership structure of these facilities varies. In some instances, a dermatologist or plastic surgeon is the owner and in others, it is an esthetician. Some are owned by unlicensed investors. Determination for licensure is complex and heavily fact-dependent and it may be best for potential owners of medical spas and IV therapy businesses to seek legal counsel.

In Rhode Island the determination for the requirement of a healthcare facility license for a medical spa or IV therapy business is based on the ownership structure, services offered, and professional licensure (if any) held by the owners of the medical spa or IV therapy business.

In the event that the owner and/or operator holds no professional license or does not qualify for an exemption via a professional service corporation, **an organized ambulatory care facility license is needed.**

Certain professional license holders (e.g., physicians, dentists, registered nurses, physician assistants) are permitted to form a professional service corporation (PSC) under R.I. Gen. Laws Chapter 7-5.1. By forming a PSC, professional license holders can be exempt from an organized ambulatory care facility license (unless providing services within a mobile unit), under R.I. Gen. Laws Chapter 23-17, if the individuals of the PSC are owning and operating the business. Individuals who form a PSC may require prior written approval of the applicable board as discussed in R.I. Gen. Laws § 7-5.1-3.

R.I. Gen. Laws § 7-5.1-3 authorizes a combination of professional licenses to form a PSC (e.g., physician and dentist). At least one individual of the PSC must be able to perform the services they are offering to qualify for the exemption from an organized ambulatory care facility license. For example, a PSC that is comprised of nurses who are offering Botox at their medical spa would not qualify for an exemption from an organized ambulatory care facility license, as nurses are not able to examine, diagnose, prescribe, or administer Botox. In this example, the group of nurses would need to include a physician, physician assistant (PA), or certified nurse practitioner (CNP) in the ownership of the PSC to be exempt from an organized ambulatory care facility license.

[1] RIDOH and the boards acknowledge and appreciate the South Carolina Department of Labor, Licensing and Regulation and the Alabama Board of Medical Examiners for addressing many of the IV therapy business issues in their well-reasoned Advisory (South Carolina, Dated August 15, 2023) and Declaratory Ruling (Alabama, dated July 21, 2022). The issues raised in both are also an accurate representation of current IV practices in Rhode Island.

In some instances, a single provider or group of providers may form a PSC to be exempt from an organized ambulatory care facility license but then hire a management company that will actively operate the business with significant influence and no active involvement of the PSC members. This "leasing" of the PSC to circumvent the need for a facility license is a misrepresentation of the purpose of the law. Such arrangements will require the management company to receive an organized ambulatory care facility license and members of the PSC who engage in such practice may have adverse action taken against their professional license.

Medical spas and IV therapy businesses who elect to use a management company remain responsible for the limited services provided by the management company.

Medical spas whose business model involves providing, arranging to provide, offers to provide or in any other way provides for the delivery of direct nursing services in the home or in a location that is not the business's brick and mortar establishment (e.g., workplace, pool side, event space), **requires a home nursing care provider (HNCP) license regardless of professional license held**. An HNCP license requires a certificate of need (CON) pursuant to R.I. Gen. Laws Chapter 23-15.

Medical spas that wish to utilize a mobile unit and perform services in a van, trailer, or other **mobile method require an organized ambulatory care facility (OACF) license.** An OACF license requires prior Initial Licensure review and recommendation by the Health Services Council pursuant to R.I. Gen. Laws §§ 23-17-14.3 and 23-17-14.4, prior to issuance of the license by the Center for Health Facilities Regulation (CHFR).

There are various ways a healthcare business, like a medical spa or IV therapy business, can be structured. RIDOH, including the professional boards, does not provide advice or guidance on such matters and individuals should seek legal counsel for those questions.

Regardless of the ownership and/or professional license of the medical spa and/or IV therapy business, neither the business nor the business owner is permitted to exercise any control over the manner in which the physician, PA, or CNP provides medical services and must not interfere in the independent exercise of the responsible practitioner's medical judgment.

Standard of Care in Medical Spas and IV Therapy Businesses

Prior to the patient receiving any service or procedure in a medical spa or IV therapy business, the patient must first be assessed by a Rhode Island licensed practitioner[2]. Only the following individuals may diagnose, treat, correct, advise, or prescribe medication (including intravenous fluids) to a person for any human disease, ailment, injury, infirmity, deformity, pain, or other medical condition:

1. A physician licensed to practice allopathic or osteopathic medicine in this state, pursuant to the provisions of R.I. Gen. Laws Chapter 5-37.

[2] For the purpose of this document, the term "practitioner" means physician, physician assistant, and/or certified nurse practitioner.

2. A licensed physician assistant who is qualified by academic and practical training to provide medical and surgical services in collaboration with physicians and pursuant to the provisions of R.I. Gen. Laws Chapter 5-54.
3. A certified nurse practitioner licensed in accordance with R.I. Gen. Laws Chapter 5-34.
    a. **Only family practice CNPs and adult gerontology CNPs are permitted to participate in medical spas and IV therapy businesses.** All other CNP foci are prohibited from participating in medical spas and IV therapy businesses as the procedures are not within their scope of practice and training.
4. A dentist licensed to practice dentistry in the state and pursuant to R.I. Gen. Laws Chapter 5-31.1.
    a. Dentistry, as defined in R.I. Gen. Laws § 5-31.1-1(6), means the evaluation diagnosis, prevention, and/or treatment (nonsurgical, surgical, or related procedures) of diseases, disorders and/or conditions of the oral cavity, cranio-maxillofacial area and/or the adjacent and associated structures and their impact on the human body.

The physician, PA, CNP, or dentist must create a comprehensive medical record that complies with the standard of care. It is critical that the practitioner obtain informed consent and document the consent in the medical record. Informed consent is an educational process involving the patient in shared decision-making during which the practitioner should be able to determine if the patient has the ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision. The practitioner must present relative information accurately and sensitively, in keeping with the patient's preferences for receiving medical information.

In addition to informed consent, the medical record must also include:

1. Patient history;
2. Examination results;
3. Records of drugs (including intravenous fluids) prescribed, dispensed, and/or administered;
4. A diagnosis;
5. The nature and purpose of recommended interventions;
6. The burden, risks, and expected benefits of all options, including foregoing treatment; and
7. Patient's decision.

Medical records must be stored for at least seven years[3].

Some medical spas may try to circumvent the necessity of a physical assessment by a practitioner through the use of standing orders. The issuance of standing orders in this scenario, by a practitioner for a registered nurse (RN) or other provider to follow, does not satisfy the requisite provider-patient relationship. **The use of standing orders for an individualized assessment, diagnosis and treatment of patients is considered unprofessional conduct and can result in disciplinary action on one's license.**

[3] See: https://health.ri.gov/medicalrecords/

Scope of Practice and Standard of Care Requirements for IV Therapy Businesses

The services offered at an IV therapy business fall under the practice of medicine[4] and require an evaluation, diagnosis, and treatment of the patient.

As stated previously, only physicians, physician assistants, and CNPs may diagnose, treat, correct, advise, or prescribe IV medication to a person for any human disease, ailment, injury, infirmity, deformity, pain, or other condition.

It should be noted that emergency medical service practitioners (e.g., EMTS)[5], phlebotomists, licensed practical nurses, nursing assistants, medical assistants, dentists[6], podiatrists, chiropractors, veterinarians, naturopaths, and midwives are unable to provide services in these businesses as **it is outside of their scopes of practice** (i.e., diagnose, treat, prescribe, and/or administer IV fluids)**.**

In certain instances, an RN is the only licensed healthcare provider onsite at an IV therapy business. **The RN is operating outside of their scope of practice if they are diagnosing, prescribing, compounding, and/or treating the patient with IV hydration or therapy.**

While some IV therapy businesses have a physician, PA, and/or CNP owner, co-owner, investor, or associate, it may be that no practitioner evaluates the patient to make a diagnosis and prescribe a specific therapy to treat that diagnosis. Instead, the practitioner may be a "medical director," "consultant," "collaborator," "on staff," or "available" but only an RN assesses and treats the patient. This is insufficient to establish a valid practitioner-patient relationship that is required prior to the prescription and administration of drugs including IV therapies. Only licensed prescribers, namely physicians, PAs, and CNPs (only family practice CNPs or adult gerontology CNPs) can participate in an IV therapy business setting, evaluate the patient, make a diagnosis, and prescribe a treatment.

An appropriately licensed practitioner must first assess the patient (performing a history and physical exam) and document in a written medical record the assessment and plan (e.g., a diagnosis with a valid corresponding treatment regimen)[7]. Ideally, the exam is in person, as a complete medical assessment is difficult to conduct via telemedicine. For example, if a patient has signs of heart failure, listening to the heart and lungs with a stethoscope and looking for pitting edema in the lower extremities is critical, as such evidence would be a contraindication for additional fluids.

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[4] The term "practice of medicine," as used in this document, does *not* hold the same meaning as used in R.I. Gen. Laws § 5-37-1 or the rules and regulations for *Licensure and Discipline of Physicians* (216-RICR-40-05-1).
[5] While emergency medical practitioners can administer IVs, they cannot provide IVs in an IV therapy business as emergency medical service practitioners licensure is "solely in affiliation with an ambulance service currently licensed by RIDOH unless providing care as a Good Samaritan." From the rules and regulations for *Emergency Medical Services,* 216-RICR-20-10-2.
[6] Dentists can provide IV fluids in the normal course of their dental practice. They are prohibited from providing IV fluids in IV therapy businesses.
[7] This is required regardless of whether insurance will be billed for services.

A simple questionnaire without an appropriate clinical assessment (i.e., a history and physical examination) is prohibited and may be considered professional misconduct.

The practitioner must create a comprehensive medical record that complies with the standard of care in the same manner detailed above. IV therapy businesses with a practitioner available via telemedicine must still follow the above requirements for medical records and standard of care.

It is common that when a practitioner is only available via telemedicine, the IV therapy business will utilize the NPI number of a physician, PA, or CNP to acquire necessary supplies and then use standing orders directing the administration of IVs. **The issuance of standing orders for an RN to follow does not satisfy the standard of care by a physician, PA, or CNP; and the use of standing orders for this business model is considered unprofessional conduct and may result in disciplinary action against the licensed independent practitioner.**

IV treatments need to be individualized for patients and prescribed in the same manner as an urgent care center, emergency department, or hospital.

An IV therapy business cannot remove the requirement for practitioner involvement by allowing the patient to direct their own care; and **the practitioner (or nurse) engages in unprofessional conduct by allowing the patient to select their own medications and/or IVs from a menu**.

Compounding

Generally, the operation of an IV therapy business involves walk-in patients being offered a menu of pre-selected mixtures of additives to basic IV fluids (e.g., saline). These mixtures may include amino acids, vitamins, minerals, nutrients, and some medications like famotidine, omeprazole, ibuprofen, or ondansetron. These mixtures are offered to patients, often with catchy names, for the treatment of dehydration, migraines, hangovers, nausea, athletic or postoperative recovery, appetite regulation, and/or inflammation support. In some instances, the IV therapy business may make a "custom" IV mix based on the patient's selection or examination results.

The addition of any drug(s)/medication(s), vitamin(s), mineral(s), amino acid(s,) or other substance to an IV bag is, by law, compounding. Pursuant to the rules and regulations for *Pharmacists, Pharmacies, and Manufacturers, Wholesalers, and Distributors* (216-RICR-40-15-1), compounding is defined as "[t]he act of combining two or more ingredients as a result of a practitioner's prescription or medication order occurring in the course of professional practice based upon the individual needs of a patient and a relationship between the practitioner, patient and pharmacists."

The Food and Drug Administration (FDA) defines compounding as "[t]he process of combining, mixing, or altering ingredients to create a medication tailored to the needs of an individual patient. Compounding includes the combining of two or more drugs."[8] Thus, compounding must

[8] *See*: Drug Compounding and Drug Shortages | FDA (fda.gov)

result from a valid practitioner's order in the course of professional practice and not from a patient-driven menu akin to ordering at a restaurant.

The United States Pharmacopeia (USP) is the recognized publication that contains standardized requirements for compounding, including sterile compounding found in USP <797> and has been adopted by the FDA and RIDOH as the enforceable standard. Furthermore, all compounding is also subject to the requirements outlined in the rules and regulations for *Pharmacists, Pharmacies, and Manufacturers, Wholesalers, and Distributors* (216-RICR-40-15-1).

The USP <797> applies to all persons who prepare compounded sterile preparations (CSPs) and all places where CSPs are prepared for human and animal patients. This includes, but is not limited to, pharmacists, technicians, nurses, physicians, veterinarians, dentists, naturopaths, and chiropractors in all places including, but not limited to, hospitals and other healthcare institutions, medical and surgical patient treatment sites, infusion facilities, pharmacies, and physicians' or veterinarians' practice sites.

Rhode Island law allows pharmacists to compound drugs and oversee trained personnel compounding drugs. Physicians are permitted to compound as well as delegate compounding to other healthcare professionals, provided the compounding occurs under a physician's supervision. Pursuant to the Rules and Regulations for *Licensure and Discipline of Physicians* (216-RICR-40-05-1), physicians are required to follow USP <797> and the rules and regulations for *Pharmacists, Pharmacies, and Manufacturers, Wholesalers and Distributors* (216-RICR-40-15-1) when compounding. **The regular storage, preparation, and compounding of drugs by anyone other than a licensed physician, pharmacist, or pharmacy is prohibited unless licensed by RIDOH in these professions.** IV therapy businesses that elect to compound must have a physician on-site for supervised compounding or have a licensed pharmacy on-site to prepare compounds under the supervision of a pharmacist. The physician or pharmacist supervising the compounding must be on-site; remote supervision of compounding is prohibited. An IV therapy business that does not prepare their own compounds may receive compounds from a licensed pharmacy or a federally registered outsourcing facility (i.e., 503B Outsourcing Facility).

The USP <797> "immediate use" provision governs the emergency preparation of a sterile drug product, and in certain circumstances, this provision allows for the preparation of a sterile product to be made outside of full USP compliance. In some cases, IV therapy businesses have been interpreting the concept of "immediate use" to allow the compounding of IVs to circumvent USP requirements, especially for sterility and training. The "immediate use" provision is not a workaround for the quality and safety standards that govern sterile product preparation. Walk-in or concierge IV therapy services do not fall under USP <797> "immediate use" definition.

Scope of Practice in Medical Spas and IV Therapy Businesses

Scope of practice for professions can be found in R.I. laws and regulations promulgated by RIDOH. With the development of new technologies and procedures, RIDOH relies heavily on the professional boards to advise on what new procedures fall within the scope of practice of each licensee.

The following chart is a visual of common procedures that are performed in medical spas and IV therapy businesses that RIDOH and the respective boards have determined are within each licensee's scope of practice, provided that such licensee has the requisite training and experience**. This list is not exhaustive and any questions about procedures not listed should be directed to the applicable board and/or to RIDOH.**

	Physician[1]	PA[1,2]	CNP[1,3]	Pharmacist	Dentist[1]	RN	LPN	Electrologist	Esthetician	Tattoo Artist	Permanent Makeup Artist
Body Sculpting	Yes	No	No	No	No	No	No	No	No	No	No
Chemical Peels	Yes	Yes	Yes	No	No	No	No	No	Yes[7]	No	No
Cryolipolysis (Cool Sculpting)	Yes	No	No	No	No	No	No	No	No	No	No
Dermal Filler	Yes	Yes	Yes	Yes[4]	Yes	No	No	No	No	No	No
Dermaplaning	Yes	Yes	Yes	No	No	No	No	No	No	No	No
Hair Transplant	Yes	Yes	No	No	No	No	No	No	No	No	No
Inkless Stretch Mark Revision	Yes	Yes	No	No	No	No	No	No	No	Yes	Yes
Intravenous Fluids	Yes	Yes	Yes	No	No[5]	Yes[1,4]	No	No	No	No	No
Laser Hair Removal	Yes	Yes	Yes	No	No	No	No	Yes[6]	No	No	No
Laser Tattoo Removal	Yes	Yes	No	No	No	No	No	No	No	No	No
Liposuction	Yes	No	No	No	No	No	No	No	No	No	No
Microblading	Yes	Yes	No	No	No	No	No	No	No	Yes	Yes
Micro Channeling	Yes	Yes	Yes	No	No	No	No	No	No	No	No
Microneedling	Yes	Yes	No	No	No	No	No	No	No	No	No
Neuromodulators (Botox)	Yes	Yes	Yes	Yes[4]	Yes	No	No	No	No	No	No
Oxygen Therapy	Yes	Yes	Yes	No	No[5]	Yes[1,4]	Yes[1,4]	No	No	No	No
Platelet-Rich Fibrin	Yes	No	No	No	No[5]	No	No	No	No	No	No
Platelet Rich Plasma	Yes	No	No	No	No[5]	No	No	No	No	No	No
Pulsed Intense Light	Yes	Yes	No	No	No	No	No	No	No	No	No
Radio Frequency	Yes	Yes	No	No	No	No	No	No	Yes	No	No
Saline Tattoo Removal	Yes	Yes	Yes	No	No	No	No	No	No	Yes	Yes

1. Must have appropriate training in these procedures.
2. In collaboration with a physician.
3. Family practice CNPs and adult gerontology CNPs only.
4. Must have a valid prescription by a physician, PA, or CNP.
5. Dentists can provide this procedure during the course of normal dental work; however, dentists cannot perform such procedure in a medical spa and/or IV therapy businesses.
6. Must meet training requirements in accordance with R.I. Gen. Laws 5-32-21
7. The acidity of the chemical peel cannot exceed 30%.

Ablative lasers or ablative energy devices are intended to excise or vaporize the outer layer of skin. These procedures should only be performed by a physician or delegated to an appropriately trained PA, with training and experience in the use of these devices. Examples of ablative lasers include carbon dioxide (CO_2) lasers and erbium lasers.

Body sculpting (also known as body contouring) is the use of non-invasive means to change the shape of an area of the body. This includes the use of very cold temperatures, heat, laser, red light or radiofrequency energy to destroy fat cells. This includes the use of Zerona®, truSculpt®, CoolSculpting®, ScupltSure®, EMSCULPT neo®, Morpheus8 Body, Vanquish RF and other devices.

Chemical Peels means a procedure in which a chemical solution is applied to the skin to remove the top layers. Chemical peels are used to treat wrinkles, discolored skin, and scars. They can be done at different depths from light to deep. Deeper chemical peels offer more dramatic results but also require a longer recovery period.

Cryolipolysis, also known as "CoolSculpting®" means the use of very cold temperature to break down fat cells.

Dermal Filler means injection of synthetic substances (e.g., hyaluronic acid, calcium hydroxyapatite, polymethylmethacrylate, Poly-L-lactic acid), collagen, or fat in order to increase the amount of collagen in a body area.

Dermaplaning is a treatment in which dead skin cells and peach fuzz are scraped off with a scalpel.

Hair Transplant means the surgical technique that removes hair follicles from one part of the body, called the "doner site", to a bald or balding part of the body known as the "recipient site."

Hyaluron pens are prohibited for use. They have not been approved by the Food and Drug Administration and are not for legal sale in the United States.

Inkless stretchmark revision means a procedure that involves injecting a serum and/or vitamins into the dermis layer of the skin using a tattoo needle, causing microabrasions. It is also known as dry tattooing, medical needling, inkless needling, and MCA needling.[9] This process may also be used to improve the appearance of scars.

Intravenous Fluids means injecting liquids to a person through a vein. This includes providing stock intravenous (IV) fluids (e.g., 0.9% normal saline, lactated Ringer's solutions) with or without the addition of vitamins, minerals, amino acids, medications, etc. Intravenous fluids are, by law, drugs that must be prescribed by a licensed independent practitioner (physician, physician assistant, or CNP) for a specific patient with a specific diagnosis for which the IV fluids are indicated.

[9] A tattoo is defined as inserting a colored ink into the skin through a needle to mark or color the skin by introduction of non-toxic dyes or pigments into the skin. From the rules and regulations for *Tattoo Artists and Tattoo Parlors*, 216-RICR-40-10-16.

Laser Hair Removal means using a non-ablative laser to perform hair removal or reduction. It differs from electrolysis, which is the use of an electric current to destroy hair follicles.

Laser tattoo removal means a procedure that uses laser light energy to break up tattoo pigment into small particles in which the body's immune system clears over time.

Liposuction means a cosmetic surgical procedure for removing excess fat from under the skin by suction.

Microblading means a semipermanent eyebrow tattooing procedure which uses a handheld tool with tiny needles to inject pigment into the skin.

Micro Channeling means the use of ultra-fine needles to inject customized serums (often containing dermal fillers, platelet rich plasma, and/or Botox) directly into the skin.

Microneedling means the use of thin needles to make tiny holes in the top layer of skin. The damage helps stimulate the skin's healing process, so it produces more collagen and elastin (proteins that keep skin firm and smooth).

Neuromodulators (Botox) means a wrinkle-relaxing injection of botulinum toxin, commercially known as Botox Cosmetic, Dysport, Xeomin, or Jeuveau – that are used to treat wrinkles, frown lines, and crow's feet.

Non-Ablative Lasers, light treatments and energy device treatments that do not excise or vaporize the outer layer of skin, may be provided by a physician or delegated to an appropriately trained CNP or PA with training and experience in these treatments. Laser hair removal uses a non-ablative laser. An electrologist who has completed training pursuant to R.I. Gen. Laws § 5-32-21 may perform laser hair removal without physician supervision.

Oxygen Therapy means the provision of supplemental oxygen.

Platelet Rich Fibrin (PRF) means the process of harvesting one's blood and mixing it with a protein matrix called fibrin. The mixture then is turned into a gel made up of a high concentration of white blood cells, fibrin, and stem cells (growth factors) and injected into other areas of the body.

Platelet Rich Plasma (PRP) means the process of harvesting one's blood, centrifuging it to separate platelets and plasma from other blood cells and injecting the platelets and plasma back into the body.

Pulsed Intense Light means the use of light energy of multiple wavelengths to remove pigmented skin areas including age spots, facial telangiectasia (broken blood vessels), freckles, and birthmarks by focusing the energy into the dermis.

Radio Frequency means a non-surgical skin tightening procedure involving an electromagnetic device that generates heat to stimulate the production of collagen, elastin, and new skin cells.

Saline tattoo removal means injecting saline into an existing tattoo in order to dissolve the ink. This procedure may only be performed by tattoo artists and permanent makeup artists.

Any license type not listed above, such as nursing assistants, emergency medical service practitioners (e.g., EMTs)[10], optometrists, veterinarians, or hairdressers cannot perform any of the above medical procedures as they are not within their scopes of practice.

Persons with no professional licensing are prohibited from performing any medical procedures. **A course certificate of completion for any of the above procedures does not constitute a license**. Performing any medical procedures without a license may subject an individual to fines and/or civil or criminal penalties.

[10] While some of these procedures can be performed by emergency medical service practitioners, they cannot provide services in a medical spa setting, as emergency medical service practitioners licensure is "solely in affiliation with an ambulance service currently licensed by RIDOH unless providing care as a Good Samaritan." From the rules and regulations for *Emergency Medical Services,* 216-RICR-20-10-2.

From: Barb Doty
To: Rep. Sam Kito
Subject: SB 108
Date: Tuesday, April 10, 2018 1:53:49 PM

Rep. Kito:
I oppose the removal of sectons 3 and4 of this bill as the required licensing of medical assistants which are entry level and do not have prescribing or independent medical care privileges would be costly, unnecessary, and add to the already onerous administrative burden of medical practice that is driving the cost of Alaska's health care through the roof without significant improvement in health outcomes. Your recommendation is ill advised.
Barbara J Doty M.D.

Alaskan family Physician for 35 years
Former member, American Academy of Family PHysicians Board of Directors

From:	Bj Aldrich
To:	Rep. Sam Kito; Rep. Adam Wool; Rep. Andy Josephson; Rep. Louise Stutes; Rep. Chris Birch; Rep. Gary Knopp; Rep. Colleen Sullivan-Leonard
Subject:	SB 108
Date:	Tuesday, April 10, 2018 3:36:32 PM

Dear State Representative,

My name is B.J. Aldrich and I am a Family Practice physician. I am the director of the Student Health and Counseling Center at the University of Alaska Fairbanks.

I am writing to you about SB 108 which was introduced by Sen. Cathy Giessel. I support this bill overall, particularly Section 3 relating to the delegation of routine medical procedures to medical assistants. Regarding Section 4, while I don't believe state certification is necessary for medical assistants, I am not against it.

I have heard that Rep. Kito is considering removing sections 3 and 4 and requiring **all** medical assistants to be licensed. I oppose this move as I believe it is unnecessary and will add costs and overhead burden to the hiring of medical assistants. At our clinic here, we utilize medical assistants to perform routine tasks directly under the supervision of licensed medical providers. Due to this supervision necessity along with the option of certification, I believe requiring medical assistants to be licensed is unwarranted.

I ask that you please support passing SB 108 as written.

Respectfully,

Betty J. (B.J.) Aldrich MD
Director
Student Health and Counseling Center
University of Alaska Fairbanks
907-474-7043, fax 907-474-5777

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From:	Harbir Makin
To:	Rep. Sam Kito
Subject:	SB 108
Date:	Tuesday, April 10, 2018 3:27:39 PM

Dear Representative Kito:

This bill just does not make sense ! All the medical assistants do in an office is check in and check out patients, and at the most check blood pressure etc. They do not make any treatment decisions like an RN, a NP or a PA might.

This is another layer of bureaucracy that makes hiring more difficult and expensive. These workers really pose no threat to the patients, and unlike nurses, nurse practitioners or physician assistants, the MA's do not make any treatment decisions.

I hope you will reconsider the consequences of this bill. We are already struggling with high costs in running primary care offices.

Best,

Harbir Makin, MD

From: robtory haight
To: Rep. Sam Kito
Subject: SB 108
Date: Tuesday, April 10, 2018 6:17:51 PM

Dear Rep. Kito, I am against requiring all MA's in Alaska to be certified/licensed. I have been practicing medicine in Alaska for 20 years. In that time, I have relied heavily on unlicensed MA's to perform routine functions in the care of my patients. In the past 18 years in Juneau, I have worked almost exclusively with unlicensed MA's. These workers work under close supervision of licensed medical providers and are trained well in outpatient medical procedures such as drawing blood, performing x-rays, giving vaccinations, and taking medical histories from patients. Many primary care clinics would not be able to afford licensed LPNs or RNs and requiring current working unlicensed MA's to stop working in order to obtain the required certification would cause a serious disruption in patient care.

Thank you for your time.

Robert W. Haight MD/Family and Urgent Care Medicine/Juneau, AK

From: Crisandra McCarthy
To: Rep. Sam Kito
Subject: SB 108
Date: Tuesday, April 10, 2018 4:06:08 PM

Please keep SB 108 as written and do not amend it. If your guidelines for amending it is using that of the Nurse Aide statutory provisions, please be informed that as medical assistants, we receive different training compare to what they get. As the saying goes, "DO NOT FIX WHAT IS NOT BROKEN". As a Medical Assistant, we work side by side as a team with our doctors/providers when providing patient care. Never in my entire Medical Assisting Career have I had to use my independent judgement when giving patient care. Not only were Nationally recognize as Certified Medical Assistants, we are also Internationally recognize. This is a waste of the state money whose already broke & man power.

Crisandra McCarthy,CMA(AAMA)
Student Health & Counseling Center
1788 Yukon Drive, PO Box 755580
Fairbanks, AK 99775
P:(907)474-7043
F:(907)474-5777

From: Margaret E Kellogg
To: Rep. Sam Kito
Subject: SB 108
Date: Wednesday, April 11, 2018 9:46:14 AM

Making MA's be licensed in the state of Alaska is a bad idea. Certified yes. Most MA's don't do anything that should require a license. They take vitals
room patience and assist patients administratively. They do not prescribe meds or anything that should require them to be licenseed.

--

Margaret E. Kellogg Office Manager/Insurance Coordinator
Student Health & Counseling Center
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From: Robin Wahto
To: Rep. Sam Kito
Subject: SB 108 - MEDICAL CARE/LICENSING/MEDICAL BOARD
Date: Wednesday, April 11, 2018 9:29:19 AM

Representative Kito,
I am opposed to the proposed changes to SB 108 that would remove Section 3 and 4. Requiring all medical assistants to be certified/licensed with the state will create unnecessary costs, and cause barriers to the hiring of medical office personnel. This will negatively impact patient care.

I do not believe there is legitimate public health and safety concerns to warrant the licensing of all medical assistants. Medical assistants have been employed by physicians in Alaska since the 1960's; I personally have been a member of the Alaska Medical Assistant Society (established in 1968) since 1981 and am not aware of any reported problems or actual events related to patient safety involving medical assistants during the past 35 years.

Medical assistants work under supervision of the physicians that employ them. SB 108 as passed by the Senate would establish authority for the Alaska Medical Board to set regulations regarding the delegation of duties to medical assistants. It is my feeling that the current version of SB 108 appropriately allows certification/licensing of medical assistants to be directed by the Alaska Medical Board.

There are currently only two other states in the US, South Dakota and Washington, that require full licensing of medical assistants. There are several other states that require limited licensing. In these states, it is my understanding that the licensed medical assistants are allowed to perform more advanced procedures; whereas medical assistants who are not licensed are allowed to perform routine duties. I believe this type of limited licensing would be most beneficial for the state of Alaska. This can be accomplished with the current version of SB108.

I support SB108 as passed by the Senate.

Robin Wahto
Director of UAA Medical Assisting Program 1990 - 2017

From: Dwight Ellerbe
To: Rep. Sam Kito
Subject: SB 108
Date: Wednesday, April 11, 2018 9:51:31 AM

I am not in favor of the amendment to require licensing of Medical Assistants. This would incur huge and unnecessary administrative costs and hassles for both the MA workforce and the physicians that hire them. Please eliminate this amendment.

Dwight M Ellerbe MD
Alaska Center for Ear Nose and Throat

From: George Rhyneer
To: Rep. Sam Kito
Subject: SB 108
Date: Wednesday, April 11, 2018 11:04:06 AM

Dear Representative Kito: Please don't amend SB 108 to require medical assistants to have a license. It's a heavy and not needed requirement that is a significant burden and without a major necessity. Medical assistants work in and under the license and supervision of their doctor who is by tradition and law responsible for their actions. Also medical assistants have an extremely varied job which is very different from one office to another, making some sort of license difficult to design or administer to cover all of their myriad duties. It would cost something to design, administer and follow by the division of licensing and have little or no effect on the quality of services now provided. George S. Rhyneer, MD, cardiologist in Anchorage (former member of Medical licensing board)

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Alaska State Medical Association

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April 11, 2018

Honorable Representative Sam Kito
Alaska State House
State Capitol, Room 124
Juneau, AK 99801

RE: House CS for SS for Senate Bill 108

Dear Chairman Kito:

On behalf of the Alaska State Medical Association representing over 500 Alaska based physicians, I am submitting this letter in strong opposition to House CS for SS for Senate Bill 108. ASMA supported the Senate version of SB 108 as transmitted to the House. The three goals of the Senate version were to:

1. Allow the Executive Director of the Medical Board to issue temporary licenses to clean applications as opposed to waiting for the Board to meet and issue the licenses. ASMA supports this provision. (Section 1&2)

2. Allow the Board to adopt regulations providing for delegation of routine medical procedures to unlicensed personnel. ASMA supports this provision. (Section 3) and,

3. Allow the Board to adopt requirements for certification of medical assistants. This provision was for the sole purpose of allowing a physician to delegate looking up information on the prescription drug database (PDMP). Current law requires persons using the PDMP to be licensed or registered under title 08 of Alaska statutes. (Section 4) ASMA believes full certification is overkill for the sole purpose of using the PDMP and will add costs but has noted it is workable and supports passage.

House CS for SS for Senate Bill 108 removes sections (3) and (4) and would require **all** medical assistants to be licensed. ASMA believes this will create unnecessary costs and burden hiring employees, affecting hundreds of medical offices, rural health clinics, hospitals, and nursing homes across the state. If passed overall healthcare costs will go up not down.

The state's Nursing Board currently authorizes APRN's to delegate routine medical procedures like injections to medical assistances under their supervision. (AS 08.69.805) It was recently discovered that Medical doctors lack the same authority under State Statues. This discovery has disrupted current practice norms that have existed for decades and needs to be fixed. This strange state of affairs is the primary but not only reason ASMA supports passage of the original Senate version of SB 108.

Sincerely,

Mike Haugen
Executive Director
Alaska State Medical Association

CC: Senator Kathy Giessel, Crystal Koeneman

Hillside Family Medicine, LLC

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John Nolte, M.D. ● Miriam Nolte, M.D. ● Scott DeBerard, D.O. ● Rachel Coleman, PA-C
Julie Wilson, M.D. ● Jennifer Davis, PA-C ● Helene Eliassen, M.D. ● Tonya Caylor, M.D.

To: Honored Representatives

From: John Nolte, MD

Re: SB 108

Dear Representatives,

The local chapter of the AAFP has informed us of the pending bill which the local American Association of Family Physicians and the Alaska State Medical Association endorse. We are also aware of intent by Rep Kito to modify the bill to require licensure of medical assistants which the above organizations and Hillside Family Practice opposes.

My wife and I operate a busy family practice clinic in south anchorage since 1998. We have hired numerous medical assistants over the years – many certified MA's and many uncertified. While Rep Kitos' intent to protect the public from MA's that have been fired is laudable, frankly it has not been a problem so long as a clinic follows good employment practices. We have found checking references, the state criminal database and the Medical Group Management Association has caught the few bad players. Creating another level of bureaucracy increases cost, delays employment and outweighs any potential good. Are we going to not hire a person because they have been fired?

Many of our assistants have no medical training. They are looking for experience to help guide their search for a well matched occupation. In fact, our untrained assistants include 4 current physicians, 5 PA's, 2 RNs. Young people use this opportunity as a stepping stone for advancement in the medical field. How are you going to license someone like that? Many start as a receptionist, then desire to help with medical care and are taught skills as they go. When do they become medical assistants and not receptionists? All of our providers are actively involved in teaching from career academy, medical students, residents, PA's and NP's – we love helping young people develop and grow.

I encourage you to not make entering the medical profession more burdensome than it already is.

Respectfully – John Nolte, MD

John Nolte, M.D. ● Miriam Nolte, M.D. ● Scott DeBerard, D.O. ● Rachel Coleman, PA-C
Julie Wilson, M.D. ● Jennifer Davis, PA-C ● Helene Eliassen, M.D. ● Tonya Caylor, M.D.

Proposed State Medical Board Statement on Late Term Abortion

Alaska state law allows for elective late term abortions, up until the time of delivery. The Alaska State Medical Board believes this is not ethical medical practice and does not embody the values of Alaskans. Many Alaskans and even physicians are unaware of this. We encourage Alaskans to engage with their representatives and to advocate for new legislation to bring state law into alignment with community values on this issue.

Waiver Request to initiate Regulation Project

Approval Details

Motion: Dr. Taylor
Second: Dr. Heilala

Open Date: 7/30/2025 10:41 AM AKDT
Close Date: 8/1/2025 10:00 PM AKDT

Approval Description

The motion is for the Alaska State Medical Board to approve the request for a waiver to Administrative Order 358 in order to pursue a new regulation project related to limiting medical board licensees from performing hormonal and surgical treatment for gender dysphoria on minors.

Approval Results

Vote **Passed**

4/5 (**80%**) Voted “Yes”.
0/5 (**0%**) Voted “No”.
0/5 (**0%**) Voted “Abstain”.
1/5 (**20%**) No vote placed.

Voter	Final Vote	Electronic Vote Date	Signature
David Paulson	NONE		
David Wilson	YES	7/30/2025	
Brent Taylor	YES	7/30/2025	
Matt Heilala	YES	7/30/2025	
David Barnes	YES	7/30/2025	

Comment Date	Participant	Comment

Chapter 40. State Medical Board.

(Words in **boldface and underlined** indicate language being added; words [CAPITALIZED AND BRACKETED] indicate language being deleted. Complete new sections are not in boldface or underlined.)

12 AAC 40.956. UNPROFESSIONAL CONDUCT. For purposes of AS 08.64.240(b) and AS 08.64.326, "unprofessional conduct" means an act or omission by an applicant or licensee that does not conform to the generally accepted standards of practice for the profession for which the applicant seeks licensure or a permit under AS 08.64 or which the licensee is authorized to practice under AS 08.64. "Unprofessional conduct" includes the following:

(1) submitting or causing the submission of testimony, a statement, or a document for consideration by the board knowing it contained false, misleading, or omitted material information or was fraudulently obtained; for purposes of this paragraph, "document" includes an affidavit, certificate, transcript, diploma, board certification information, reference letters, or translation of a foreign language document;

(2) misrepresenting, concealing, or failing to disclose material information to

(A) obtain a license or permit under AS 08.64; or

(B) renew a license under AS 08.64;

(3) purchase, sale, barter, or alteration of a license or permit issued under AS 08.64;

(4) the use of a license or permit obtained as described in (3) of this section;

(5) committing, or attempting to commit, fraud or deception, or attempting to subvert the process relating to an examination required under AS 08.64;

(6) practicing a profession licensed under AS 08.64 without a required license or permit or with a lapsed, expired, retired, or inactive license or permit;

(7) permitting or employing an unlicensed person to practice a profession licensed under AS 08.64

(A) without the required license or permit under AS 08.64; or

(B) while the person's license or permit was revoked, suspended, surrendered, or canceled in this state;

(8) delegating professional practice responsibilities that require a license or permit under AS 08.64 to a person who does not possess the appropriate education, training, or licensure to perform the responsibilities;

(9) failing to prepare and maintain accurate, complete, and legible records in accordance with generally accepted standards of practice for each patient and to make those records available to the board and the board's representatives for inspection for investigation purposes;

(10) falsifying, intentionally making an incorrect entry, destroying, or failing to maintain patient or facility medical records for at least seven years from the date of the last entry;

(11) failing to provide copies of complete patient records in the licensee's custody and control within 30 days after receipt of a written request from the patient or the patient's guardian;

(12) intentionally or negligently releasing or disclosing confidential patient information; this paragraph does not apply to disclosures required under state or federal law or when

disclosure is necessary to prevent an imminent risk of harm to the patient or others;
(13) offering, giving, soliciting, or receiving fees or other benefits, in whole or in part, to a person for bringing in or referring a patient;
(14) harassing, disruptive, or abusive behavior by a licensee directed at staff or a patient, a patient's relative, or a patient's guardian;
(15) disruptive behavior by a licensee at the workplace that interferes with the provision of patient care;
(16) discriminating on the basis of the patient's race, religion, color, national origin, ancestry, or sex in the provision of professional services;
(17) conviction of a felony or a crime involving moral turpitude; under this paragraph, a "crime involving moral turpitude" includes the following:

(A) homicide;
(B) manslaughter;
(C) assault;
(D) stalking;
(E) kidnapping;
(F) sexual assault;
(G) sexual abuse of a minor;
(H) unlawful exploitation of a minor, including possession or distribution of child pornography;
(I) indecent exposure;
(J) unlawful distribution or possession for distribution of a controlled substance;

for purposes of this subparagraph, "controlled substance" has the meaning given in AS 11.71.900;
(18) using alcohol or other drugs (A) to the extent that the use interferes with professional practice functions of the licensee or endangers the safety of patients; or (B) that is illegal under state or federal law;
(19) failing (A) to comply with AS 08.64.336; or (B) to report to the board or the board's representatives facts known to the licensee regarding incompetent or repeated negligent conduct, gross negligence, unprofessional conduct, sexual misconduct, or other illegal conduct by another licensee under AS 08.64.326;
(20) failing to report to the board or the board's representatives that the licensee's hospital privileges have been denied, revoked, suspended, or limited by a hospital or other health care facility for disciplinary reasons by the physician in charge; this paragraph does not apply to a temporary suspension pending completion of medical records by the governing body of the hospital or other health care facility;
(21) facilitating the practice of a profession licensed under AS 08.64 by a person who is not licensed, incompetent, or mentally, emotionally, or physically unable to practice safely;
(22) failing to fulfill the responsibility and duties of a collaborating physician in any collaborative relationship entered into under AS 08.64 with a physician assistant;
(23) violating provisions of any disciplinary sanction issued under AS 08.64;
(24) failing to cooperate with an official investigation by the board or the board's representatives, including failing to timely provide requested information;
(25) failing to allow the board or the board's representative, upon written request, to examine and have access to records maintained by the licensee that relate to the licensee's

practice under AS 08.64;
(26) failing to report to the board, no later than 30 days after
(A) the effective date of the action, any criminal charges by a law enforcement agency, or any disciplinary action against the licensee taken by another licensing jurisdiction, health care entity, or regulatory agency;
(B) the date of conviction, any conviction of a crime referred to in AS 08.64.326(a)(4);
(27) providing treatment, rendering a diagnosis, or prescribing medications based solely on a patient-supplied history that a physician licensed in this state received by telephone, facsimile, or electronic format;
(28) after performing surgery, failing to continue care of a surgical patient of the licensee through a post-surgical recovery and healing period, either by providing the care directly, delegating the care to one or more individuals who have the appropriate education, training, and licensure or certification to provide definitive care, or coordinating with another qualified physician or other medical professional who agrees to assume responsibility for managing the patient's post-surgical care;
(29) for a physician or physician assistant, prescribing, dispensing, or furnishing a prescription medication without first conducting a physical examination of the person, unless the licensee has a patient-physician or patient-physician assistant relationship with the person; this paragraph does not apply to prescriptions written or medications issued
(A) for use in emergency treatment;
(B) for expedited partner therapy for sexually transmitted diseases;
(C) in response to an infectious disease investigation, public health emergency, infectious disease outbreak, or act of bioterrorism; or
(D) by a physician or physician assistant practicing telemedicine under AS 08.64.364;
(30) failing to notify the board of the location of patient records within 30 days after a licensee has retired or closed a practice; or
(31) knowingly delegating a function, task, or responsibility to another person if the delegation would be reasonably likely to pose a substantial risk of harm to a patient;
(32) permitting patient care that includes administering a botulinum toxin or dermal filler, autotransplanting biological materials, or treating with chemical peels below the dermal layer, or hot lasers, by a person who is not an appropriate health care provider trained and licensed under AS 08 to perform the treatment;
(33) failure of a licensee who has a federal Drug Enforcement Administration (DEA) registration number to register with the controlled substance prescription database under AS 17.30.200;
(34) failure of a licensee or licensee's designee to review the controlled substance prescription database under AS 17.30.200, when prescribing, dispensing, or administering a controlled substance designated schedule II or III under federal law to a patient;
(35) any conduct described in (1) - (34) of this section that occurred in another licensing jurisdiction and is related to the applicant's or licensee's qualifications to practice.
(36) providing medical or surgical intervention to treat gender dysphoria or facilitate gender transition by altering sex characteristics inconsistent with the biological sex at birth, including but not limited to puberty blockers, cross-sex

hormones, mastectomy, phalloplasty, or genital modification to a minor under the age of 18 years old. Exceptions Include but are not limited to: Treatments for congenital sex development disorders or non-elective procedures for physical injury.

Definitions:
"Biological Sex": The male or female designation based on chromosomes, gonads, hormones, and genitals at birth, irrespective of psychological identity.

"Gender Transition": Any process to align sex characteristics with a gender identity different from biological sex.

Proposed definition of “written prescription” to clarify prescribing procedures for physician assistants per 12 AAC 40.450 (i) Authority to Prescribe, Order, Administer and Dispense.

> ***“A written prescription refers to a paper document that has been in the control of a patient prior to receipt by a Retail/Community Pharmacy for the purpose of dispensing medications.***
>
> ***ePrescriptions, which can be directly transmitted from a Hospital Medical Record Database to a Retail Pharmacy, must adhere to the prescription requirements set forth by the DEA and AK Board of Pharmacy for Physician Assistants. ePrescriptions are exempt from the additional prescription requirements that the AK Medical Board requires for written prescriptions by PAs specified in 12 AAC 40.450 (i).”***

12 AAC 40.450. Authority to prescribe, order, administer, and dispense medications.

(a) A physician assistant who prescribes, orders, administers, or dispenses controlled substances must

(1) have a current Drug Enforcement Administration (DEA) registration number, valid for that handling of that controlled substance on file with the department; and

(2) comply with 12 AAC 40.976.

(b) Repealed 9/1/2007.

(c) A physician assistant with a valid DEA registration number may order, administer, dispense, and write a prescription for a schedule II, III, IV, or V controlled substance only with the authorization of the physician assistant's primary collaborating physician. The authorization must be documented in the physician assistant's current collaborative plan on file with the division.

(d) The physician assistant's authority to prescribe may not exceed that of the primary collaborating physician as documented in the collaborative plan on file with the division.

(e) A physician assistant with a valid DEA registration number may request, receive, order, or procure schedule II, III, IV, or V controlled substance supplies from a pharmaceutical distributor, warehouse, or other entity only with the authorization of the physician assistant's primary collaborating physician. If granted this authority, the physician assistant is responsible for complying with all state and federal inventory and record keeping requirements. The authorization must be documented in the physician assistant's current collaborative plan on file with the division. Within 10 days after the date of issue on the form, the physician assistant shall provide to the primary collaborating physician a copy of each DEA Form 222 official order form used to obtain controlled substances.

(f) A physician assistant may prescribe, order, administer, or dispense a medication that is not a controlled substance only with the authorization of the physician assistant's primary collaborating physician. The authorization must be documented in the physician assistant's current collaborative plan on file with the division.

(g) A graduate physician assistant licensed under this chapter may not prescribe, order, administer, or dispense a controlled substance.

(h) Termination of a collaborative plan terminates a physician assistant's authority to prescribe, order, administer, and dispense medication under that plan.

(i) A prescription written under this section by a physician assistant must include the

(1) primary collaborating physician's name;

(2) primary collaborating physician's DEA registration number;

(3) physician assistant's name; and

(4) physician assistant's DEA registration number.

(j) In this section, unless the context requires otherwise,

(1) "order" means writing instructions on an order sheet to dispense a medication to a patient from an on-site pharmacy or drug storage area; for purposes of this paragraph, "on-site pharmacy" means a secured area that provides for the storage and dispensing of controlled substances and other drugs and is located in the facility where the physician assistant is practicing;

(2) "prescription" means a written document regarding a medication prepared for transmittal to a licensed pharmacy for the dispensing of the medication;

(3) "schedule," used in conjunction with a controlled substance, means the relevant schedule of controlled substances under 21 U.S.C. 812 (Sec. 202, Federal Controlled Substances Act).

Dear Alaska State Medical Board,

Thank you for considering my request to expunge my record of an incident from 1997. For background, I was already licensed in NJ when I applied for my license in Alaska. I was planning to move to Barrow, AK for my first job after residency, and I was very excited about the opportunity to provide care in this underserved area. When I filled out the medical license application, there was a question asking whether I had ever been on probation during medical school. I answered no, which I believed to be true. The medical school answered yes, referring to a time during my third year of medical school when I had failed a test and was on probation until I successfully repeated it. I don't have any real recollection of this, but I was notified by letter that I was on probation, and then again by letter when I was off of probation. While the probation lasted from December to July of the next year due to my hectic schedule not allowing me time to take the test again, there were no actions regarding the probation during that time other than the letters. Third year of medical school is very hectic and difficult, and after successfully repeating the test, I moved on with my studies and didn't give it any further thought.

I sent the application form to Indiana University School of Medicine, so I saw what was on it. I had no reason to lie about such a small matter, and even if I had wanted to, I would have known that the medical school would answer in the affirmative, so there would not have been any point in trying to deceive the Medical Board. It would not even have made sense to do such a thing intentionally.

As I had previously been licensed in NJ without any problem, I was very surprised and upset to find out that I had incorrectly filled out the application.

After the issue with my AK medical license application was raised, the Dean of Indiana University School of Medicine wrote a letter on my behalf, stating that the probation was purely for tracking purposes, and there were no academic or other concerns. I apologized to the Medical Board for incorrectly filling out the application, and explained that it had been an error as I did not recall being on probation. I never had any intent to mislead the Medical Board.

The Medical Board fined me 1000 dollars and put a reprimand in the National Practitioners Data Bank stating that I had failed to disclose the probation.

This happened in 1997, right after residency. Since then I have been licensed in ten more states. I have had no further issues, and have always been very cautious when filling out applications. I have spent much of my career providing care in underserved locations including Alaska, Montana, Wisconsin, North Dakota and others. I am now working in Addiction Medicine fighting the opioid crisis.

I am respectfully requesting that this reprimand be expunged from my record. I now live in NJ, which participates in the Interstate Medical License Compact. Because of this citation, I am not eligible to participate in the Compact, which impacts my ability to get licenses in a timely manner to work in different states. I have dealt with having this on my record for almost thirty years, which has been inconvenient and embarrassing, but it is now impacting my livelihood. I hope you agree that accidentally checking the wrong box should not prevent me from being able to participate in the IMLC.

Thank you kindly for your time and consideration.

Sincerely,

Ardis Fisch MD
8/6/2025

ARDIS FISCH LICENSE ACTION DOCUMENTS

SEP 1 ? 1997

	YES	NO
21. Have you ever been charged or convicted of a violation of a law, statute, or regulation of the United States, Canada, or Mexico, excluding minor traffic violations?	☐	☒
22. Have you ever been charged with or convicted of a violation of any United States, Canadian, or Mexican narcotics or controlled substances laws?	☐	☒
23. During your medical school education, were you ever placed on probation, suspended, restricted, or otherwise disciplined for any reason?	☐	☒
24. Have you ever been under investigation or disciplined by military authorities or any hospital, medical school, or internship or residency program relating to the practice of medicine (including been placed on probation, received a letter of reprimand, censured, etc.)?	☐	☒
25. Have you ever had hospital privileges revoked, conditioned, restricted, or had any disciplinary action regarding your privileges (with the exception of temporary suspension pending completion of medical records)?	☐	☒
26. Have you ever applied for and been denied a DEA Registration Number?	☐	☒
27. Have you ever surrendered your DEA Registration Number?	☐	☒
28. Have you ever been convicted of a violation of any federal or state narcotic laws?	☐	☒
29. Have you ever had any malpractice settlements or judgements paid on your behalf?	☐	☒

PERSONAL HISTORY

30. Within the five years immediately preceding your completion and submission of this application for licensure, have you been diagnosed with, or treated for, or had problems related to emotional or mental illness, drug addiction or alcoholism?	☐	☒

If you answer "YES" to the above question, please provide detailed information including the names, addresses, and telephone numbers of any counselors, therapists, or other providers from whom you sought treatment.

MEDICAL WORK HISTORY

31. Please include all medical work history since graduation from medical school. (You may enclose a C.V. as long as all information required is included.)

Dates	Name and Address	Privileges/Scope of Practice
6/94 - 6/97	Hunterdon Med Center 2100 Wescott Dr Flemington	Residency
- 5/97	K. Stafford, Cornerstone Family Practice 1 Wescott Dr Flemington	Moonlighting, Part time Physician

(Use additional sheets if necessary)

08-4105 (Rev. 11/96)

EXHIBIT A

OCT-06-2006 FRI 01:18 PM OCC LIC STATION B FAX NO. 907 465 2489 P. 10

MD/DO

State of Alaska
Department of Commerce and Economic Development
Division of Occupational Licensing
State Medical Board
333 Willoughby Avenue, Ninth Floor
P.O. Box 110806, Juneau, Alaska 99811-0806
(907) 465-2541

RECEIVED
AUG 05 1997
DIVISION OF
OCCUPATIONAL LICENSING
JUNEAU

FOR OFFICE USE ONLY
DATE
STUDENT AFFAIRS
JUL 15 1997
MEDICINE 1

I am applying for a license to practice medicine and surgery in the State of Alaska. The State Medical Board requires independent verification of my completion of medical school and receipt of medical school diploma. Please complete this form and return it directly to the address above. Please consider my signature below as authorization to honor such request. Thank you for your assistance.

RE: Name ARDIS FISCH (M.D./D.O.)

Maiden Name or Other Names Used N/A

Date of Birth 8/22/67 Social Security Number _____
(Optional, but requested for identification purposes only.)

Signature of Physician/Applicant

PLEASE DO NOT DETACH

(Below to be completed by MD/DO school)

Medical School Indiana University School of Medicine

Exact Date on Medical School Diploma May 15, 1994

During his/her medical school education, was he/she ever placed on probation, suspended, restricted, or otherwise disciplined for any reason? ☒ Yes ☐ No

If yes, please explain Placed on academic probation due to a Deferred mark in Surgery clerkship and required to complete additional study in Surgery Clerkship; this was sucessfully completed and was removed from academic probation on 7/12/93

During his/her medical school education, was he/she ever under investigation or disciplined for any reason related to the practice of medicine? (Such discipline includes having been placed on probation, issued a letter of reprimand, censured, etc.) ☐ Yes ☒ No

If yes, please give nature and length of probation: _____

Signed: Ann W. Richmond
Ann W. Richmond, Ph.D.
Title: Associate Dean
Program: School of Medicine
Date: July 28, 1997

SEAL
(if applicable)

EXHIBIT B

10/9/97

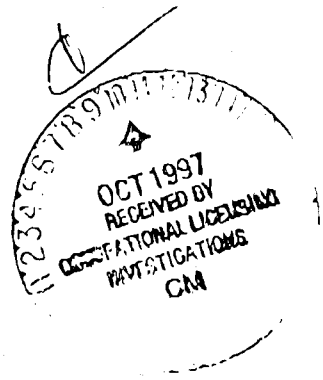
08-4105 i (Rev. 11/96)

OCT-06-2006 FRI 01:19 PM OCC LIC STATION B FAX NO. 907 465 2489 P. 11

INDIANA UNIVERSITY

SCHOOL OF MEDICINE

October 10, 1997



Collin Matthews
Investigator, State Medical Board
3601 C Street, Suite 722
Anchorage, Alaska 99503-5986

REF: Ardis Fisch, M.D.

Dear Mr. Matthews:

This is in response to your letter dated September (October) 10, 1997 concerning Ardis Fisch, M.D. who graduated from Indiana University School of Medicine in 1994.

Enclosed is a letter dated December 15, 1992 in which Ardis Fisch was placed on academic probation because of a deferred mark (DF) in the third year junior clerkship. Also enclosed is a letter dated July 13, 1993 in which she was removed from academic probation for satisfactorily completing the additional study. This process is not punitive but an internal method of monitoring students completion of required objectives.

Dr. Fisch was an excellent student who did very good work and completed the M.D. degree without any concerns or issues pending. I strongly recommend licensing.

Sincerely,

Fred L. Ficklin

Fred L. Ficklin, Ed.D.
Assistant Dean

FLF:slk

enc.

cc: Dr. Fisch

OFFICE OF THE DEAN

STUDENT AND CURRICULAR AFFAIRS

John D. VanNuys Medical Science Building 162
635 Barnhill Drive
Indianapolis, Indiana 46202-5120

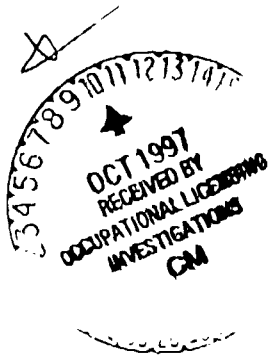
317-274- 1965
Fax: 317-274-4309

EXHIBIT C

(123)

INDIANA UNIVERSITY | Student Promotions Committee

SCHOOL OF MEDICINE



December 15, 1992

Ardis B. Fisch
4141 Meander Bend, Apt. 3B
Indianapolis, Indiana 46268

Dear Ms. Fisch:

The Student Promotions Committee of the Indiana University School of Medicine met on December 14, 1992 and reviewed your academic record.

It was noted that you received a Deferred (DF) mark in the Surgery clerkship which you completed on October 5, 1992. This constitutes your first academic deficiency. After discussing your record, it was voted to place you on academic probation and require that you follow your instructor's recommendation as stated on your evaluation form as soon as possible. Your grade will be determined after you have completed this requirement and you will be removed from probation after satisfactory completion.

Should you have any questions about the Committee action, please feel free to contact Dr. James E. Carter, Associate Dean for Student and Curricular Affairs, in the Medical Science Building, Room 164 (phone 274-7175), or Dr. Fred L. Ficklin, Assistant Dean and Secretary to the Committee, in the Medical Science Building, Room 164 (phone 274-7806).

Sincerely,

L. R. Willis, Ph.D.
Professor of Pharmacology & Medicine
Chairman, Student Promotions Committee

FLF:pm

cc: Dr. Carter
Student File
Student Promotions Committee File

EXHIBIT C

(263)

INDIANA UNIVERSITY

SCHOOL OF MEDICINE

July 13, 1993

Ardis B. Fisch
4141 Meander Bend, #3B
Indianapolis, IN 46268

Dear Ms. Fisch:

The Student Promotions Committee of the Indiana University School of Medicine met on July 12, 1993 and reviewed your academic record.

It was noted that you have satisfactorily completed the additional study in Surgery Clerkship as required. It was voted to remove you from this academic probation and the Committee also wishes you continued success in your medical education.

Should you have any questions about the Committee action, please feel free to contact Dr. James E. Carter, Associate Dean for Student and Curricular Affairs, in the Medical Science Building, Room 164 (phone 274-7175), or Dr. Fred L. Ficklin, Assistant Dean and Secretary to the Committee, in the Medical Science Building, Room 162 (phone 274-7806).

Sincerely,

L. R. Willis, Ph.D.
Professor of Pharmacology & Medicine
Chairman, Student Promotions Committee

FLF:bp

cc: Dr. Carter
Student File
Student Promotions Committee File

STUDENT PROMOTIONS COMMITTEE

John D. VanNuys Medical Science Building 162
635 Barnhill Drive
Indianapolis, Indiana
46202-5120

317-274-7806
Fax: 317-274-4309

EXHIBIT C

(383)

STATE OF ALASKA

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

BEFORE THE STATE MEDICAL BOARD

In the Matter of:)
)
Ardis B. Fisch, M.D.)
)
Respondent)

Case No: 2850-97-16

MEMORANDUM OF AGREEMENT

IT IS HEREBY AGREED by the Department of Commerce and Economic Development, Division of Occupational Licensing (Division) and Ardis B. Fisch, M.D.

1. Licensure. Fisch does not presently hold a license to practice medicine in Alaska, however, she has applied for a permanent license.

2. Admission/Jurisdiction. Fisch admits and agrees that the Medical Board has jurisdiction over the subject matter of her license and over this agreement.

3. Facts/Allegations/Admissions.

a. Fisch submitted an application for Alaska licensure which was received by the Division of Occupational Licensing (Division), Department of Commerce & Economic Development, State of Alaska, on September 19, 1997.

b. that Fisch, in response to Question 23, which asks, "During your medical school education, were you ever placed on probation, suspended, restricted, or otherwise disciplined for any reason?" answered No by checking the NO block on the application. See Exhibit A.

STATE OF ALASKA
DIVISION OF OCCUPATIONAL LICENSING
3601 C STREET, ANCHORAGE, ALASKA 99503
907-269-8160 907-269-8156

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c that on August 5, 1997, in response to a routine inquiry, the Division received written information stating that Fisch had been placed on academic probation during the period December 15, 1992 to July 12, 1993, while she was attending Indiana University School of Medicine, Indianapolis, Indiana. See Exhibit B.

d. that on October 10, 1997, additional written information was received substantiating that Fisch was notified by letter dated December 15, 1992, that she had been placed on probation, and that she was notified by letter dated July 13, 1993, that she had been removed from academic probation. See Exhibit C.

e. that Fisch's answer to Question #23 on her Alaska application for licensure was false.

f. that Fisch denies she intentionally provided a false answer, and that it is her contention she had forgotten about the probationary period.

g. Fisch admits that as a result of the above facts, grounds exist for possible denial of her medical license application for a permanent licensed pursuant to AS 08.01.175 and 08.64.326(a)(1) and (8) (c).

4. Formal Hearing Process. It is the intent of the parties to this Memorandum of Agreement to provide for the compromise and settlement of all issues which could be raised by a Statement of Issues to deny licensure through a formal hearing process.

5. Waiver of Rights. Fisch agrees that she has the right to consult with an attorney of her own choosing and that she has the right to an administrative hearing on the facts of this case. She understands and agrees that by signing this Memorandum of Agreement, she is waiving her rights to a hearing. Further, she understands and agrees that she is relieving the Division of any burden it has of proving the allegations. Fisch further understands and agrees that by signing this Memorandum of Agreement she is voluntarily and knowingly giving up her rights to present oral and documentary evidence, to present rebuttal evidence, to cross-examine witnesses against her, and to appear the Board's decision to Superior Court.

MEMORANDUM OF AGREEMENT
Ardis B. Fisch

STATE OF ALASKA
DIVISION OF OCCUPATIONAL LICENSING
3601 C STREET, ANCHORAGE, ALASKA 99503
907-269-8160 907-269-8156

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6. Effect of Not Acceptance of Agreement. Fisch and the Division agree that this Memorandum of Agreement is subject to the approval of the Board. they agree that if the Board rejects the agreement, it will be void, and a Statement of Issues may be filed. If this agreement is rejected by the Board it will not constitute a waiver of Fisch's right to a hearing on the matters alleged in a Statement of Issues and any admissions contained herein will have no effect. Fisch agrees that, if the Board rejects this agreement, the Board may decide the matter after a hearing, and its consideration of this agreement alone shall not be grounds for claiming that the Board is biased against her, that it cannot fairly decide the case, or that it has received ex parte communication.

7. Memorandum of Agreement, Decision and Order. Fisch agrees that the Board has the authority to enter into this Memorandum of Agreement and to issue the following Decision and Order.

PROPOSED DECISION AND ORDER

IT IS HEREBY ORDERED that upon adoption of this agreement by the Board, and provided that Fisch has met all other licensing requirements, Fisch will be issued a permanent license to practice medicine in Alaska. The license will be unrestricted.

A. Reprimand

The Board issues the following reprimand to Fisch:

Question #23 on the Alaska State Medical Board application for licensure as a Medical Doctor asks whether the applicant was "placed on probation" during their medical school education. Dr. Fisch answered the question by marking the "NO" response. While participating in a "Surgery clerkship" at the Indiana University School of Medicine, Fisch was placed on probation during the period December 15, 1992 to July 12, 1993. Dr. Fisch was notified in writing of the fact she was placed on probation, and was again notified that she had been removed from academic probation. Dr. Fisch contends she did not intend to deceive either the Board or the State of Alaska when she responded with a NO answer, but that she had forgotten about the matter.

STATE OF ALASKA
DIVISION OF OCCUPATIONAL LICENSING
3601 C STREET, ANCHORAGE, ALASKA 99503
907-269-8160 907-269-8156

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The integrity of the medical licensing process relies heavily on the veracity of the applicant, and the Board wants applicants to be candid in their responses to the application questions. Accordingly , you are hereby publicly reprimanded because you did not disclose your temporary academic probation in response to Question #23.

B. Civil Fine

Fisch shall pay a civil fine of $1000.00 within ninety days of the date of the issuance of her permanent license. The fine shall be paid in the form of cashier's check or personal check made payable to The State of Alaska. The fine shall be sent to Investigator Colin Matthews, State Medical Board, 3601 C Street, Suite 722, Anchorage, Alaska 99503.

C. Violation of Agreement

If Fisch fails to comply with any term or condition of this agreement, her license will automatically be suspended. If her license is automatically suspended under this paragraph, she will be entitled to a hearing within seven (7) days.

D. IT IS HEREBY FURTHER ORDERED that this order shall take effect immediately upon its adoption by the Board and is a public record of the Board and the State of Alaska. The State may provide a copy of it to any person or entity making a relevant inquiry. If Fisch fails to comply with any term or condition of this agreement, her license shall be automatically suspended. If her license is automatically suspended under this paragraph, she shall be entitled to a hearing within seven (7) days.

E. Address of the Board

All communications concerning this Memorandum of Agreement should be sent to :

Colin Matthews
Investigator/Discipline Monitor
3601 "C" Street, Suite 722
Anchorage, Alaska 99503
Phone (907) 269-8179
Fax (907) 269-8156

STATE OF ALASKA
DIVISION OF OCCUPATIONAL LICENSING
3601 C STREET, ANCHORAGE, ALASKA 99503
907-269-8163 907-269-8156

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IT IS HEREBY FURTHER ORDERED that this Order is a public record of the Board and the State of Alaska.

DATED this 5TH day of November, 1997, at Anchorage Alaska.

Jeffrey W. Bush,
~~WILLIAM L. HENSLEY~~,
A\ COMMISSIONER
DEPARTMENT OF COMMERCE
AND ECONOMIC DEVELOPMENT

Gary J. Veres, Chief Investigator
Catherine Reardon, Director
Division of Occupational Licensing

I, Ardis B. Fisch, have read this Memorandum of Agreement, understand it, and agree to be bound by its terms and conditions.

DATE 11/4/97 Ardis B. Fisch

SUBSCRIBED AND SWORN TO before me this 4th day of November 1997, at Oakland, New Jersey.

Barbara A. Hegranes
Notary Public in and for Passaic City

My commission expires:

BARBARA A. HEGRANES
Notary Public of New Jersey
My Commission Expires June 5, 2002

STATE OF ALASKA
DIVISION OF OCCUPATIONAL LICENSING
3601 C STREET ANCHORAGE, ALASKA 99503
907-269-8150 907-269-8156

OCT-06-2006 FRI 01:18 PM OCC LIC STATION B FAX NO. 907 465 2489 P. 08

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF OCCUPATIONAL LICENSING

STATE MEDICAL BOARD

In the Matter of)
)
Ardis B. Fisch, MD)
)
Respondent)

Case No. 2850-97-16

ORDER

The Alaska State Medical Board, hereby adopts and accepts in its entirety the Memorandum of Agreement with Ardis B. Fisch, MD, which imposes a reprimand and civil fine on Dr. Fisch. This disciplinary action is taken for Dr. Fisch's failure to disclose information on her application for a license to practice medicine in Alaska.

The board further agrees to grant to Dr. Fisch an unrestricted license to practice medicine as a physician in Alaska with the impositon of this disciplinary action.

DATED this 6th day of February, 1998, at Juneau, Alaska.

ALASKA STATE MEDICAL BOARD

By _____
Sarah A. Isto, MD, Chair

STATE OF ALASKA
DIVISION OF OCCUPATIONAL LICENSING
3601 C STREET, ANCHORAGE, ALASKA 99503
907-269-8160 907-269-8155

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STATE OF ALASKA

DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT

DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING

BEFORE THE STATE MEDICAL BOARD

In the Matter of:)
)
Ardis B. Fisch, M.D.)
)
Respondent)
Case No. 2850-97-16

ORDER

The Medical Board for the State of Alaska, having reconsidered the facts in Case number 2850-97-16, hereby rescinds the public reprimand and expunges the 1997 disciplinary action from Alaska's licensing database in this matter.

This Order takes effect immediately upon signature of this Order in accordance with the approval of the Board.

DATED this __22__ day of August, 2025, at _____, Alaska.

ALASKA STATE MEDICAL BOARD

By: _____
Brent Taylor, M.D.
Board Chair

State of Alaska
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
550 West 7th Avenue, Suite 1500
Anchorage, Alaska 99501-3567
Telephone 907-269-8160 Fax 907-269-8195