Board Members:

Brent Taylor, MD
(Chair)

David Barnes, DO

Michael McNamara, MD

David Paulson, MD

David Wilson
Public Member

Upcoming Meetings:

Feb. 20, 8:30 a.m.
March 19, 4:00 p.m.
April 16, 4:00 p.m.

ALASKA STATE MEDICAL BOARD

MONTHLY MEETING

THURSDAY, JANUARY 15, 2026

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/ZVzhXqWMS4qMSpaTtagffA

Agenda

4:00 p.m. 1. Call to Order/Roll Call

4:03 p.m. 2. Review/Approval of Agenda

4:05 p.m. 3. Ethics Disclosure

4:10 p.m. 4. Deliberative Case
- a. OAH No. 25-0010-MED, K.L.

4:30 p.m. 5. Interviews
- a. Gamil Makar, MD
- b. Christopher Melcher, PA

5:00 p.m. 6. Division Update – Director Sylvan Robb
- a. Administrative Order 360
- b. Legal opinion on expungement matters
- c. Budget Update

5:30 p.m. 7. New Business
- a. List of proposed regulation changes -compliance with AO 360

5:45 p.m. 8. Wrap up / Adjourn

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Commerce, Community, and Economic Development

DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING
Juneau Office

P.O. Box 110806
Juneau, Alaska 99811-0806
Main: 907.465.2550
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MEMORANDUM

TO: Members of Professional Licensing Boards DATE: October 7, 2025

FROM: Sylvan Robb, Director RE: Administrative Order 360

I am providing additional information to clarify the purpose and expectations of Administrative Order 360, which was issued by Governor Dunleavy on August 4, 2025, to improve the quality, transparency, and efficiency of the State's regulatory environment. The full language of AO 360 can be found at https://gov.alaska.gov/admin-orders/administrative-order-no-360/.

There are several goals associated with this Administrative Order, but I'd like to highlight #3: "Ensure boards and commissions adjust regulatory structures as necessary to maintain critical consumer protection while eliminating unnecessary barriers to entry for new professionals." This goal highlights that all state boards are critical components to accomplishing the purpose of this initiative.

The *division* is responsible for providing key deliverables throughout this project:

1. **Hold stakeholder meetings:** These meetings invite members of the public to provide suggestions on regulations that they feel can be removed or improved. The division has scheduled stakeholder meetings with corresponding windows for receiving written comments. Input from stakeholders is vitally important in the development of the boards' regulatory reform plans this winter.

   These meetings are different than oral testimony on proposed regulations, so boards themselves are not holding these meetings. However, members are welcome to attend and listen.

   We have organized the meetings as follows:

   - Health care professions: Thursday, October 9th, 9:00 - 11:00 a.m.; Monday, October 27th, 6:00 - 8:00 p.m., Wednesday, October 29th, 11:30 a.m. - 1:30 p.m.
   - Non-health care professions: Thursday, October 9th, 9:00 - 11:00 a.m.; Monday, October 27th, 6:00 - 8:00 p.m., Wednesday, October 29th, 11:30 a.m. - 1:30 p.m.

2. **Review guidance documents:** Documents—such as PDFs and web pages—providing guidance on regulatory requirements will be published in the Online Public Notice System (OPN) and moved forward for review by the Department of Law. Guidance documents are intended to *explain* requirements contained in statutes or regulations or to provide background information. This includes forms, checklists, applications, FAQs, board opinions, and other types of information relating to the public process. The legal review will ensure no existing or new documents contain guidance that should

actually be promulgated as a regulation. Once legal reviews are completed next spring, the division and its boards may need to address any changes.

3. **Establish a baseline of current regulatory requirements:** Using statewide guidance, staff are currently reviewing regulations and determining what constitutes a regulatory requirement using the guidance provided by the Department of Law. All requirements are counted and identified as "mandatory"— required by federal, statutory, or court-ordered mandates—or "discretionary"—those that the board has the ability to evaluate, interpret, and adopt. Discretionary requirements with room for improvement in quality, transparency, and efficiency will be identified by staff and moved forward for each board to consider including it its regulatory reform plan.

Individual professional licensing *boards* are responsible for implementing the deliverables of AO 360 now through 2027. Meeting these deadlines set by the Office of the Governor will require boards to either hold additional meetings or significantly expand their agendas:

1. **Review public and staff recommendations for regulatory reform (starting in November):** Individual boards will review the input received from the public and additional changes recommended by staff. This is the opportunity to jump start any pending board regulations changes or plans that have been put "on the back burner."

2. **Develop a regulatory reform plan (due in February):** Design and approve a plan to reduce specific regulatory requirements by 15% in calendar year 2026, culminating in a total reduction of 25% by the end of calendar year 2027. This plan must be completed and provided to me by February 13. I will submit it to the department to be included as part of the department's overall plan. After the Office of the Governor has reviewed and approved the proposed plan, it will be posted on OPN. At that point, any regulation change included in the board's plan has the green light to move forward through the usual regulations adoption process. (No additional waiver is required.)

To summarize, AO 360 requires the division to review regulations, count the number of requirements, determine which are discretionary, and make a recommendation to each board so it can approve a regulatory reform plan. It does not diminish the authority of the board to propose and adopt regulations concerning their industry. The Office of the Governor encourages each board and agency to focus on the end goals of regulatory transparency and efficiency rather than becoming overly concerned about the specific deliverables along the way. All departments of state government are encouraged to use this structured opportunity to work with their stakeholders and think deeply about ways to best serve the public through this initiative.

As required by the initiative, Sara Chambers has been designated by Commissioner Sande as our department's Agency Regulatory Liaison, providing training and guidance, as well as serving as the point of contact with the Office of the Governor and the Department of Law for all divisions and corporate agencies within the DCCED umbrella. She is assisting us in seeking modifications to the statewide schedule of deadlines, as long as we are making progress toward the Governor's goal.

Timelines and guidance are fast-moving and subject to change. The key deadlines the board should know are:

- **Informational sessions for board members to hear details and ask questions:**
    - Monday, October 13 at 12:00 p.m.
    - Meeting ID: 219 918 166 590
    - Passcode: Hm2TC2ad

    - Thursday, October 16 at 11:00 a.m.
    - Meeting ID: 248 100 560 125 1

    - Passcode: 3tf2oH7t

    - Monday, October 20 at 1:00 p.m.
    - Meeting ID: 289 987 973 913 6
    - Passcode: hh2pX6aD
- **Stakeholder meetings** are scheduled for the month of October—see above.
- **Your proposed regulatory reform plan** is due by February 13.

Your board liaison will work with your chair to schedule the meetings necessary for you to review public and staff recommendations, discuss merits and potential changes, and ultimately adopt your reform plan. If you have questions or concerns, please attend one of the informational sessions or reach out to me so I can provide you with timely responses.

Sincerely,

Sylvan Robb
Director

From:	Campbell, Karmen L (CED)
To:	Norberg, Natalie M (CED)
Cc:	Saviers, Glenn A (CED); Robb, Sylvan S (CED)
Subject:	MED - AO360 Requirements
Date:	Friday, October 31, 2025 9:33:59 AM
Attachments:	image001.png AO360 Medical Statutes and Regs.pdf Medical Board Adopted by Reference Discretionary Requirements.docx

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Good morning,

Please see your program's attached AO 360 regulations requirements and adopted by reference requirement tracker.

Glenn is going to try and review all the boarded programs to share some suggestions; she will share that once she finished reviewing MED's regulations. Given the tight timeline for the board to determine what items it can eliminate and streamline, Sylvan noted that you should not wait for Glenn's feedback to get your board working on looking for their reductions.

The baseline number of requirements for MED is 1,224. 359 of these requirements are from the regulations, and 865 requirements are from documents adopted by reference in the regulations. The 25% target is against the 1,224 number.

Please let me know if you have any questions.

Best regards,

Karmen Campbell
Director's Assistant
Division of Corporations, Business, and Professional Licensing
https://www.commerce.alaska.gov/web/cbpl

Medical Board Adopted by Reference Discretionary Requirements:

Documents Adopted by Reference	# of Discretionary Requirements
Practice Bulletin, Number 135, June 2013, Second-Trimester Abortion, Reaffirmed 2017	59
MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE	53
Code of Ethics – American Medical Association 2016	525
Code of Ethics – American Osteopathic Association 2016	33
Code of Ethics - American Podiatric Medical Association 2017	110
Guidelines for Ethical Conduct for the Physician Assistant Profession 2013	85
Total:	**865**

Practice Bulletin, Number 135, June 2013, Second-Trimester Abortion, Reaffirmed 2017: 59

Requirement Count Summary

Here is a breakdown of the discrete regulatory-style requirements found in the document:

Section	Requirement Examples	Count
Clinical Recommendations	Cervical preparation before D&E, antibiotic prophylaxis, uterotonic use, referral facilitation, etc.	18
Box 1: Medical Abortion Regimens	Specific drug dosages and timing protocols	9
Postabortion Hemorrhage Management	Primary, secondary, tertiary treatment steps	10

Section	Requirement Examples	Count
Complication Prevention	Use of vasopressin, cervical dilation protocols, training recommendations	6
Contraceptive Guidance	Immediate IUD insertion, method eligibility	4
Summary Recommendations (Level A, B, C)	Reiterated clinical directives	12

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE: 53

Requirement Count Summary

Section	Requirement Examples	Count
Preamble & Expectations	Maintain professionalism, supervise non-physicians, protect confidentiality	5
Establishing Physician–Patient Relationship	Verify patient identity, disclose provider credentials, obtain consent	6
Licensure	Must be licensed in the patient's state	1
Evaluation & Treatment	Must conduct evaluation before treatment or prescribing	3
Informed Consent	Must obtain and document informed consent with specific elements	7

Section	Requirement Examples	Count
Continuity of Care	Must provide follow-up access and documentation	2
Emergency Services	Must provide an emergency plan and protocol	2
Medical Records	Must maintain and document all telemedicine-related records	3
Privacy & Security	Must comply with HIPAA, maintain policies, ensure secure transmission	6
Online Disclosures	Must disclose services, fees, credentials, privacy practices, etc.	10
Patient Rights	Must allow access, feedback, and complaint mechanisms	3

Code of Ethics – American Medical Association 2016: 525

Requirement Count Summary

Section	Topic Area	Approx. Count
Chapter 1	Patient–Physician Relationships	85
Chapter 2	Consent, Communication & Decision Making	70
Chapter 3	Privacy, Confidentiality, Medical Records	25

Section	Topic Area	Approx. Count
Chapter 4	Genetics & Reproductive Medicine	30
Chapter 5	End-of-Life Care	20
Chapter 6	Organ Procurement & Transplantation	15
Chapter 7	Research & Innovation	90
Chapter 8	Physicians & Public Health	65
Chapter 9	Professional Self-Regulation	40
Chapter 10	Interprofessional Relationships	35
Chapter 11	Financing & Delivery of Health Care	50

Code of Ethics – American Osteopathic Association 2016: 33

Requirement Count Summary

The AOA Code of Ethics includes 19 numbered sections, each containing at least one requirement. Some sections contain multiple discrete requirements. Here's a breakdown:

Section	Topic	Requirement Count
1–2	Confidentiality, Disclosure	2
3	Non-discrimination, Emergency Care	3
4	Abandonment	2

Section	Topic	Requirement Count
5	Competence, Continuing Education	2
6	Professional Self-Regulation	2
7	Advertising	2
8	Credentials, Representation	3
9	Consultation	1
10–11	Disputes Among Physicians	2
12	Fees, Fee Splitting	2
13	Respect for Law	2
14	Community Participation	1
15–16	Sexual Misconduct, Harassment	2
17	Gifts from Industry	3
18	Misrepresentation	1
19	Research Ethics	2

Code of Ethics - American Podiatric Medical Association 2017: 110

Requirement Count Summary

The APMA Code of Ethics is structured into three main categories:

- Medical Ethics (ME)
- Business Ethics (BE)
- Association Ethics (AE)

Each category contains multiple subsections with specific obligations. Here's the breakdown:

Section	Topic Area	Approx. Count
ME1–ME7	Professional judgment, informed consent, confidentiality, patient respect, professionalism, physician health, research ethics	45
BE1–BE7	Advertising, business transactions, referrals, supervision, legal compliance, staff respect, managed care	55
AE1–AE4	Conflicts of interest, confidentiality, commercial relationships, association conduct	10

Guidelines for Ethical Conduct for the Physician Assistant Profession 2013: 85

Requirement Count Summary

The document is organized into five major sections, each containing multiple ethical obligations:

Section	Topic Area	Approx. Count
The PA and the Patient	Role, consent, confidentiality, end-of-life, diversity, reproductive care	40
The PA and Individual Professionalism	Conflicts of interest, competency, harassment, identity	15

Section	Topic Area	Approx. Count
The PA and Other Professionals	Teamwork, impairment, supervision, illegal conduct	10
The PA and the Health Care System	Research, education, expert witness, workplace actions	10
The PA and Society	Lawfulness, executions, access to care, community well-being	10

Statutes and Regulations
Medical

April 2025

3767

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DEPARTMENT OF COMMERCE, COMMUNITY,
AND ECONOMIC DEVELOPMENT

DIVISION OF CORPORATIONS, BUSINESS
AND PROFESSIONAL LICENSING

Rev. 4/04/2025

(b) The board may not impose disciplinary sanctions on a physician or physician assistant for prescribing, dispensing, or administering a prescription drug that is a controlled substance if the requirements under (a) of this section and AS 08.64.363 are met.

(c) Notwithstanding (a) and (b) of this section,

(1) a physician may not prescribe, dispense, or administer an abortion-inducing drug under (a) of this section unless the physician complies with AS 18.16.010; and

(2) a physician or physician assistant may not prescribe, dispense, or administer a prescription drug in response to an Internet questionnaire or electronic mail message to a person with whom the physician or physician assistant does not have a prior physician-patient relationship.

(d) In this section,

(1) "controlled substance" has the meaning given in AS 11.71.900;

(2) "prescription drug" has the meaning given in AS 08.80.480;

(3) "primary care provider" has the meaning given in AS 21.07.250.

Sec. 08.64.366. Liability for services rendered by a mobile intensive care paramedic. *[Repealed, Sec. 18 ch 29 SLA 2021.]*

Sec. 08.64.367. Use of amygdalin (laetrile); investigational drugs, biological products, or devices. (a) A physician may not be subject to disciplinary action by the board for prescribing or administering amygdalin (laetrile) to a patient under the physician's care who has requested the substance unless the board in a hearing conducted under AS 44.62 (Administrative Procedure Act) has made a formal finding that the substance is harmful.

(b) A hospital or health facility may not interfere with the physician-patient relationship by restricting or forbidding the use of amygdalin (laetrile) when prescribed or administered by a physician and requested by a patient unless the substance as prescribed or administered by the physician is found to be harmful by the board in a hearing conducted under the provisions of AS 44.62 (Administrative Procedure Act).

(c) A physician may not be subject to disciplinary action by the board for prescribing, dispensing, or administering an investigational drug, biological product, or device, or providing related treatment, to a patient for the purpose of sustaining the patient's life if the patient

(1) has a terminal illness;

(2) is ineligible or unable to participate in a current clinical trial for the investigational drug, biological product, or device;

(3) has considered, after consultation with the physician, all other treatment options currently approved by the United States Food and Drug Administration; and

(4) has given informed consent in writing for the use of the investigational drug, biological product, or device.

(d) In this section,

(1) "investigational drug, biological product, or device" means a drug, biological product, or device that has successfully completed Phase 1 studies of clinical trials for investigation and remains in ongoing clinical trials under Phase 2 or Phase 3 or is in the new drug application process following Phase 3 of clinical trials, but has not been approved for general use the United States Food and Drug Administration;

(2) "terminal illness" means a disease, that, without life-sustaining procedures, will result in death in the near future or a state of permanent unconsciousness from which recovery is unlikely.

Sec. 08.64.369. Health care professional to report certain injuries. (a) A health care professional who initially treats or attends to a person with an injury described in (b) of this section shall make certain that an oral report of the injury is made promptly to the Department of Public Safety, a local law enforcement agency, or a village public safety officer. The health care professional shall make certain that a written report of an injury described in (b)(1) or (2) of this section is submitted to the Department of Public Safety within three working days after the person is treated. The report shall be on a form provided by the Department of Public Safety.

(b) The following injuries shall be reported under (a) of this section:

(1) second or third degree burns to five percent or more of a patient's body;

(2) a burn to a patient's upper respiratory tract or laryngeal edema due to the inhalation of super-heated air;

(3) a bullet wound, powder burn, or other injury apparently caused by the discharge of a firearm;

(4) an injury apparently caused by a knife, axe, or other sharp or pointed instrument, unless the injury was clearly accidental; and

(5) an injury that is likely to cause the death of the patient, unless the injury was clearly accidental.

(c) person who, in good faith, makes a report under this section, or who participates in judicial proceedings related to a report under this section, is immune from any civil or criminal liability that might otherwise be incurred as a result of making such a report or participating in the judicial proceedings.

(d) In this section, "health care professional" includes an emergency medical technician certified under AS 18.08, health aide, physician, nurse, mobile intensive care paramedic licensed under AS 18.08, and physician assistant, but does not include a practitioner of religious healing.

Sec. 08.64.360. Penalty for practicing without a license or in violation of law. Except for a physician assistant or a person licensed or authorized under another law of the state who engages in practices for which that person is licensed or authorized under that law, a person practicing medicine or osteopathy in the state without a valid license or permit is guilty of a class A misdemeanor. Each day of illegal practice is a separate offense.

Sec. 08.64.362. Limitation of liability. An action may not be brought against a person for damages resulting from a report made in good faith to a public agency by the person or participation by the person in an investigation by a public agency or an administrative or judicial proceeding relating to the report if the report relates to a person licensed under this chapter.

Sec. 08.64.363. Maximum dosage for opioid prescriptions. (a) A licensee may not issue

(1) an initial prescription for an opioid that exceeds a seven-day supply to an adult patient for outpatient use;

(2) a prescription for an opioid that exceeds a seven-day supply to a minor; at the time a licensee writes a prescription for an opioid for a minor, the licensee shall discuss with the parent or guardian of the minor why the prescription is necessary and the risks associated with opioid use.

(b) Notwithstanding (a) of this section, a licensee may issue a prescription for an opioid that exceeds a seven-day supply to an adult or minor patient if, in the professional medical judgment of the licensee, more than a seven-day supply of an opioid is necessary for

(1) the patient's acute medical condition, chronic pain management, pain associated with cancer, or pain experienced while the patient is in palliative care; the licensee may write a prescription for an opioid for the quantity needed to treat the patient's medical condition, chronic pain, pain associated with cancer, or pain experienced while the patient is in palliative care; the licensee shall document in the patient's medical record the condition triggering the prescription of an opioid in a quantity that exceeds a seven-day supply and indicate that a nonopioid alternative was not appropriate to address the medical condition;

(2) a patient who is unable to access a practitioner within the time necessary for a refill of the seven-day supply because of a logistical or travel barrier; the licensee may write a prescription for an opioid for the quantity needed to treat the patient for the time that the patient is unable to access a practitioner; the licensee shall document in the patient's medical record the reason for the prescription of an opioid in a quantity that exceeds a seven-day supply and indicate that a nonopioid alternative was not appropriate to address the medical condition; in this paragraph, "practitioner" has the meaning given in AS 11.71.900; or

(3) the treatment of a patient's substance abuse or opioid dependence; the licensee may write a prescription for an opioid approved for the treatment of substance abuse or opioid dependence for the quantity needed to treat the patient's substance abuse or opioid dependence; the licensee shall document in the patient's medical record the reason for the prescription of an opioid approved for the treatment of substance abuse or opioid dependence in a quantity that exceeds a seven-day supply and indicate that a nonopioid alternative was not appropriate for the treatment of substance abuse or opioid dependence.

(c) In this section,

(1) "adult" means

(A) an individual who has reached 18 years of age; or

(B) an emancipated minor;

(2) "emancipated minor" means a minor whose disabilities have been removed for general purposes under AS 09.55.590;

(3) "minor" means an individual under 18 years of age who is not an emancipated minor.

ARTICLE 3.
MISCELLANEOUS PROVISIONS

Section

Sec. 08.64.364. Prescription of drugs without physical examination. (a) The board may not impose disciplinary sanctions on a physician or physician assistant for rendering a diagnosis, providing treatment, or prescribing, dispensing, or administering a prescription drug that is not a controlled substance to a person without conducting a physical examination if

(1) the physician, physician assistant, or another licensed health care provider in the medical practice is available to provide follow-up care; and

(2) the physician or physician assistant requests that the person consent to sending a copy of all records of the encounter to the person's primary care provider if the prescribing physician or physician assistant is not the person's primary care provider and, if the person consents, the physician or physician assistant sends the records to the person's primary care provider.

licensee is competent to resume practice. However, a license may not be returned to the licensee if the voluntary surrender resulted in the dropping or suspension of civil or criminal charges against the physician.

Sec. 08.64.335. Reports of disciplinary action or license suspension or surrender. The board shall promptly report to the Federation of State Medical Boards for inclusion in the nationwide disciplinary data bank license and permit refusals under AS 08.64.240, actions taken by the board under AS 08.64.331, and license and permit suspensions or surrenders under AS 08.64.332 or 08.64.334.

Sec. 08.64.336. Duty of physicians and hospitals to report. (a) A physician who professionally treats a person licensed to practice medicine or osteopathy in this state for alcoholism or drug addiction, or for mental, emotional, or personality disorders, shall report it to the board if there is probable cause that the person may constitute a danger to the health and welfare of that person's patients or the public if that person continues in practice. The report must state the name and address of the person and the condition found.

(b) A hospital that revokes, suspends, conditions, restricts, or refuses to grant hospital privileges to, or imposes a consultation requirement on, a person licensed to practice medicine or osteopathy in the state shall report to the board the name and address of the person and the reasons for the action within seven working days after the action is taken. A hospital shall also report to the board the name and address of a person licensed to practice medicine or osteopathy in the state if the person resigns hospital staff privileges while under investigation by the hospital or a committee of the hospital and the investigation could result in the revocation, suspension, conditioning, or restricting of, or the refusal to grant, hospital privileges, or in the imposition of a consultation requirement. A report is required under this subsection regardless of whether the person voluntarily agrees to the action taken by the hospital. A report is not required if the sole reason for the action is the person's failure to complete hospital records in a timely manner or to attend staff or committee meetings. In this subsection "consultation requirement" means a restriction placed on a person's existing hospital privileges requiring consultation with a designated physician or group of physicians in order to continue to exercise the hospital privileges.

(c) Upon receipt of a report under (a) or (b) of this section, the board shall investigate the matter and, upon finding that there is reasonable cause to believe that the person who is the subject of the report is a danger to the health or welfare of the public or to the person's patients, the board may appoint a committee of three qualified physicians to examine the person and report its findings to the board. Notwithstanding the provisions of this subsection, the board may summarily suspend a license under AS 08.64.331(c) before appointing an examining committee or before the committee makes or reports its findings.

(d) If the board finds that a person licensed to practice medicine or osteopathy is unable to continue in practice with reasonable safety to the person's patients or to the public, the board shall initiate action to suspend, revoke, limit, or condition the person's license to the extent necessary for the protection of the person's patients and the public.

(e) A physician, hospital, hospital committee, or private professional organization contracted with under AS 08.64.101(5) to identify, confront, evaluate, and treat individuals licensed under this chapter who abuse addictive substances that in good faith submits a report under this section or participates in an investigation or judicial proceeding related to a report submitted under this section is immune from civil liability for the submission or participation.

(f) A physician or hospital may not refuse to submit a report under this section or withhold from the board or its investigators evidence related to an investigation under this section on the grounds that the report or evidence

(1) concerns a matter that was disclosed in the course of a confidential physician-patient or psychotherapist-patient relationship or during a meeting of a hospital medical staff, governing body, or committee that was exempt from the public meeting requirements of AS 44.62.310; or

(2) is required to be kept confidential under AS 18.23.030.

Sec. 08.64.338. Medical and psychiatric exams. For the purposes of an investigation under this chapter, the board may order a person to whom it has issued a license or permit to submit to a medical or psychiatric examination by a physician or other practitioner of the healing arts appointed by the board. An examination shall be at the board's expense. An examination may include the required submission of biological specimens requested by the examining physician or practitioner.

Sec. 08.64.340. Statement of grounds of refusal or revocation of license. If the board refuses to issue a license or revokes a license, it shall file a brief and concise statement of the grounds and reasons for the action in the office of the secretary of the board and in the department. The statement, together with the written decision of the board, shall remain of record in the department.

Sec. 08.64.345. Reports relating to malpractice actions and claims. A person licensed under this chapter shall report in writing to the board concerning the outcome of each medical malpractice claim or civil action in which damages have been or are to be paid by or on behalf of the licensee to the claimant or plaintiff, whether by judgment or under a settlement. This report shall be made within 30 days after resolution of the claim or termination of the civil action.

(e) The board may suspend a license upon receipt of a certified copy of evidence that a license to practice medicine in another state or territory of the United States or province of Canada has been suspended or revoked. The suspension remains in effect until a hearing can be held by the board.

(f) The board shall be consistent in the application of disciplinary sanctions. A significant departure from earlier decisions of the board involving similar situations must be explained in findings of fact or orders made by the board.

Sec. 08.64.332. Automatic suspension for mental incompetency or insanity. Notwithstanding AS 44.62, if a person holding a license to practice medicine or osteopathy under this chapter is adjudged mentally incompetent or insane by a final order or adjudication by a court of competent jurisdiction or by voluntary commitment to an institution for the treatment of mental illness, the person's license shall be suspended by the board. The suspension shall continue in effect until the court finds or adjudges that the person has been restored to reason or until a licensed psychiatrist approved by the board determines that the person has been restored to reason.

Sec. 08.64.333. Disciplinary sanctions: physician licensed in another state. (a) The board may sanction a physician licensed in another state who provides health care services through telehealth under AS 08.02.130(b) if the board finds after a hearing that

(1) one or more of the grounds listed in AS 08.64.326(a)(1) – (13) exist with respect to that physician;

(2) the physician exceeded the scope of the physician's privilege to practice in this state under AS 08.02.130; or

(3) the physician prescribed, dispensed, or administered through telehealth to a patient located in the state a controlled substance listed in AS 11.71.140 – 11.71.190.

(b) If the board finds grounds to sanction a physician under (a) of this section, the board may

(1) permanently prohibit the physician from practicing in the state;

(2) prohibit the physician from practicing in the state for a determinate period;

(3) censure the physician;

(4) issue a letter of reprimand to the physician;

(5) place the physician on probationary status under (d) of this section;

(6) limit or impose conditions on the physician's privilege to practice in the state;

(7) impose a civil fine of not more than $25,000;

(8) issue a cease and desist order prohibiting the physician from providing health care services through telehealth under AS 08.02.130(b); an order issued under this paragraph remains in effect until the physician submits evidence acceptable to the board showing that the violation has been corrected;

(9) promptly notify the licensing authority in each state in which the physician is licensed of a sanction imposed under this subsection.

(c) In a case finding grounds for sanction under AS 08.64.326(a)(13), the final findings of fact, conclusions of law, and order of the authority that suspended or revoked a license or certificate constitute a prima facie case that the license or certificate was suspended or revoked and the grounds under which the suspension or revocation was granted.

(d) The board may place a physician on probation under this section until the board finds that the deficiencies that required the imposition of a sanction have been remedied. The board may require a physician on probation to

(1) report regularly to the board on matters involving the reason for which the physician was placed on probation;

(2) limit the physician's practice in the state to those areas prescribed by the board;

(3) participate in professional education until the board determines that a satisfactory degree of skill has been attained in areas identified by the board as needing improvement.

(e) The board may summarily prohibit a physician from practicing in the state under AS 08.02.130(b) if the board finds that the physician, by continuing to practice, poses a clear and immediate danger to public health and safety. A physician prohibited from practicing under this subsection is entitled to a hearing conducted by the office of administrative hearings (AS 44.64.010) not later than seven days after the effective date of the order prohibiting the physician from practicing. The board may lift an order prohibiting a physician from practicing if the board finds after a hearing that the physician is able to practice with reasonable skill and safety. The physician may appeal a decision of the board under this subsection to the superior court.

(f) The board shall take measures to recover from a physician the cost of proceedings resulting in a sanction under (b) of this section, including the costs of investigation by the board and department, and hearing costs.

(g) The board may prohibit a physician from practicing in the state upon receipt of a certified copy of evidence that a license to practice medicine in another state or territory of the United States or province or territory of Canada has been suspended or revoked. The prohibition remains in effect until a hearing can be held by the board.

(h) The board shall be consistent in the application of disciplinary sanctions. A significant departure from earlier decisions of the board involving similar situations must be explained in findings of fact or orders made by the board.

Sec. 08.64.334. Voluntary surrender. The board, at its discretion, may accept the voluntary surrender of a license. A license may not be returned unless the board determines, under regulations adopted by it, that the

(4) has been convicted, including conviction based on a guilty plea or plea of nolo contendere, of

(A) a class A or unclassified felony or a crime in another jurisdiction with elements similar to a class A or unclassified felony in this jurisdiction;

(B) a class B or class C felony or a crime in another jurisdiction with elements similar to a class B or class C felony in this jurisdiction if the felony or other crime is substantially related to the qualifications, functions, or duties of the licensee; or

(C) a crime involving the unlawful procurement, sale, prescription, or dispensing of drugs;

(5) has procured, sold, prescribed, or dispensed drugs in violation of a law regardless of whether there has been a criminal action or harm to the patient;

(6) intentionally or negligently permitted the performance of patient care by persons under the licensee's supervision that does not conform to minimum professional standards even if the patient was not injured;

(7) failed to comply with this chapter, a regulation adopted under this chapter, or an order of the board;

(8) has demonstrated

(A) professional incompetence, gross negligence or repeated negligent conduct; the board may not base a finding of professional incompetence solely on the basis that a licensee's practice is unconventional or experimental in the absence of demonstrable physical harm to a patient;

(B) addiction to, severe dependency on, or habitual overuse of alcohol or other drugs that impairs the licensee's ability to practice safely;

(C) unfitness because of physical or mental disability;

(9) engaged in unprofessional conduct, in sexual misconduct, or in lewd or immoral conduct in connection with the delivery of professional services to patients; in this paragraph, "sexual misconduct" includes sexual contact, as defined by the board in regulations adopted under this chapter, or attempted sexual contact with a patient outside the scope of generally accepted methods of examination or treatment of the patient, regardless of the patient's consent or lack of consent, during the term of the physician-patient relationship, as defined by the board in regulations adopted under this chapter, unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the physician-patient relationship, was in a dating, courtship, or engagement relationship with the licensee;

(10) has violated AS 18.16.010;

(11) has violated any code of ethics adopted by regulation by the board;

(12) has denied care or treatment to a patient or person seeking assistance from the physician if the only reason for the denial is the failure or refusal of the patient to agree to arbitrate as provided in AS 09.55.535(a);

(13) has had a license or certificate to practice medicine in another state or territory of the United States, or a province or territory of Canada, denied, suspended, revoked, surrendered while under investigation for an alleged violation, restricted, limited, conditioned, or placed on probation unless the denial, suspension, revocation, or other action was caused by the failure of the licensee to pay fees to that state, territory, or province; or

(14) prescribed or dispensed an opioid in excess of the maximum dosage authorized under AS 08.64.363.

(b) In a case involving (a)(13) of this section, the final findings of fact, conclusions of law and order of the authority that suspended or revoked a license or certificate constitutes a prima facie case that the license or certificate was suspended or revoked and the grounds under which the suspension or revocation was granted.

Sec. 08.64.331. Disciplinary sanctions. (a) If the board finds that a licensee has committed an act set out in AS 08.64.326(a), the board may

(1) permanently revoke a license to practice;

(2) suspend a license for a determinate period of time;

(3) censure a licensee;

(4) issue a letter of reprimand;

(5) place a licensee on probationary status and require the licensee to

(A) report regularly to the board on matters involving the basis of probation;

(B) limit practice to those areas prescribed;

(C) continue professional education until a satisfactory degree of skill has been attained in those areas determined by the board to need improvement;

(6) impose limitations or conditions on the practice of a licensee;

(7) impose a civil fine of not more than $25,000; or

(8) impose one or more of the sanctions set out in (1) – (7) of this subsection.

(b) The board may end the probation of a licensee if it finds that the deficiencies which required this sanction have been remedied.

(c) The board may summarily suspend a license before final hearing or during the appeals process if the board finds that the licensee poses a clear and immediate danger to the public health and safety if the licensee continues to practice. A person whose license is suspended under this section is entitled to a hearing conducted by the office of administrative hearings (AS 44.64.010) not later than seven days after the effective date of the order, and the person may appeal the suspension after a hearing to a court of competent jurisdiction.

(d) The board may reinstate a license that has been suspended or revoked if the board finds after a hearing that the applicant is able to practice with reasonable skill and safety.

extension for the same reasons the board may refuse to grant a license under AS 08.64.240. Permits and extensions of permits issued to an individual under this section are not valid for more than 240 calendar days during any consecutive 24 months.

(f) Notwithstanding (e) of this section, a permit issued under this section may be extended by the board or its designee for a time period that exceeds the limit established in (e) of this section if the board or its designee determines that the extension is necessary in order to provide essential medical services for the protection of public health and safety and the board has received a

(1) clearance report from the National Practitioner Data Bank;
(2) physician profile from the American Medical Association or the American Osteopathic Association;
(3) clearance report from the United States Drug Enforcement Administration; and
(4) completed application form and the fee required for licensure under this chapter.

Sec. 08.64.276. Retired status license. (a) On retiring from practice and payment of an appropriate one-time fee, a licensee in good standing with the board may apply for the conversion of an active or inactive license to a retired status license. A person holding a retired status license may not practice medicine, osteopathy, or podiatry in the state. A retired status license is valid for the life of the license holder and does not require renewal. A person holding a retired status license is exempt from AS 08.64.312.

(b) A person with a retired status license may apply for active licensure. Before issuing an active license under this subsection, the board may require the applicant to meet reasonable criteria as determined under regulations of the board, which may include submission of continuing medical education credits, reexamination requirements, physical and psychiatric examination requirements, an interview with the entire board, and review of information in the national data bank of the National Federation of State Medical Boards.

Sec. 08.64.279. Interview for permits. An applicant for an intern permit, a resident permit, or a temporary permit for locum tenens practice may be interviewed in person by the board, a member of the board, the executive secretary of the board, or a person designated for that purpose by the board.

Sec. 08.64.312. Continuing education requirements. (a) The board shall promote a high degree of competence in the practice of medicine, osteopathy, and podiatry by requiring every licensee of medicine, osteopathy, and podiatry in the state to fulfill continuing education requirements.

(b) Before a license may be renewed, the licensee shall submit evidence to the board or its designee that continuing education requirements prescribed by regulations adopted by the board have been met. Continuing education requirements must include not less than two hours of education in pain management and opioid use and addiction in the two years preceding an application for renewal of a license, unless the licensee demonstrates to the satisfaction of the board that the licensee's practice does not include pain management and opioid treatment or prescribing.

(c) The board or its designee may exempt a physician, osteopath, or podiatrist from the requirements of (b) of this section upon an application by the physician, osteopath, or podiatrist giving evidence satisfactory to the board or its designee that the physician, osteopath, or podiatrist is unable to comply with the requirements because of extenuating circumstances. However, a person may not be exempted from more than 15 hours of continuing education in a five-year period; a person may not be exempted from the requirement to receive at least two hours of education in pain management and opioid use and addiction unless the person has demonstrated to the satisfaction of the board that the person does not currently hold a valid federal Drug Enforcement Administration registration number.

Sec. 08.64.313. Inactive license. A licensee who does not practice in the state may hold an inactive license. A person, who practices in the state, however infrequently, shall hold an active license.

Sec. 08.64.315. Fees. The department shall set fees under AS 08.01.065 for each of the following:

(1) application;
(2) license by examination;
(3) license by endorsement or waiver of examination;
(4) temporary permit;
(5) locum tenens permit;
(6) license renewal, active;
(7) license renewal, inactive;
(8) license by reexamination.

Sec. 08.64.326. Grounds for imposition of disciplinary sanctions. (a) The board may impose a sanction if the board finds after a hearing that a licensee

(1) secured a license through deceit, fraud, or intentional misrepresentation;

(2) engaged in deceit, fraud, or intentional misrepresentation while providing professional services or engaging in professional activities;

(3) advertised professional services in a false or misleading manner;

(1) an active license from a board of medical examiners established under the laws of a state or territory of the United States or a province or territory of Canada issued after thorough examination; or

(2) passed an examination as specified by the board in regulations.

(b) The board shall adopt regulations under (a) of this section that require an applicant to demonstrate professional competence in pain management and addiction disorders. An applicant may include past professional experience or professional education as proof of professional competence.

Sec. 08.64.255. Interviews. An applicant for licensure may be interviewed in person by the board or by a member of the board before a license is issued. The interview must be recorded. If the application is denied on the basis of the interview, the denial shall be stated in writing, with the reasons for it, and the record shall be preserved.

Sec. 08.64.260. Reexamination. (a) If the applicant fails the examination, the applicant may, on the same application and payment of a reexamination fee, take another examination not less than six months nor more than two years after the date of the first examination. If the applicant fails a second examination, the applicant may, after a year or more of further study or training approved by the board, make a new application for licensure.

(b) *[Repealed, Sec. 21 ch 87 SLA 1987.]*

(c) *[Repealed, Sec. 21 ch 87 SLA 1987.]*

(d) *[Repealed, Sec. 21 ch 87 SLA 1987.]*

Sec. 08.64.270. Temporary permits. (a) The board, a member of the board, the executive secretary, or a person designated by the board to issue temporary permits may issue a temporary permit to a physician applicant, osteopath applicant, or podiatry applicant who meets the requirements of AS 08.64.200, 08.64.205, 08.64.209, or 08.64.225 and pays the required fee.

(b) A temporary permit issued under this section is valid for six months and shall be reviewed by the board at the next regularly scheduled board meeting that occurs after its issuance.

(c) A temporary permit issued under this section may not be renewed.

(d) The fee for a permit issued under this section is one-fourth of the fee for a biennial license, plus the appropriate application fee.

(e) Upon application by the permittee and approval of the board, a permit issued under this section may be converted to a biennial license upon payment of the biennial fee minus the six-month permit fee paid under (d) of this section, plus the appropriate application fee.

Sec. 08.64.272. Residency and internship permits. (a) A person may not serve as a resident or intern without a permit issued under this section.

(b) For the limited purpose of residency or internship, the board may issue a permit to an applicant without examination if the applicant meets the requirements of AS 08.64.200(a)(1) and applicable regulations of the board, meets the requirements of AS 08.64.279, pays the required fee, and has been accepted by an eligible institution in the state for the purpose of residency or internship.

(c) A permit issued under this section is valid for the period specified by the board, but not to exceed 36 months after the date of issue. Upon application by a person who pays the required fee and has been accepted by an eligible institution in the state for the purpose of residency or internship, the board may renew a permit issued under this section for a period specified by the board, but not to exceed 36 months after the date of renewal.

Sec. 08.64.275. Temporary permit for locum tenens practice. (a) A member of the board, its executive secretary, or a person designated by the board to issue temporary permits may grant a temporary permit to a physician or osteopath for the purpose of

(1) substituting for another physician or osteopath licensed in this state;

(2) being temporarily employed by a physician or osteopath licensed in this state while that physician or osteopath evaluates the permittee for permanent employment; or

(3) being temporarily employed by a hospital or community mental health center while the facility attempts to fill a vacant permanent physician or osteopath staff position with a physician or osteopath licensed in this state.

(b) A physician applying under (a) of this section shall pay the required fee and shall meet the requirements of AS 08.64.279 and the requirements of either AS 08.64.200 or 08.64.225. In addition, the physician shall submit evidence of holding a license to practice medicine in a state or territory of the United States or in a province or territory of Canada.

(c) An osteopath applying under (a) of this section shall pay the required fee and shall meet the requirements of AS 08.64.205 and 08.64.279. In addition, the osteopath shall submit evidence of holding a license to practice in a state or territory of the United States or in a province or territory of Canada.

(d) Within 10 days after the permit has been granted, the board member shall forward to the department a report of the issuance of the permit.

(e) A permit issued under this section is initially valid for 90 consecutive calendar days. Upon request by a permittee, a permit issued under this section shall be extended for 60 calendar days by the board or its designee if, before the expiration of the initial 90-day permit, the permittee submits to the department a completed application form and the fee required for licensure under this chapter, except that the board may refuse to grant a request for an

(2) take the examination required by AS 08.64.210; the State Medical Board shall call to its aid a podiatrist of known ability who is licensed to practice podiatry to assist in the examination and licensure of applicants for a license to practice podiatry;

(3) receive education in pain management and opioid use and addiction, unless the applicant has demonstrated to the satisfaction of the board that the applicant does not currently hold a valid federal Drug Enforcement Administration registration number; an applicant may include past professional experience or professional education as proof of professional competence;

(4) meet other qualifications of experience or education that the board may require.

(b) The provisions of AS 08.64.180—08.64.190, 08.64.220, and 08.64.230—08.64.380 relating to the practice of medicine or osteopathy apply to the application procedure, testing, and practice of podiatry, as appropriate.

Sec. 08.64.210. Examination required. (a) The applicant shall take examinations in subjects the board considers necessary, unless excused under provisions of AS 08.64.250.

(b) The deadline for submitting an exam application to the board shall be established by regulation.

Sec. 08.64.220. Contents of examination and grading. (a) The board shall offer a written examination sufficient to test the applicant's fitness to practice medicine or osteopathy.

(b) *[Repealed, Sec. 27 ch 148 SLA 1970.]*

(c) The examinations, answers, and scores shall be preserved and filed.

Sec. 08.64.225. Foreign medical graduates. (a) Applicants who are graduates of medical colleges not accredited by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association shall

(1) meet the requirements of AS 08.64.200(a)(3) – (5) and 08.64.255;

(2) have successfully completed

(A) three years of postgraduate training as evidenced by a certificate of completion of the first year of postgraduate training from the facility where the applicant completed the first year of internship or residency and a certificate of successful completion of two additional years of postgraduate training at a recognized hospital; or

(B) other requirements establishing proof of competency and professional qualifications as the board considers necessary to ensure the continued protection of the public adopted at the discretion of the board by regulation, including education in pain management and opioid use and addiction, unless the applicant has demonstrated to the satisfaction of the board that the applicant does not currently hold a valid federal Drug Enforcement Administration registration number; an applicant may include past professional experience or professional education as proof of professional competence; and

(3) have passed examinations as specified by the board in regulations.

(b) Requirements establishing proof of competency under (a)(2)(B) of this section may include

(1) current licensure in another state and an active medical practice in that state for at least three years; or

(2) current board certification in a practice specialty by the American Board of Medical Specialties.

(c) In this section, "recognized hospital" means a hospital that has been approved for internship or residency training by the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada.

Sec. 08.64.230. License granted. (a) If a physician applicant passes the examination and meets the requirements of AS 08.64.200 and 08.64.255, the board or its executive secretary shall grant a license to the applicant to practice medicine in the state.

(b) If an osteopath applicant passes the examination and meets the requirements of AS 08.64.205 and 08.64.255, the board or its executive secretary shall grant a license to the applicant to practice osteopathy in the state.

(c) Each license shall be signed by the secretary and president of the board, and have the seal of the board affixed to it.

Sec. 08.64.240. License refused. (a) The board may not grant a license if

(1) the applicant fails or cheats during the examination;

(2) the applicant has surrendered a license in another jurisdiction while under investigation and the license has not been reinstated in that jurisdiction;

(3) the board determines that the applicant is professionally unfit to practice medicine or osteopathy in the state; or

(4) the applicant fails to comply with a requirement of this chapter.

(b) The board may refuse to grant a license to any applicant for the same reasons that it may impose disciplinary sanctions under AS 08.64.326.

Sec. 08.64.250. License by credentials. (a) The board may waive the examination requirement and license by credentials if the physician, osteopath, or podiatry applicant meets the requirements of AS 08.64.200, 08.64.205, or 08.64.209, submits proof of continued competence as required by regulation, pays the required fee, and has

(d) A podiatrist practicing in the state on March 26, 1976, is exempt from this section, and shall be issued a license without examination if application is made within one year of March 26, 1976.

Sec. 08.64.180. Application for license. A person who desires to practice medicine, or osteopathy in the state shall apply in writing to the department for a license.

Sec. 08.64.190. Contents of application. The application must state the name, age, residence, the time spent in medical or osteopathy study, the place, year, and school in which degrees were granted, the applicant's medical work history, and other information the board considers necessary. The application shall be made under oath. The board may verify information in the application through direct contact with the appropriate schools, medical boards, or other agencies that can substantiate the information.

Sec. 08.64.200. Qualifications of physician applicants. (a) Except for foreign medical graduates as specified in AS 08.64.225, each physician applicant shall

(1) submit a certificate of graduation from a legally chartered medical school accredited by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association;

(2) submit a certificate from a recognized hospital or hospitals certifying that the applicant has satisfactorily performed the duties of resident physician or intern for a period of

(A) one year if the applicant graduated from medical school before January 1, 1995, as evidenced by a certificate of completion of the first year of postgraduate training from the facility where the applicant completed the first year of internship or residency; and

(B) two years if the applicant graduated from medical school on or after January 1, 1995, as evidenced by a certificate of completion of the first year of postgraduate training from the facility where the applicant completed the first year of internship or residency and a certificate of successful completion of one additional year of postgraduate training at a recognized hospital;

(3) submit a list of negotiated settlements or judgements in claims or civil actions alleging medical malpractice against the applicant, including an explanation of the basis for each claim or action;

(4) not have a license to practice medicine in another state, country, province, or territory that is currently suspended or revoked for disciplinary reasons; and

(5) receive education in pain management and opioid use and addiction, unless the applicant has demonstrated to the satisfaction of the board that the applicant does not currently hold a valid federal Drug Enforcement Administration registration number; an applicant may include past professional experience or professional education as proof of professional competence.

(b) The board shall determine whether each physician applicant has any disciplinary or other actions recorded in the nationwide disciplinary data bank of the Federation of State Medical Boards. If the physician applicant was licensed or practiced in a jurisdiction that does not record information with the data bank of the Federation of State Medical Boards, the board shall contact the medical regulatory body of that jurisdiction to obtain comparable information about the applicant.

Sec. 08.64.205. Qualifications for osteopath applicants. Each osteopath applicant shall meet the qualifications prescribed in AS 08.64.200(a)(3) – (5) and shall

(1) submit a certificate of graduation from the legally chartered school of osteopathy approved by the board;

(2) submit a certificate from a hospital approved by the American Medical Association or the American Osteopathic Association that certifies that the osteopath has satisfactorily completed and performed the duties of intern or resident physician for

(A) one year if the applicant graduated from a school of osteopathy before January 1, 1995, as evidenced by a certificate of completion of the first year of postgraduate training from the facility where the applicant completed the first year of internship or residency; or

(B) two years if the applicant graduated from a school of osteopathy on or after January 1, 1995, as evidenced by a certificate of completion of the first year of postgraduate training from the facility where the applicant completed the first year of internship or residency and a certificate of successful completion of one additional year of postgraduate training at a recognized hospital;

(3) take the examination required by AS 08.64.210 or be certified to practice by the National Board of Examiners for Osteopathic Physicians and Surgeons or by the National Board of Osteopathic Medical Examiners;

(4) receive education in pain management and opioid use and addiction, unless the applicant has demonstrated to the satisfaction of the board that the applicant does not currently hold a valid federal Drug Enforcement Administration registration number; an applicant may include past professional experience or professional education as proof of professional competence.

Sec. 08.64.209. Qualifications for podiatry applicants. (a) Each applicant who desires to practice podiatry shall meet the qualifications prescribed in AS 08.64.200(a)(3) – (5) and shall

(1) submit a certificate of graduation from a legally chartered school of podiatry approved by the board;

medical study, the place of medical study, and the year and school from which degrees were granted. The record must also show whether the applicant was granted a license or rejected.

(b) The board shall maintain records for each person licensed under this chapter concerning the outcome of malpractice actions and claims as reported under AS 08.64.200(a) and 08.64.345. The board must periodically review these records to determine if the licensee should be found to be professionally incompetent under AS 08.64.326(a)(8)(A).

(c) The board shall make available to the public the information maintained under (a) and (b) of this section for each person licensed under this chapter.

Sec. 08.64.160. Applicability of Administrative Procedure Act. The board shall comply with AS 44.62 (Administrative Procedure Act).

ARTICLE 2.
LICENSING

Section

Sec. 08.64.170. License to practice medicine, podiatry, or osteopathy. (a) A person may not practice medicine, podiatry, or osteopathy in the state unless the person is licensed under this chapter, except that

(1) a physician assistant may examine, diagnose or treat persons under the supervision, control, and responsibility of either a physician licensed under this chapter or a physician exempted from licensing under AS 08.64.370;

(2) a person who is licensed or authorized under another law of the state may engage in a practice that is authorized under that law; and

(3) a person may perform routine medical duties delegated under AS 08.64.106.

(b) *[Repealed, § 4 ch 101 SLA 1974.]*

(c) A chiropodist practicing in the state on May 16, 1972, is exempt from this section.

(5) under regulations adopted by the board, contract with private professional organizations to establish an impaired medical professionals program to identify, confront, evaluate, and treat persons licensed under this chapter who abuse alcohol, other drugs, or other substances or are mentally ill or cognitively impaired;

(6) adopt regulations that establish guidelines for a physician or physician assistant who is rendering a diagnosis, providing treatment, or prescribing, dispensing, or administering a prescription drug to a person without conducting a physical examination under AS 08.64.364; the guidelines must include a nationally recognized model policy for standards of care of a patient who is at a different location than the physician or physician assistant;

(7) require that a licensee who has a federal Drug Enforcement Administration registration number register with the controlled substance prescription database under AS 17.30.200(o).

(b) The board may adopt regulations authorizing

(1) the executive secretary to grant a license to an applicant under this chapter; the regulations must provide

(A) that the applicant meet the requirements provided under this chapter;

(B) that the executive secretary may not grant a license under this chapter if the applicant has submitted

(i) a list of one or more negotiated settlements and judgments under AS 08.64.200(a)(3);

(ii) information that the applicant had a license to practice medicine in another state, country, province, or territory that was suspended or revoked under AS 08.64.200(a)(4); or

(iii) information that requires consideration by the board;

(C) other requirements that the board determines necessary; and

(2) a member of the board, the executive secretary, or a person designated by the board to issue a temporary permit under AS 08.64.270(a) or 08.64.275(a) if the applicant meets the requirements established under this chapter.

Sec. 08.64.103. Investigator; executive secretary. (a) After consulting with the board, the department shall employ two persons who are not members of the board; one shall be assigned as the investigator for the board; the other shall be assigned as the executive secretary for the board. The investigator shall

(1) conduct investigations into alleged violations of this chapter and into alleged violations of regulations and orders of the board;

(2) at the request of the board, conduct investigations based on complaints filed with the department or with the board; and

(3) be directly responsible and accountable to the board, except that only the department has authority to terminate the investigator's employment and the department shall provide day to day and administrative supervision of the investigator.

(b) The executive secretary is the principal executive officer of the board and shall perform duties as prescribed by the board. The executive secretary is in the partially exempt service under AS 39.25.120 and is entitled to receive a monthly salary equal to a step in Range 23 on the salary schedule set out in AS 39.27.011(a).

Sec. 08.64.105. Regulation of abortion procedures. The board shall adopt regulations necessary to carry into effect the provisions of AS 18.16.010 and shall define ethical, unprofessional, or dishonorable conduct as related to abortions, set standards of professional competency in the performance of abortions, and establish procedures and set standards for facilities, equipment, and care of patients in the performance of an abortion.

Sec. 08.64.106. Delegation of routine medical duties. The board shall adopt regulations authorizing a physician, podiatrist, osteopath, or physician assistant licensed under this chapter to delegate routine medical duties to an agent of the physician, podiatrist, osteopath, or physician assistant. The regulations must

(1) require that an agent who is not licensed under this chapter may perform duties delegated under this section only if the agent meets applicable standards established by the board;

(2) require that a physician, podiatrist, osteopath, or physician assistant may not delegate duties related to pain management and opioid use and addiction; and

(3) define the phrase "routine medical duties."

Sec. 08.64.107. Regulation of physician assistants. The board shall adopt regulations regarding the licensure of physician assistants and the medical services that they may perform, including the

(1) educational and other qualifications, including education in pain management and opioid use and addiction;

(2) application and licensing procedures;

(3) scope of activities authorized; and

(4) responsibilities of the supervising or training physician.

Sec. 08.64.110. Per diem and expenses. The members of the board are entitled to per diem and expenses authorized by law.

Sec. 08.64.130. Board records. (a) The board shall preserve a record of its proceedings, which must contain the name, age, residence and duration of residence of each applicant for a license, the time spent by the applicant in

CHAPTER 64.
MEDICINE

Article

ARTICLE 1.
STATE MEDICAL BOARD

Section

Sec. 08.64.010. Creation and membership of State Medical Board. The governor shall appoint a board of medical examiners, to be known as the State Medical Board, consisting of five physicians licensed in the state and residing in as many separate geographical areas of the state as possible, one physician assistant licensed under AS 08.64.107, and two persons with no direct financial interest in the health care industry.

Sec. 08.64.050. Oath of office. Each member shall take an oath of office. The oath shall be filed and preserved in the department.

Sec. 08.64.060. Seal. The board shall adopt a seal.

Sec. 08.64.070. Officers. The board shall elect a president and secretary from among its members. The president and secretary may administer oaths.

Sec. 08.64.075. Designees. If this chapter authorizes a designee to perform a duty, the board may designate a single board member, the executive secretary, or another employee of the department.

Sec. 08.64.085. Meetings of the board. The board shall meet at least four times a year.

Sec. 08.64.090. Quorum. Five members of the board constitute a quorum for the transaction of all business properly before the board.

Sec. 08.64.100. Power of board to adopt regulations. The board may adopt regulations necessary to carry into effect the provisions of this chapter.

Sec. 08.64.101. Duties. (a) The board shall

(1) except as provided in regulations adopted by the board under (b) of this section, examine and issue licenses to applicants;

(2) develop written guidelines to ensure that licensing requirements are not unreasonably burdensome and the issuance of licenses is not unreasonably withheld or delayed;

(3) after a hearing, impose disciplinary sanctions on persons who violate this chapter or the regulations or orders of the board;

(4) adopt regulations ensuring that renewal of licenses is contingent on proof of continued competency on the part of the licensee;

ARTICLE 4.
GENERAL PROVISIONS

Section

Sec. 08.64.370. Exceptions to application of chapter. This chapter does not apply to

(1) officers in the regular medical service of the armed services of the United States or the United States Public Health Service while in the discharge of their official duties;

(2) a physician or osteopath licensed in another state who is asked by a physician or osteopath licensed in this state to help in the diagnosis or treatment of a case, unless the physician is practicing under AS 08.02.130(b);

(3) the practice of the religious tenets of a church;

(4) a physician in the regular medical service of the United States Public Health Service or the armed services of the United States volunteering services without pay or other remuneration to a hospital, clinic, medical office, or other medical facility in the state;

(5) a person who is certified as a direct-entry midwife by the department under AS 08.65 while engaged in the practice of midwifery whether or not the person accepts compensation for those services;

(6) a physician licensed in another state who, under a written agreement with an athletic team located in the state in which the physician is licensed, provides medical services to members of the athletic team while the athletic team is traveling to or from or participating in a sporting event in this state.

Sec. 08.64.380. Definitions. In this chapter,

(1) "board" means the State Medical Board;

(2) "department" means the Department of Commerce, Community, and Economic Development;

(3) *[Repealed, Sec. 18 ch 29 SLA 2021.]*

(4) *[Repealed, Sec. 18 ch 29 SLA 2021.]*

(5) "opioid" includes the opium and opiate substances and opium and opiate derivatives listed in AS 11.71.140 and 11.71.160;

(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;

(7) "practice of podiatry" means the medical, mechanical, and surgical treatment of ailments of the foot, the muscles and tendons of the leg governing the functions of the foot, and superficial lesions of the hand other than those associated with trauma; the use of preparations, medicines, and drugs as are necessary for the treatment of these ailments; the treatment of the local manifestations of systemic diseases as they appear in the hand and foot, except that

(A) a patient shall be concurrently referred to a physician or osteopath for the treatment of the systemic disease itself;

(B) general anesthetics may be used only in colleges of podiatry approved by the board and in hospitals approved by the joint commission on the accreditation of hospitals, or the American Osteopathic Association; and

(C) the use of X-ray or radium for therapeutic purposes is not permitted.

CHAPTER 40.
STATE MEDICAL BOARD.

Articles

ARTICLE 1.
LICENSING.

Section

12 AAC 40.010. APPLICATION FOR LICENSE BY CREDENTIALS. (a) Before the board will consider issuance of a license, an applicant for licensure by credentials shall

(1) file a complete application; and

(2) if required under 12 AAC 40.055, be interviewed in accordance with AS 08.64.255.

(b) A complete application must include the following items

(1) submitted by the applicant:

(A) a completed application on a form provided by the department, including a photograph of the applicant;

(B) a completed authorization for release of records on a form provided by the department and signed by the applicant;

(C) a true and correct attestation listing each hospital at which the applicant has held privileges within the five years immediately before the date that the applicant signs the application form, and a disclosure of any disciplinary action against the applicant by any hospital or other health care facility at any time, including whether

(i) the applicant's employment or privileges were restricted, terminated, or investigated; or

(ii) the applicant is currently under investigation for a complaint or accusation regarding the applicant's practice;

(D) all application and licensing fees required under 12 AAC 02.250;

(E) verification of the applicant's post-graduate training that meets the requirements of (h) of this section, if applicable;

(F) an attestation that the applicant has completed education in pain management and opioid use and addiction; if the applicant does not currently hold a valid federal Drug Enforcement Administration registration number, verification will be waived until the applicant applies for a valid registration number;

(G) a true and correct attestation whether the applicant has been the subject of a revoked or restricted DEA registration;

(2) submitted directly to the division office upon the applicant's request:

Exam not required for license under Credential Per 08.64.250

(A) evidence that the applicant has passed an appropriate examination that meets the requirements set out under (c) of this section;

(B) verification of licensure from the appropriate licensing authority in each state, territory, province, or other country where the applicant holds or has ever held a license to practice medicine;

(C) clearance from the Federation of State Medical Boards or the Federation of Podiatric State Medical Boards;

(D) verification from the applicant's medical school that the applicant completed medical school and received a medical school diploma;

(E) verification of the applicant's completion of post-graduate training that meets the requirements of (h) of this section, if applicable;

(F) for foreign medical graduates, verification from the Educational Commission for Foreign Medical Graduates (ECFMG) of successful ECFMG certification, or a certified true copy of the applicant's certificate from the Educational Commission for Foreign Medical Graduates (ECFMG).

(c) The evidence that an applicant has passed an appropriate examination as required by (b)(2)(A) of this section must be either

(1) verification of an examination in the medical and basic science subjects as a prerequisite to licensure in a state or territory of the United States, District of Columbia, Puerto Rico, or a province or territory of Canada; or

(2) an official transcript from

(A) the Federation of State Medical Boards documenting successful passage of the FLEX exam;

(B) the National Board of Medical Examiners documenting successful passage of the NBME exam;

(C) the National Board of Osteopathic Medical Examiners documenting successful passage of the NBOME or COMLEX examination;

(D) the National Board of Medical Examiners or the Federation of State Medical Boards documenting successful passage of the United States Medical Licensing Examination (USMLE); or

(E) the National Board of Podiatric Examiners (NBPME) documenting successful passage of the NBPME or Podiatric Medical Licensing Examination for States (PMLexis); or

(3) official transcripts from the appropriate administering federations or boards documenting successful passage of all segments of an acceptable examination combination in 12 AAC 40.021.

(d) Applicants are responsible for requesting transcripts and paying any fees associated with having transcripts sent directly to the board.

(e) Before the board will consider issuance of a license, an applicant must receive clearance from the National Practitioner Data Bank.

(f) If necessary, the board will require an applicant to provide additional information to verify that the applicant meets the licensing requirements in AS 08.64.250 and this chapter.

(g) The board will waive the verification requirements set out in (b)(2)(B) of this section for an applicant who is unable to obtain verification of licensure from another country that does not have diplomatic relations with the United States, and the board will waive the verification requirements set out in (b)(2)(G) and (H) of this section for an applicant who is unable to obtain those verifications due to circumstances beyond the applicant's control as determined by the board, if the board is able to satisfactorily substantiate through other means that the applicant has met those licensure, education, and training requirements. The applicant must submit to the board a written request for a waiver that

(1) explains the reason for the applicant being unable to obtain those verifications; and

(2) documents that licensure, education, and training requirements have been met.

(h) An applicant for licensure under this section who graduated from a medical school described in AS 08.64.200(a) or a school of osteopathy described in AS 08.64.205 must submit direct source verification of successful completion of the post-graduate training required under AS 08.64.200(a) or 08.64.205. Any other applicant must submit direct source verification of successful completion of the post-graduate training required under AS 08.64.225(a), if applicable. Training periods of less than 12 months will not be accepted.

(i) Except for a diploma written in Latin, a document submitted under this section must be either written in English or accompanied by a certified English translation of that document.

(j) If a foreign medical graduate applicant for licensure in this state took the FLEX examination series before the implementation of the USMLE examination series, but did not achieve a minimum standard score of 75 for each component of the examination series, and has not otherwise provided evidence satisfactory to the board that the applicant has passed an appropriate examination as described in (c) of this section, the applicant may submit an official transcript from the Federation of State Medical Boards documenting that the applicant achieved a weighted average score of 75 or higher. The board will not accept a weighted average score if the applicant

(1) is not currently licensed in at least one other state;

(2) has been the subject of disciplinary action for a violation substantially similar to one listed in AS 08.64.326 in any state or other jurisdiction within the five years immediately preceding application for a license in this state; or

(3) is not currently board-certified by a member board of the American Board of Medical Specialties or the American Osteopathic Association.

(k) Notwithstanding (b)(2) of this section, an applicant for licensure by credentials may submit the credentials verification documents through the Federation Credentials Verification Service of the Federation of State Medical Boards of the United States, Inc., sent directly to the department from FCVS.

Authority: AS 08.64.100 AS 08.64.200 AS 08.64.205 AS 08.64.210 AS 08.64.225 AS 08.64.240 AS 08.64.250 AS 08.64.255

Editor's note: Information on the verification process described in 12 AAC 40.010(k) may be obtained from the Federation of State Medical Boards of the United States, Inc., P.O. Box 619850, Dallas, TX 75261-9850; telephone: (817)868-4000; website at www.fsmb.org.

12 AAC 40.015. APPLICATION FOR LICENSE BY EXAMINATION. (a) Repealed 6/28/97.

(b) A complete application for a license by examination must meet the requirements of AS 08.64.200, 08.64.205, 08.64.209, or 08.64.225 and include the following documents

(1) submitted by the applicant:

(A) a completed application on a form provided by the department, including a photograph of the applicant;

(B) a completed authorization for release of records on a form provided by the department and signed by the applicant;

(C) a true and correct attestation listing each hospital at which the applicant has held privileges within the five years immediately before the date the applicant signs the application form, and a disclosure of any disciplinary action against the applicant by any hospital or other health care facility at any time, including whether

(i) the applicant's employment or privileges were restricted, terminated, or investigated; or

(ii) the applicant is currently under investigation for a complaint or accusation regarding the applicant's practice;

(D) all application and licensing fees required under 12 AAC 02.250;

(E) an attestation that the applicant has completed education in pain management and opioid use and addiction; if the applicant does not currently hold a valid federal Drug Enforcement Administration registration number, verification will be waived until the applicant applies for a valid registration number;

(F) verification that the applicant has completed at least two hours of education in pain management and opioid use and addiction earned in a Category I continuing medical education program accredited by the American Medical Association, a Category I or II continuing medical education program accredited by the American Osteopathic Association, or a continuing medical education program from a provider that is approved by the Council on Podiatric Medical Education; if the applicant does not currently hold a valid federal Drug Enforcement Administration registration number, verification will be waived until the applicant applies for a valid registration number;

(G) a true and correct attestation whether the applicant has been the subject of a revoked or restricted DEA registration;

(2) submitted directly to the division office upon the applicant's request:

(A) clearance from the Federation of State Medical Boards or the Federation of Podiatric State Medical Boards;

(B) verification from the applicant's medical school that the applicant completed medical school and received a medical school diploma;

(C) verification of completion of post-graduate training from the facility where the applicant completed the internship or residency program, if applicable; training periods of less than 12 months in a program will not be accepted;

(D) for foreign medical graduates, verification from the Educational Commission for Foreign Medical Graduates (ECFMG) of successful ECFMG certification, or a certified true copy of the applicant's certificate from the Educational Commission for Foreign Medical Graduates (ECFMG).

(c) After passing the written examination an applicant must be interviewed in accordance with AS 08.64.255 if the board determines that, under 12 AAC 40.055, an interview is required before the board will consider issuance of a license.

(d) Before the board will consider issuance of a license, an applicant

(1) shall provide for official examination results to be sent to the department directly from the examination agency; and

(2) must receive clearance from the National Practitioner Data Bank.

(e) If necessary, the board will require an applicant to provide additional information to verify that the applicant meets the licensing requirements in

(1) AS 08.64.200, 08.64.205, 08.64.209, or 08.64.225; and

(2) this chapter.

(f) Except for a diploma written in Latin, a document submitted under this section must be either written in English or accompanied by a certified English translation of that document.

(g) Notwithstanding (b)(2) of this section, an applicant for licensure by examination may submit the credentials verification documents through the Federation Credentials Verification Service of the Federation of State Medical Boards of the United States, Inc., sent directly to the department from FCVS.

Authority: AS 08.64.100 AS 08.64.180 AS 08.64.190 AS 08.64.205 AS 08.64.209 AS 08.64.210 AS 08.64.225 AS 08.64.240 AS 08.64.255

Editor's note: Information on the verification process described in 12 AAC 40.015(g) may be obtained from the Federation of State Medical Boards of the United States, Inc., P.O. Box 619850, Dallas, TX 75261-9850; telephone: (817) 868-4000; website at www.fsmb.org.

12 AAC 40.016. APPLICATION FOR LICENSE BY FOREIGN MEDICAL GRADUATES. (a) An applicant for licensure by examination who is a graduate of a medical college not accredited by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association must

(1) have graduated from a school listed in the *World Directory of Medical Schools*, produced by the World Federation for Medical Education, after successful completion of a medical curriculum extending over a period of at least four academic years; the four academic years must consist of at least 32 months of actual instruction, consisting of a minimum of 4,000 hours, with at least 80 percent of actual in-person attendance required; if an applicant has matriculated in more than one medical school, the applicant must have matriculated in the medical school awarding the degree of doctor of medicine or its equivalent for at least the last full academic year of medical education received before the granting of the degree;

(2) meet the requirements of AS 08.64.225, 12 AAC 40.015, 12 AAC 40.020, and this section; and

(3) have successfully completed three years of postgraduate training that meets the requirements of AS 08.64.225(a)(2)(A), including

(A) at least one continuous year of training in a general medical program that includes basic clinical training; training periods of less than 12 months in a program will not be accepted; and

(B) at least two years of training in one continuous single program; a year of full-time employment as a faculty member at a medical college accredited by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association may be substituted for a year of required postgraduate training, up to the maximum required under this subsection; training periods of less than 12 months in a program will not be accepted.

(b) An applicant for licensure by credentials who is a graduate of a medical college not accredited by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association must

(1) have graduated from a school listed in the *World Directory of Medical Schools*, produced by the World Federation for Medical Education, after successful completion of a medical curriculum extending over a period of at least four academic years; the four academic years must consist of at least 32 months of actual instruction, consisting of a minimum of 4,000 hours, with at least 80 percent of actual in-person attendance required; if an applicant has matriculated in more than one medical school, the applicant must have matriculated in the medical school awarding the degree of doctor of medicine or its equivalent for at least the last full academic year of medical education received before the granting of the degree;

(2) meet the requirements of AS 08.64.225, 08.64.250, 12 AAC 40.010, and this section; and

(3) establish proof of competency and professional qualifications by meeting one of the following requirements:

(A) have successfully completed three years of postgraduate training that meets the requirements of AS 08.64.225(a)(2)(A), including

(i) at least one continuous year of training in a general medical program that includes basic clinical training; training periods of less than 12 months in a program will not be accepted; and

(ii) at least two years of training in one continuous single program; a year of full-time employment as a faculty member at a medical college accredited by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association may be substituted for a year of required postgraduate training, up to the maximum required under this subsection; training periods of less than 12 months in a program will not be accepted;

(B) hold a current, active, unrestricted license to practice medicine in another state and

(i) have engaged in the active practice of medicine in that state for at least three years before the date of application for licensure in this state;

(ii) hold a current certification in a practice specialty issued by the American Board of Medical Specialties; and

(iii) have successfully completed postgraduate training that meets the requirements of AS 08.64.225(a)(2)(A) and includes at least one continuous year in a general medical program that includes basic clinical training.

(c) If necessary to determine whether an applicant for licensure who is a graduate of a medical college not accredited by the Association of American Medical Colleges and the Council on Medical Education of the

American Medical Association is competent and able to safely practice medicine in this state, the board may require the applicant to pass the Special Purpose Examination (SPEX) administered by the Federation of State Medical Boards or to undergo a formal assessment of professional competency by a program approved by the board for that purpose.

(d) Nothing in this section requires the board to evaluate for equivalency any education or training required under this section.

Authority: AS 08.64.100 AS 08.64.205 AS 08.64.225
AS 08.64.180 AS 08.64.209 AS 08.64.250
AS 08.64.200 AS 08.64.210 AS 08.64.255

Editor's note: Information about the *World Directory of Medical Schools* described in 12 AAC 40.016(a) and (b) may be obtained from the World Federation for Medical Education, c/o Medical Schools Council, Woburn House, 20 Tavistock Square, London WC1H 9HD; website at https://wfme.org/world-directory/.

12 AAC 40.017. DENIAL OF APPLICATION. The board may deny an application for licensure if the applicant is the subject of an unresolved investigation, complaint review procedure, or other disciplinary proceeding undertaken by a certifying or licensing agency of another state, territory of the United States, or other country.

Authority: AS 08.64.100 AS 08.64.240

12 AAC 40.020. LICENSE BY EXAMINATION. (a) The physician qualification examination required for licensure in this state is the most current version of the United States Medical Licensing Examination (USMLE).

(b) The minimum passing score for

(1) step 1 of the USMLE is 176 in the three-digit scoring system and 75 in the two-digit scoring system;

(2) step 2 of the USMLE is 167 in the three-digit scoring system and 75 in the two-digit scoring system; and

(3) step 3 of the USMLE is 177 in the three-digit scoring system and 75 in the two-digit scoring system.

(c) Repealed 4/27/97.

(d) Repealed 4/27/97.

(e) Repealed 4/27/97.

(f) Repealed 4/27/97.

(g) Repealed 9/1/2007.

(h) Repealed 9/1/2007.

(i) Except as provided in (m) of this section, if an applicant does not pass all steps of the USMLE within the seven years after the date the applicant first passes step one or step two, whichever is earlier, the applicant must retake and pass all steps including steps previously passed.

(j) Except as provided in (m) of this section, if an applicant has passed any step of the USMLE in another state during the five years before application in this state, the applicant need only take the steps not passed as long as all steps are passed within seven years.

(k) An applicant for licensure under this section may make two attempts to pass each step or step component of the USMLE. An applicant who fails any step or step component of the USMLE on the second attempt must complete a supervised course of study approved by the board before permission to retake the step or step component will be given.

(l) An osteopathic applicant for licensure by examination may substitute the applicant's successful passing of all three levels of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) administered by the National Board of Osteopathic Medical Examiners for the applicant's successfully passing of all three steps of the USMLE examination. The osteopathic applicant may only use the substitution if the applicant successfully passed all three levels of the COMLEX examination in sequential order within seven years of the applicant's successfully passing level one of the COMLEX examination. An osteopathic applicant for licensure under this subsection may make two attempts to pass each level of the COMLEX examination. If the applicant takes any level of the COMLEX examination and fails the second attempt, the applicant must complete a supervised course of study approved by the board, before permission to retake the level of the COMLEX examination will be given. The minimum passing score for all levels of the COMLEX examination is 75.

(m) An applicant that is enrolled in a dual degree medical program for M.D. and Ph.D. degrees must complete all three steps of the USMLE within 10 years from the date that the applicant passed the first step of the USMLE.

Authority: AS 08.64.100 AS 08.64.210 AS 08.64.220

12 AAC 40.021. ACCEPTABLE EXAMINATION COMBINATIONS. (a) The board will accept the following combinations of examinations described in 12 AAC 40.020 if successfully completed before January 1, 2000:

(1) (NBME part one or USMLE step one) plus (NBME part two or USMLE step two) plus (NBME part three or USMLE step three);

(2) (FLEX component one) plus (USMLE step three); or

(3) (NBME part one or USMLE step one) plus (NBME part two or USMLE step two) plus (FLEX component two).

(b) Applicants who are graduates of medical colleges not accredited by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association shall pass all components of an examination described in 12 AAC 40.020. The board will not accept combinations of examinations.

Authority: AS 08.64.100 AS 08.64.210 AS 08.64.220

12 AAC 40.022. POSTGRADUATE TRAINING AND ACTIVE DUTY MILITARY SERVICE. The board may accept one year of active duty military service as described in AS 08.01.064(a)(2) as a general medical officer or flight surgeon, verified by the unit hospital commander or senior medical officer, as meeting the second year of postgraduate training required under AS 08.64.200(a)(2)(B) or 08.64.205(2)(B).

Authority: AS 08.01.064 AS 08.64.200 AS 08.64.205
AS 08.64.100

12 AAC 40.023. TRAINING REQUIREMENTS FOR PODIATRY APPLICANT. In addition to meeting the application requirements in AS 08.64.209, an applicant for a license to practice podiatry shall submit to the board

(1) a certified true copy of a certificate verifying the applicant's successful completion of surgical residency training in a hospital accredited by the American Podiatric Medical Association Council on Podiatric Medical Education or the American Board of Podiatric Surgery for a period of at least

(A) one year if the applicant graduated from an accredited school of podiatry on or before December 31, 2010; or

(B) two years if the applicant graduated from an accredited school of podiatry on or after January 1, 2011;

(2) verification of the applicant's completions of at least two hours of education in opioid use and addiction

(A) education under this paragraph must be earned in a continuing medical education program from a provider that is approved by the Council on Podiatric Medical Education;

(B) for an applicant who does not currently hold a valid federal Drug Enforcement Administration registration number, the verification will be waived until the applicant applies for a valid registration number.

Authority: AS 08.64.100 AS 08.64.190 AS 08.64.209

Editor's note: Information on accredited hospitals described in 12 AAC 40.023 may be obtained by contacting the American Podiatric Medical Association Council on Podiatric Medical Education, 9312 Old Georgetown Road, Bethesda, Maryland 20814-1621 or the American Board of Podiatric Surgery, 1601 Dolores Street, San Francisco, California 94110-4906.

12 AAC 40.024. LICENSING REQUIREMENTS FOR APPLICANTS FROM FIFTH PATHWAY PROGRAMS. (a) A physician applicant who earned a certificate of completion from a fifth pathway program supported by the American Medical Association may apply for and receive licensure by examination in this state, if otherwise eligible for licensure.

(b) If otherwise eligible for licensure, and in order to be licensed in this state, a physician applicant for licensure by credentials who earned a certificate of completion from a fifth pathway program not supported by the American Medical Association must provide verification of full and unrestricted licensure in at least one licensing jurisdiction in the United States, with evidence of successful completion of post graduate training recognized by the American Board of Medical Specialties and evidence of board certification by a board under the American Board of Medical Specialties.

(c) In this section, "fifth pathway program" means a program by which students who have attended four years at a foreign medical school that requires one year of social service before awarding the degree may complete their supervised clinical work at a United States medical school, become eligible for entry to residency training in the United States, and ultimately obtain a license to practice in the United States.

Authority: AS 08.64.100 AS 08.64.200 AS 08.64.225

12 AAC 40.025. LAPSED PHYSICIAN LICENSES. (a) A physician license that has been lapsed for at least 60 days but less than one year will be reinstated if the applicant

(1) submits a completed renewal application on a form provided by the department;

(2) pays the applicable biennial license renewal fee established in 12 AAC 02.250(a);

(3) submits proof of meeting the continuing medical education requirements in 12 AAC 40.200 - 12 AAC 40.220; and

(4) receives clearance from the Federation of State Medical Boards and documentation of the clearance is sent directly to the division by that federation.

(b) A physician license that has been lapsed for at least one year but less than five years will be reinstated if the applicant meets the requirements in (a)(2) - (4) of this section and

(1) submits a completed reinstatement application on a form provided by the department;

(2) provides a true and correct attestation whether the applicant has been the subject of a revoked or restricted DEA registration;

(3) arranges for verification of licensure to be sent directly to the division from the appropriate licensing authority in each state, territory, province, or other country where the applicant is or has been licensed as a physician;

(4) is qualified for a license under AS 08.64.230 and is not disqualified by AS 08.64.240; and

(5) provides a true and correct attestation listing each hospital at which the applicant has held privileges during the five years immediately before the date the applicant signs the application form and a disclosure regarding of any disciplinary action by any hospital or other health care facility at any time, including whether

(A) the applicant's employment or privileges have been restricted, terminated, or investigated; or

(B) the applicant is currently under investigation for a complaint or accusation regarding the applicant's practice.

(c) Notwithstanding (a) and (b) of this section, the board may refuse to reinstate a physician license for the same reasons that it may impose disciplinary sanctions against a licensee under AS 08.64.326 and this chapter.

Authority: AS 08.01.100 AS 08.64.100 AS 08.64.240

12 AAC 40.030. RE-EXAMINATION FEES. Repealed 5/18/85.

12 AAC 40.031. ACTIVATING A RETIRED STATUS LICENSE. (a) An applicant holding a retired status license under AS 08.64.276 will, in the board's discretion, be issued an active license to practice medicine, podiatry, or osteopathy in this state, as appropriate, if the applicant

(1) submits a new and complete application as required by 12 AAC 40.010, documenting compliance with

(A) AS 08.64.200 and 08.64.250, if a physician applicant;

(B) AS 08.64.209 and 08.64.250, if a podiatry applicant; or

(C) AS 08.64.205, if an osteopath applicant;

(2) submits evidence of at least 50 hours of continuing medical education credits earned within the two years immediately before the date of application;

(3) submits evidence of successful completion of the Special Purpose Examination (SPEX) prepared by the Federation of State Medical Boards;

(4) submits, at the request of the board, physical and mental examination reports from practitioners approved by the board indicating that, at the time of the examination, the applicant is mentally and physically capable of practicing medicine, podiatry, or osteopathy safely;

(5) submits information from the disciplinary data bank of the Federation of State Medical Boards;

(6) is interviewed by a member of the board; and

(7) pays the fees established in 12 AAC 02.250.

(b) If the report required in (a)(5) of this section shows evidence of disciplinary action in this state or another licensing jurisdiction within the five years immediately before the date of application under (a)(1) of this section, the board will, in its discretion, deny an application for reactivation, if the evidence demonstrates that the applicant is not capable of practicing medicine, podiatry, or osteopathy safely or lawfully.

Authority: AS 08.64.100 AS 08.64.180 AS 08.64.276

12 AAC 40.033. INACTIVE PHYSICIAN LICENSE. (a) A physician who is not practicing in the state may hold an inactive license that may be renewed.

(b) A physician may apply for an inactive license at the time of license renewal by

(1) indicating on the form for license renewal that the physician is requesting an inactive license;

(2) paying the inactive biennial license fee established in 12 AAC 02.250; and

(3) submitting proof of meeting the continuing medical education requirements in 12 AAC 40.200 - 12 AAC 40.220;

(c) A physician licensed as inactive may not practice as a physician in the state.

(d) A physician licensed as inactive who wishes to resume active practice as a physician in the state must

(1) repealed 12/7/2006;

(2) submit a written request for reactivation;

(3) request a clearance report from the Federation of State Medical Boards' Board Action Data Bank be sent directly to the board;

(4) pay the physician biennial license renewal fee established in 12 AAC 02.250, less any inactive license fee previously paid for the same licensing period;

(5) submit proof of meeting the continuing medical education requirements in 12 AAC 40.200 - 12 AAC 40.220;

(6) arrange for verification of licensure to be sent directly to the division from each state other than this state where the applicant is or has been licensed as a physician; and

(7) provide a true and correct attestation whether the applicant has been the subject of a revoked or restricted DEA registration.

(e) Notwithstanding (a) and (b) of this section, the board may refuse to reactivate a physician license for the same reasons that it may impose disciplinary sanctions against a licensee under AS 08.64.326 and this chapter.

Authority: AS 08.64.100 AS 08.64.240 AS 08.64.313

12 AAC 40.035. TEMPORARY PERMIT APPLICATION REQUIREMENTS. (a) A member of the board, the executive secretary, or a person designated by the board to issue temporary permits, may issue a temporary physician permit to an applicant who

(1) meets the requirements of AS 08.64.270; and

(2) has a complete application under 12 AAC 40.010 or 12 AAC 40.015 on file with the division; and

(3) if an interview is required under 12 AAC 40.055, is interviewed in accordance with AS 08.64.279.

(b) Repealed 8/9/2000.

(c) Repealed 8/9/2000.

(d) A member of the board, the executive secretary, or a person designated by the board to issue temporary permits, may expedite the issuance of a temporary physician permit to an applicant who

(1) meets the requirements of AS 08.64.270; and

(2) has on file with the division

(A) a completed application on a form provided by the department;

(B) a completed authorization for release of records on a form provided by the department and signed by the applicant;

(C) payment of all required application and licensing fees;

(D) repealed 7/7/2022;

(E) repealed 7/7/2022;

(F) repealed 7/7/2022;

(G) clearance from the Federation of State Medical Boards or the Federation of Podiatric State Medical Boards; and

(H) clearance from the National Practitioner Data Bank; and

(3) has no adverse or derogatory history, including

(A) grounds for which the board may impose disciplinary sanctions under AS 08.64.326;

(B) malpractice settlements or payments in excess of $50,000 individually or $100,000 in the aggregate;

(C) any criminal charge or conviction, including conviction based on a guilty plea or plea of nolo contendere;

(D) any complaint, investigation, or action, regarding the practice of medicine, in another state or territory of the United States, a province or territory of Canada, a federal agency, the armed forces of the United States, or any international jurisdiction;

(E) any adverse action taken by a hospital, health care facility, health care entity, residency program or fellowship program.

Authority: AS 08.64.100 AS 08.64.270 AS 08.64.279
AS 08.64.180

12 AAC 40.036. LOCUM TENENS PERMIT APPLICATION REQUIREMENTS. (a) A member of the board, the executive secretary, or a person designated by the board to issue temporary permits, may issue a locum tenens permit to an applicant who

(1) meets the requirements of AS 08.64.275;

(2) has a complete application on file with the division;

(3) if an interview is required under 12 AAC 40.055, is interviewed in accordance with AS 08.64.279; and

(4) if the applicant is a foreign medical graduate, meets the requirements of 12 AAC 40.016.

(b) A complete application must include the following:

(1) direct source verification of successful completion of medical school;

(2) direct source verification of the applicant's completion of post-graduate training that meets the requirements of 12 AAC 40.010(h);

(3) verification of licensure from the appropriate licensing authority in each state, territory, or province where the applicant holds or has ever held a license, requested by the applicant and sent directly to the division from the licensing jurisdiction;

(4) all application fees required under 12 AAC 02.250 for a locum tenens permit;

(5) clearance from the Federation of State Medical Boards sent directly to the division;

(6) clearance from the National Practitioner Data Bank.

(c) Repealed 6/15/2001.

(d) A physician who is not currently licensed in this state may apply for a locum tenens permit for the purpose of substituting for a physician licensed in this state who is

(1) temporarily absent from the practice location at which the applicant will practice; or

(2) not expected to return to the practice location, if issuance of a locum tenens permit is necessary to temporarily provide essential medical services to the public or to protect the public health and safety.

(e) Notwithstanding (a) of this section, the board's designee, as identified under 12 AAC 40.910, will perform the duties described in this section, as delegated by the board.

(f) Notwithstanding (b) of this section, an applicant for a locum tenens permit may submit the credentials verification documents through the Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards of the United States, Inc., sent directly to the department from FCVS.

Authority: AS 08.64.100 AS 08.64.180 AS 08.64.279
AS 08.64.101 AS 08.64.275

12 AAC 40.038. RESIDENCY PERMIT. (a) A member of the board or the executive secretary, may issue a residency permit to an applicant who

(1) meets the requirements of AS 08.64.272;

(2) if an interview is required under 12 AAC 40.055, is interviewed in accordance with AS 08.64.279;

(3) provides a complete application;

(4) if the applicant is a foreign medical graduate, meets the requirements of 12 AAC 40.016(a)(1).

(b) A complete application must include the following:

(1) a complete notarized application form with a photograph and signed by the applicant;

(2) a certified true copy of a medical school diploma as required under AS 08.64.200, AS 08.64.205, or AS 08.64.225, or an official transcript sent directly from the medical school from which the applicant graduated to the board;

(3) verification of successful completion of medical school education sent directly by the medical school from which the applicant graduated to the board;

(4) a statement signed by the physician program director, from a residency training program approved by the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons of Canada, the American Medical Association, or the American Osteopathic Association stating that the applicant is a resident in good standing in the program and that the rotation in this state is an approved part of the post-graduate training program;

(5) a statement from the institution in this state accepting the resident applicant as a resident in training and accepting responsibility for the applicant's training while at that institution, signed by the program director, clinical director, or other physician responsible for the training of the applicant;

(6) verification of licensure from all states or licensing jurisdictions where the applicant holds or has ever held a license to practice medicine as a physician;

(7) verification of licensure from all states or licensing jurisdictions where the applicant holds or has ever held a license as a health care professional;

(8) clearance from the Federation of State Medical Boards sent directly to the board; and

(9) the application fee and the residency permit fee established in 12 AAC 02.250.

(c) A residency permit is valid only for the duration of the residency at the institution in this state, not to exceed 36 months. The permit may be renewed for an additional 36 months upon board approval of a new application by the resident.

(d) Notwithstanding (b) of this section, an applicant for a residency permit may submit the credentials verification documents through the Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards of the United States, Inc., sent directly to the department from FCVS.

Authority: AS 08.64.100 AS 08.64.272 AS 08.64.279
AS 08.64.101

12 AAC 40.040. RECOGNIZED HOSPITAL. For the purpose of AS 08.64.200(a)(2), a recognized hospital is one that has a postgraduate training program located in the United State or its territories, or in Canada, and that has been approved for internship or residency training by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada.

Authority: AS 08.64.100 AS 08.64.200

12 AAC 40.045. COURTESY LICENSE. (a) A courtesy license authorizes the holder to practice medicine, osteopathy, or podiatry for limited purposes recognized by the board in (b) and (j) of this section. A courtesy license does not authorize the holder to perform medical services outside the scope of the courtesy license issued under this section.

(b) For purposes of (a) of this section, the board will consider the following physicians to practice for limited purposes that qualify for the issuance of a courtesy license:

(1) physicians who come to the state for the purpose of conducting a specialty clinic, if the patients do not pay or give a fee or other remuneration for the services provided;

(2) out-of-state sports team physicians who accompany their team to the state for the duration of the team's presence in the state for the sporting activity and whose practice while in the state is limited to care of the applicant's team and visiting support staff personnel associated with the event;

(3) physicians who are formally contracted by state agencies to conduct specialty clinics;

(4) physicians who come to the state to provide emergency medical care or emergency mental health care, except under an emergency courtesy license as provided in (j) of this section, if

(A) the patients do not pay or give a fee or other remuneration; and

(B) the services are provided as part of an organized response to a disaster emergency

(i) that the governor has declared under AS 26.23.020; and

(ii) in which extensive injuries or deaths have occurred;

(5) physicians who will be working in a supervised hospital fellowship; and

(6) physicians who are coming into the state accompanying an employer-patient for the duration of the employer-patient's visit to the state and whose practice while in the state is limited to care of the employer-patient and accompanying family and staff.

(c) If a courtesy license is issued under (b)(5) of this section, the supervising physician shall notify the board in writing of any termination of or change to the supervisory relationship with the courtesy license holder. The supervising physician's responsibility continues until the board receives the written notice of termination or change.

(d) The board, a member of the board, the executive secretary, or the board's designee may issue a courtesy license to an applicant who

(1) submits a complete application on a form provided by the department;

(2) pays the application and licensing fees required under 12 AAC 02.250;

(3) submits verification of a current license to practice medicine in good standing and not under investigation in the state or territory, or a province of Canada in which the applicant resides;

(4) submits a description of the circumstances under which the applicant will be practicing, including the name and license number of the supervising physician if the applicant is working in a supervised hospital fellowship;

(5) submits a description of the scope of medical practice required to perform the duties for which the courtesy license is issued; the description must include the practice location, duration of practice, and patient population to be seen; the applicant must demonstrate that the scope of medical practice is for a limited purpose set out in (b) of this section;

(6) submits a signed authorization for the release of records;

* a requirement → (7) submits a certified true copy of an accredited medical school diploma or direct source verification of successful completion of medical school;

(8) submits direct source verification of the applicant's completion of post-graduate training;

(9) submits a Federation of State Medical Boards' Board Action Data Bank clearance report; and

(10) receives clearance from the National Practitioner Data Bank.

(e) A courtesy license is valid only for the shorter of the following periods:

(1) the duration of the activity as listed in (b) of this section;

(2) a period not to exceed

(A) one year after the date the courtesy license is issued under (b)(1) – (b)(3) or (b)(5) – (b)(6) of this section; or

(B) for an emergency courtesy license, six months with a six-month extension upon request, if issued under (j) of this section, or the board has determined the urgent situation no longer requires an emergency courtesy license.

(f) A courtesy license holder is subject to all relevant provisions of AS 08.64, this chapter, and any other statutes or regulations governing the practice of medicine and the prescription of drugs in this state.

(g) A courtesy license holder may not use a courtesy license

(1) for purposes of locum tenens coverage;

(2) to serve in place of a temporary license; or

(3) for purposes of employment consideration.

(h) Notwithstanding (a), (b), or (d) of this section, the board may refuse to issue a courtesy license for the same reasons that it may impose disciplinary sanctions against a licensee under AS 08.64.326.

(i) Notwithstanding (d) of this section, an applicant for a courtesy license may submit the credentials verification documents through the Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards of the United States, Inc., sent directly to the department from FCVS.

(j) The board may determine that there exists an urgent situation that requires issuance of an emergency courtesy license. In an urgent situation, the board, executive administrator, or the board's designee may issue an emergency courtesy license under this subsection to an applicant who practices medicine or osteopathy, or who practices as a physician assistant to provide emergency medical or mental health care within the scope and duration of the declared urgent situation. A courtesy license may be issued under this subsection to a person who

(1) holds a current, unencumbered license to practice as a physician, osteopath, or physician assistant in another jurisdiction, or holds a retired license under AS 08.64.276 that has been issued less than two years;

(2) submits a completed application on a form provided by the department, and

(A) if a physician or osteopath,

(i) verification of a current license to practice medicine or osteopathy in good standing and not under investigation in the jurisdiction in which the applicant resides, or verification of a retired license issued under AS 08.64.276;

(ii) clearance from the Federation of State Medical Boards;

(iii) clearance from the National Practitioner Data Bank; and

Required

(iv) a true and correct attestation whether the applicant has been the subject of a revoked or restricted DEA registration;

(B) if a physician assistant,

(i) verification of a current license to practice medicine in good standing and not under investigation in the jurisdiction in which the applicant resides;

(ii) clearance from the Federation of State Medical Boards;

(iii) clearance from the National Practitioner Data Bank; and

Required

(iv) a true and correct attestation whether the applicant has been the subject of a revoked or restricted DEA registration;

(C) repealed 5/5/2023.

(k) The board may refuse to issue a courtesy license or an emergency courtesy license for the same reasons it may deny, suspend, or revoke a license under AS 08.64.326.

(l) In this section, "urgent situation" means a health crisis affecting all or part of the state that requires increased availability of healthcare providers licensed under this chapter.

Authority: AS 08.01.062 AS 08.64.100 AS 08.64.240

12 AAC 40.046. TEMPORARY MILITARY COURTESY LICENSE. (a) The board, executive secretary, or board's designee will issue a temporary military courtesy license to an active duty military member or spouse of an active duty military member of the armed forces of the United States to practice medicine, osteopathy, podiatry, or as a physician assistant who meets the requirements of AS 08.01.063 and this section not later than 30 days after the board receives a completed application.

(b) An applicant for a temporary military courtesy license under this section

(1) must submit an application on a form provided by the department;

(2) must pay the temporary license application fee and fee for a temporary license set out under 12 AAC 02.105;

(3) must submit a copy of

(A) the applicant's current active duty military orders showing assignment to a duty station in this state; or

(B) if the applicant is the spouse of an active duty military member, the applicant's spouse's current active duty military orders showing assignment to a duty station in this state;

(4) must hold a current license that is not restricted, suspended, or revoked in any jurisdiction that authorizes the applicant to practice as a physician, osteopath, podiatrist, or physician assistant in the licensing jurisdiction; and

(5) if a physician, podiatrist, or osteopath, must submit

(A) verification of a current license to practice medicine, podiatry, or osteopathy in good standing and not under investigation by the licensing authority of another jurisdiction;

(B) clearance from the Federation of State Medical Boards;

(C) clearance from the National Practitioner Data Bank; and

(D) a true and correct attestation whether the applicant has been the subject of a revoked or restricted DEA registration;

(6) if a physician assistant, must submit

(A) verification of a current license to practice medicine in good standing and not under investigation in the jurisdiction in which the applicant resides;

(B) clearance from the Federation of State Medical Boards;

(C) clearance from the National Practitioner Data Bank; and

(D) a true and correct attestation whether the applicant has been the subject of a revoked or restricted DEA registration.

(c) A temporary military courtesy license issued to an active duty military member or spouse of an active duty military member under this section will be issued for a period of 180 days and may be renewed for one additional 180-day period, at the discretion of the board.

(d) A temporary military courtesy license holder is subject to all relevant provisions of AS 08.64, this chapter, and any other statutes or regulations governing the practice of medicine and the prescription of drugs in this state.

(e) The board may refuse to issue a temporary military courtesy license or an emergency courtesy license for the same reasons it may deny, suspend, or revoke a license under AS 08.64.326.

Authority: AS 08.01.062 AS 08.64.100 AS 08.64.240
AS 08.01.063 AS 08.64.101

12 AAC 40.050. BIOGRAPHICAL DATA. Repealed 8/30/2024.

12 AAC 40.055. INTERVIEW. (a) An applicant for a license or permit regulated by the board shall be interviewed in accordance with AS 08.64.255 or AS 08.64.279 if additional information from the applicant is necessary for the board to determine whether the applicant meets the qualifications in AS 08.64 and this chapter for the license or permit the applicant seeks.

(b) In determining whether an interview is required, the board or a member of the board will consider the information provided by the applicant on the completed application form and

(1) the applicant's disciplinary history with any medical board, licensing agency, credentialing authority, medical or professional school, internship program, residency program, or military authority;

(2) the applicant's charges or convictions of a felony, misdemeanor, or violation of a law, statute, or regulations of this or another jurisdiction, including the United States or another country, that relate to the grounds for the applicable license or permit denial or imposition of disciplinary sanctions under AS 08.64 or this chapter; the applicant's charges or convictions

(A) include those crimes involving alcohol or narcotics or other controlled substances; but

(B) exclude minor traffic violations;

(3) the applicant's mental, emotional, and physical fitness to practice in a profession regulated by the board under the standards established for the applicable license or permit denial or imposition of disciplinary sanctions under AS 08.64 or this chapter; the board will limit inquiry of the applicant's personal history under this paragraph to information concerning the five years immediately before the date of application;

(4) the applicant's history of negotiated settlements, judgments, or awards in claims or civil actions alleging medical or professional malpractice against the applicant;

(5) the information obtained from a disciplinary data bank regarding the applicant;

(6) the information supplied by the applicant's medical or professional school;

(7) the information received from the program in which the applicant completed post graduate training; and

(8) the information received from other licensing jurisdictions regarding the applicant's professional license status and history.

Authority: AS 08.64.100 AS 08.64.255 AS 08.64.279
AS 08.64.240

Re deleting

12 AAC 40.058 REVIEW OF APPLICATIONS. (a) An applicant who meets the requirements on the appropriate checklist established in this section has demonstrated the necessary qualifications for the temporary permit, residency permit, courtesy license, or physician license applied for and will be approved by the board, executive secretary, or the board's designee for issuance of that license or permit. An applicant who does not meet the requirements on the appropriate checklist in this section for that permit or license will not be issued a permit or license unless the board further reviews the application and determines that the applicant meets the qualifications in AS 08.64 and this chapter for the permit or license applied for.

(b) The form titled *Alaska State Medical Board Checklist — Physician*, dated April 2019, is adopted by reference. This form is established by the board for the use by the executive secretary or a person designated by the board in completing the application processing for a temporary permit under AS 08.64.270 or a podiatrist license under AS 08.64.209; this form is also used by a board member or the executive secretary in completing the application processing for a physician or osteopath license under AS 08.64.230, or a podiatrist license under AS 08.64.209.

(c) The form titled *Alaska State Medical Board Checklist — Resident Permit*, dated February 2018, is adopted by reference. This form is established by the board for the use by the executive secretary in completing the application processing for a residency permit under AS 08.64.272.

(d) The form titled *Alaska State Medical Board Courtesy License Checklist*, dated February 2018, is adopted by reference. This form is established by the board for the use by the executive secretary in completing the application processing for a courtesy license under AS 08.01.062 and 12 AAC 40.045.

(e) The form titled *Alaska State Medical Board Checklist – Locum Tenens Permit*, dated April 2019, is adopted by reference. This form is established by the board for the use by a board member, the executive secretary, or a person designated by the board in completing the application processing for a temporary permit for locum tenens practice under AS 08.64.275.

Authority: AS 08.01.062 AS 08.64.205 AS 08.64.270
AS 08.64.075 AS 08.64.209 AS 08.64.272
AS 08.64.100 AS 08.64.255 AS 08.64.279
AS 08.64.200

Editor's note: The application checklist forms listed in 12 AAC 40.058 are available at the Department of Commerce, Community, and Economic Development, Division of Corporations, Business and Professional Licensing offices in Anchorage and Juneau.

ARTICLE 2.
ABORTIONS.

Section

12 AAC 40.060. TERMINATION OF PREGNANCY. Termination of pregnancy must be requested by the pregnant woman.

Authority: AS 08.64.100 AS 08.64.105

12 AAC 40.070. INFORMED CONSENT. A written informed consent that complies with AS 18.16.060 shall be obtained from the patient. The written informed consent shall be on the patient's chart. The patient shall be advised of the medical implications and the possible emotional and physical sequelae of the procedure.

Authority: AS 08.64.100 AS 08.64.105

12 AAC 40.080. MEDICAL PROCEDURES. The patient shall be examined by a physician licensed in this state, and a written record of the patient's physical and emotional health shall be prepared before performing an abortion.

Authority: AS 08.64.100 AS 08.64.105

12 AAC 40.090. EVALUATION. The attending physician shall make an evaluation of the patient and an estimation of the duration of gestation based upon the patient's history, examination and test results. This information shall be recorded on the patient's chart.

Authority: AS 08.64.105

12 AAC 40.100. CONSULTATION REQUIREMENTS. Repealed 7/19/2017.

12 AAC 40.110. ABORTION PROCEDURES. The procedures described in the *Clinical Management Guidelines for Obstetrician-Gynecologists: Second-Trimester Abortion* Practice Bulletin Number 135, dated June 2013 and reaffirmed 2015, of the American College of Obstetricians and Gynecologists are adopted by reference as the standard of practice when providing an abortion after the first trimester.

Authority: AS 08.64.100 AS 08.64.105

Editor's note: A copy of the American College of Obstetricians and Gynecologists (ACOG) *Clinical Management Guidelines for Obstetrician-Gynecologists: Second-Trimester Abortion* Practice Bulletin Number 135, dated June 2013 and reaffirmed 2015, adopted by reference in 12 AAC 40.110, may be obtained from the American College of Obstetricians and Gynecologists, 409 12th Street SW, PO Box 96920, Washington, DC 20090-6920 or website at http://www.acog.org/Resources-And-Publications/Practice-Bulletins-List.

12 AAC 40.120. STANDARDS FOR HOSPITALS AND FACILITIES. (a) During the second or third trimester of a pregnancy, abortions shall be performed under sterile conditions. A bed and a registered nurse shall be available for a minimum recovery period of one-half hour. A registered nurse shall be present during the procedure.

(b) From and after the point in time when a fetus becomes viable, as determined by those medical examinations and tests that in the physician's professional judgment are necessary, an abortion may only be performed at a hospital with a neonatal intensive care unit (NICU).

Authority: AS 08.64.100 AS 08.64.105

12 AAC 40.130. RECORDS. In accord with 12 AAC 40.940, during the second or third trimester of a pregnancy, the attending physician shall record a medical history, findings of the physical examination, operative report of the abortion procedure, and pathology report as part of the clinical record to be maintained by the hospital or facility. The physician and hospital or facility shall treat the patient's identity and medical record as confidential information.

Authority: AS 08.64.100 AS 08.64.105

12 AAC 40.140. LIMITATION. A fetus that has not developed beyond 150 days after the first day of the last menstrual period may be considered non-viable. In the performance of an abortion after that date, the physician shall be guided by a reasonable judgment as to whether the fetus is viable in fact.

Authority: AS 08.64.100 AS 08.64.105

ARTICLE 3.
CONTINUING MEDICAL EDUCATION.

Section

12 AAC 40.200. GENERAL REQUIREMENTS. (a) A physician, osteopath, or podiatrist seeking renewal of a license shall obtain

(1) an average of 25 credit hours of continuing medical education during each year of the previous license period; and

(2) at least two of the total hours required to qualify for renewal must be education in pain management and opioid use and addiction, unless the licensee provides a certification under 12 AAC 40.220 that the licensee does not currently hold a valid federal Drug Enforcement Administration registration number.

(b) If a licensee fails to meet continuing medical education requirements due to illness or other extenuating circumstances, the licensee may request an extension of time in order to comply with those requirements. The request for an extension must be made on the licensee's application for license renewal. The board, or its designee, will only consider a request for extension if the licensee also agrees to enter into a memorandum of agreement with the board that specifies the date within the licensing period by which the licensee will meet the continuing education requirements and the licensee's agreement to voluntarily surrender the license to the board if the licensee fails to comply with the memorandum of agreement. The board, or its designee, will evaluate the request and proposed memorandum of agreement on an individual basis. If approved, the board, or its designee, will grant the extension of time and issue the renewed license for the next licensing period, effective from the date of the approval of the agreement.

Authority: AS 08.01.100 AS 08.64.100 AS 08.64.312
AS 08.64.075

12 AAC 40.210. CREDIT HOURS. (a) Except as provided in (b) of this section, a licensee may meet the continuing medical education requirements set out in 12 AAC 40.200(a) only by obtaining

(1) credit hours in a Category I continuing medical education program accredited by the American Medical Association;

(2) Category I or II continuing medical education hours accredited by the American Osteopathic Association; or

(3) continuing medical education hours earned from providers that are approved by the Council on Podiatric Medical Education.

(b) The board will accept the following as the equivalent of the credit hours required under 12 AAC 40.200(a)(1):

(1) a current physician's recognition award from the American Medical Association, American Podiatry Association, American Osteopathic Association, or a recognized subspecialty board; or

(2) initial certification or recertification during the concluding licensing period by a specialty board recognized by the American Medical Association or the American Osteopathic Association; or

(3) participation in a residency program during the concluding licensing period.

Authority: AS 08.64.100 AS 08.64.312

12 AAC 40.220. CERTIFICATION OF COMPLIANCE. (a) A licensee shall submit, upon a form supplied by the board, a signed statement of compliance with the continuing medical education requirement at the time the licensee applies for license renewal.

(b) The board, or its designee, will, in the board's or the board designee's discretion, require a licensee to submit additional evidence of compliance with the continuing medical education requirement. The licensee shall maintain evidence of compliance.

(c) The board, or its designee, will, in the board's or the board designee's discretion, audit the statements of compliance and additional evidence submitted under (a) and (b) of this section. If upon audit, the board or its designee determines that the statement of compliance contained misstatements and that the licensee had not met continuing medical education requirements set out in 12 AAC 40.200 and 12 AAC 40.210 by the time that the statement of compliance was signed, the board or its designee will consider the licensee as securing a license through intentional misrepresentation under AS 08.64.326(a)(1). Nothing in this subsection precludes the board from finding other grounds for imposition of disciplinary sanctions under AS 08.64.326 based on the conduct described in this subsection.

Authority: AS 08.64.075 AS 08.64.312 AS 08.64.326
AS 08.64.100

12 AAC 40.240. EXEMPTION FROM CONTINUING MEDICAL EDUCATION REQUIREMENTS. For the purposes of exempting a licensee from meeting the continuing medical education requirements in a licensing period, extenuating circumstances are those circumstances, beyond the licensee's control, that prevent the licensee from meeting the continuing medical education requirements. Extenuating circumstances include the licensee's debilitating or long-term personal illness or injury and the debilitating or long-term illness or injury of a member of the licensee's immediate family.

Authority: AS 08.64.100 AS 08.64.101 AS 08.64.312

ARTICLE 4.
MOBILE INTENSIVE CARE PARAMEDICS.

Section

12 AAC 40.300. APPLICATION FOR LICENSE. Repealed 5/5/2023.

12 AAC 40.310. QUALIFICATIONS FOR INITIAL LICENSE. Repealed 5/5/2023.

12 AAC 40.315. SPONSORSHIP. Repealed 5/5/2023.

12 AAC 40.320. APPROVED CURRICULUM. Repealed 5/5/2023.

12 AAC 40.325. INTERNSHIP REQUIREMENTS. Repealed 5/5/2023.

12 AAC 40.330. PERSONS CURRENTLY PRACTICING AS MOBILE INTENSIVE CARE PARAMEDICS. Repealed 8/25/90.

12 AAC 40.340. LICENSE ISSUANCE AND EXPIRATION. Repealed 5/5/2023.

12 AAC 40.350. RENEWAL OF LICENSE. Repealed 5/5/2023.

12 AAC 40.352. LAPSED MOBILE INTENSIVE PARAMEDIC LICENSES. Repealed 5/5/2023.

12 AAC 40.355. TEMPORARY PERMITS. Repealed 5/5/2023.

12 AAC 40.356. PROVISIONAL LICENSE. Repealed 5/5/2023.

12 AAC 40.360. GROUNDS FOR SUSPENSION, REVOCATION OR REFUSAL TO ISSUE A LICENSE. Repealed 5/5/2023.

12 AAC 40.370. SCOPE OF AUTHORIZED ACTIVITIES. Repealed 5/5/2023.

12 AAC 40.380. PROHIBITED ACTS. Repealed 5/5/2023.

12 AAC 40.390. IDENTIFICATION. Repealed 5/5/2023.

ARTICLE 5.
PHYSICIAN ASSISTANTS.

Section

12 AAC 40.400. PHYSICIAN ASSISTANT LICENSE. (a) An individual who desires to undertake medical diagnosis and treatment or the practice of medicine in AS 08.64.380(6) or AS 08.64.380(7) as a physician assistant

(1) shall apply for a permanent renewable license on a form provided by the department;

(2) shall pay the appropriate fees established in 12 AAC 02.250; and

(3) must be approved by the board.

(b) The application must contain documented evidence of

(1) graduation from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or, before 2001, by its predecessor accrediting agencies the American Medical Association's Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs;

(2) a passing score on the certifying examination administered by the National Commission on Certification of Physician Assistants;

(3) verification of current certification issued by the National Commission on Certification of Physician Assistants (NCCPA);

(4) compliance with continuing medical education standards established by the National Commission on Certification of Physician Assistants;

(5) verification of registration or licensure in all other states where the applicant is or has been registered or licensed as a physician assistant or any other health care professional;

(6) verification of successful completion of a physician assistant program that meets the requirements of (1) of this subsection; that verification must be sent directly from the program to the board;

(7) verification of the applicant's completion of at least two hours of education in pain management and opioid use and addiction earned in a continuing medical education program approved by the National Commission

on Certification of Physician assistants (NCCPA), a Category I continuing medical education program accredited by the American Medical Association, or a Category I or II continuing medical education program accredited by the American Osteopathic Association, for an applicant who does not currently hold a valid federal Drug Enforcement Administration registration number, the verification will be waived until the applicant applies for a valid registration number;

(8) clearance from the Board Action Data Bank maintained by the Federation of State Medical Boards; and

(9) clearance from the federal Drug Enforcement Administration (DEA).

(c) Repealed 9/1/2007.

(d) Notwithstanding (b) of this section, an applicant for a physician assistant license may submit the credentials verification documents through the Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards of the United States, Inc., sent directly to the department from FCVS.

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.405. TEMPORARY LICENSE. (a) A member of the board, the executive secretary, or a person designated by the board to issue temporary permits, may approve a temporary physician assistant license of an applicant who meets the requirements of 12 AAC 40.400 or 12 AAC 40.445 and pays the fee set out in 12 AAC 02.250.

(b) A temporary license is valid for six months or until the board meets and considers the application for a permanent renewable license, whichever occurs first.

(c) The board may renew a temporary license once only, based on good cause.

(d) Repealed 07/25/2008.

(e) An applicant who meets the requirements on the checklist established in this section has demonstrated the necessary qualifications for the temporary permit applied for and will be approved by the board, the executive secretary, or the board's designee for issuance of that permit. An applicant who does not meet the requirements on the checklist established in this section for that permit will not be issued a temporary permit unless the board further reviews the application and determines that the applicant meets the qualifications in AS 08.64 and this chapter for that permit. The form titled *Alaska State Medical Board – Checklist, Temporary Permit for Physician Assistant*, dated February 2018, is adopted by reference. This form is established by the board for the use by the executive secretary or another employee of the division in completing the application processing for a temporary permit under this section.

Authority: AS 08.64.100 AS 08.64.101 AS 08.64.107

Editor's note: The application checklist form listed in 12 AAC 40.405 is available at the Department of Commerce, Community, and Economic Development, Division of Corporations, Business and Professional Licensing offices in Anchorage and Juneau.

12 AAC 40.406. LOCUM TENENS AUTHORIZATION TO PRACTICE. Repealed 9/1/2007.

12 AAC 40.408. AUTHORIZATION TO PRACTICE AS A PHYSICIAN ASSISTANT. Repealed 9/1/2007.

12 AAC 40.410. COLLABORATIVE RELATIONSHIP AND PLAN. (a) A licensed physician assistant may not practice without at least one collaborative relationship established under this chapter. The collaborative relationship must be documented by a collaborative plan on a form provided by the board and must include

(1) the name, license number, and specialty, if any, for the primary supervising physician and at least one alternate collaborating physician;

(2) the name, place of employment, and both residence and mailing addresses of the physician assistant with whom the physician intends to establish a collaborative relationship;

(3) the beginning date of employment under the collaborative plan and the physical location of practice;

(4) compliance with 12 AAC 40.415 if the practice location is a remote practice location; and

(5) prescriptive authority being granted to the physician assistant by the collaborating physician under the collaborative plan.

(b) The collaborative plan must be filed with the division within 14 days after the effective date of the collaborative plan or within 14 days after the effective date of any change to that plan.

(c) Receipt by the board of the collaborative plan will be considered documented evidence of an established collaborative plan.

(d) Any physician assistant subject to a board order must have their collaborative plan approved by the board or its designee in advance of the effective date of the plan to insure that the collaborative plan conforms to the terms of the order.

(e) A copy of the current plan must be retained at the place of employment specified in the plan and must be available for inspection by the public.

(f) A change in a collaborative plan automatically suspends a licensed physician assistant's authority to practice under that collaborative plan unless the change is only to replace the primary collaborating physician with an existing alternate collaborating physician and at least one alternate collaborating physician remains in place. Any change to collaborating physicians must be reported to the board in accordance with (b) of this section.

(g) Nothing in this section prohibits periodic board review and assessment of the collaborating physician and the collaborative plan.

(h) A physician who wishes to establish a collaborative relationship with a physician assistant must hold a current, active, and unrestricted license to practice medicine in this state and be in active practice of medicine.

(i) The primary collaborating physician shall maintain in the physician's records a copy of each DEA Form 222 official order form submitted by each physician assistant with whom the physician has a collaborative relationship. The primary collaborating physician is responsible for ensuring that the physician assistant complies with state and federal inventory and record keeping requirements.

(j) In this section, "active practice" means at least 200 hours each year of practicing medicine with direct patient contact.

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.415. REMOTE PRACTICE LOCATION. (a) To qualify to practice in a remote practice location, a physician assistant with less than two years of full-time clinical experience must work 160 hours in direct patient care under the direct and immediate supervision of the collaborating physician or alternate collaborating physician. The first 40 hours must be completed before the physician assistant begins practice in the remote practice location, and the remaining 120 hours must be completed within 90 days after the date the physician assistant starts practice in the remote practice location.

(b) A physician assistant with less than two years of full-time clinical experience who practices in a remote practice location and who has a change of collaborating physician must work 40 hours under the direct and immediate supervision of the new collaborating physician within 60 days after the effective date of the new collaborative plan unless the change is only to replace the primary collaborating physician with an existing alternate collaborating physician.

(c) A physician assistant with two or more years of full-time clinical experience who applies for authorization to practice in a remote practice location shall submit with the collaborative plan

(1) a detailed curriculum vitae documenting that the physician assistant's previous experience as a physician assistant is sufficient to meet the requirements of the location assignment; and

(2) a written recommendation and approval from the collaborating physician.

(d) In this section, "remote practice location" means a location in which a physician assistant practices that is 30 or more miles by road from the collaborating physician's primary office.

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.420. CURRENTLY PRACTICING PHYSICIAN ASSISTANT. Repealed 6/28/97.

12 AAC 40.430. PERFORMANCE AND ASSESSMENT OF PRACTICE. (a) A person may perform medical diagnosis and treatment as a physician assistant only if licensed by the board and only within the scope of practice of the collaborating physician.

(b) A periodic method of assessment of the quality of practice must be established by the collaborating physician. In this subsection, "periodic method of assessment" means evaluation of medical care and clinic management.

(c) Repealed 3/27/2003.

(d) Repealed 3/27/2003.

(e) Assessments must include annual direct personal contact between the physician assistant and the primary or alternate collaborating physician, at either the physician or physician assistant's work site. The collaborating physician shall document the evaluation on a form provided by the department.

(f) Except as provided in (h) of this section, collaborative plans in effect for less than two years must include at least one direct personal contact visit with the primary or alternate collaborating physician per calendar quarter for at least four hours duration.

(g) Except as provided in (h) of this section, collaborative plans in effect for two years or more must include at least two direct personal contact visits with the primary or alternate collaborating physician per year. Each visit must be of at least four hours duration and must be at least four months apart.

(h) Physician assistants who practice under a collaborative plan for a continuous period of less than three months of each year must have at least one direct personal contact visit with the primary or alternate collaborating physician annually.

(i) Collaborative plans, regardless of duration, must include at least monthly telephone, radio, electronic, or direct personal contact between the physician assistant and the primary or alternate collaborating physician during the period in which the physician assistant is actively practicing under the collaborative plan. Dates of active practice under the collaborative plan and monthly contact must be documented.

(j) Contacts, whether direct personal contact or contact by telephone, radio, or other electronic means, must include reviews of patient care and review of health care records.

(k) The primary collaborating physician shall maintain records of performance assessments. The board may audit those records.

(l) The primary collaborating physician shall maintain on file the completed records of assessment form for at least seven years after the date of the evaluation.

(m) If an alternate collaborating physician performs the evaluation, copies of the record of assessment must be provided to the primary collaborating physician for retention in the primary collaborating physician's records.

(n) The board's executive secretary may initiate audits of performance assessment records. In any one calendar year, the performance assessment records of not more than 10 percent of the actively licensed physician assistants, selected randomly by computer, will be audited. For each audit,

(1) the collaborating physician shall produce records of assessment for the past two calendar years immediately preceding the year of audit; and

(2) if the collaborative plan has been in effect for at least one year, but less than two years, only one year of records will be audited; collaborative plans of less than one year's duration will not be audited.

(o) Repealed 5/8/2013.

(p) Repealed 5/8/2013.

(q) Repealed 5/8/2013.

(r) During an urgent situation as determined by the board, direct personal contact as required under this section may be met by audio and video means; "urgent situation" has the meaning given in 12 AAC 40.045.

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.440. STUDENT PHYSICIAN ASSISTANT PERMIT. Repealed 8/17/97.

12 AAC 40.445. GRADUATE PHYSICIAN ASSISTANT LICENSE. (a) An applicant for a license to practice as a graduate physician assistant

(1) shall apply on a form provided by the department;

(2) shall pay the fees established in 12 AAC 02.250; and

(3) must be approved by the board.

(b) The application must include

(1) evidence of having graduated from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or, before 2001, by its predecessor accrediting agencies the American Medical Association's Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs; and

(2) evidence of having been accepted to take the next entry level examination of the National Commission on Certification of Physician Assistants, Inc. (NCCPA) for initial certification.

(c) A graduate physician assistant license is automatically suspended on the date the board receives notice that the applicant failed to take or failed to pass the NCCPA certifying examination required under (b)(2) of this section.

(d) Upon request, the board will reissue a graduate physician assistant license only if the licensee was prevented from taking a scheduled examination.

(e) A licensed graduate physician assistant must be under the continuous on-site supervision of a physician assistant licensed in this state or a physician licensed in this state.

(f) When licensed, the licensee shall display a nameplate designating that person as a "graduate physician assistant."

(g) Notwithstanding (b) of this section, an applicant for a graduate physician assistant license may submit the credentials verification documents through the Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards of the United States, Inc., sent directly to the department from FCVS.

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.447. AUTHORIZATION TO PRACTICE AS A GRADUATE PHYSICIAN ASSISTANT. Repealed 9/1/2007.

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).

Authority: AS 08.64.100 AS 08.64.107 AS 17.30.200

12 AAC 40.460. IDENTIFICATION. A licensed physician assistant authorized to practice shall conspicuously display on the licensee's clothing a nameplate identifying the physician assistant as a "Physician Assistant-Certified (PA-C)" and shall display at the licensee's customary place of employment

(1) a current state license; and

(2) a sign at least five by eight inches informing the public that documents showing the licensed physician assistant's education and a copy of the current collaborative plan on file with the division are available for inspection.

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.470. RENEWAL OF A PHYSICIAN ASSISTANT LICENSE. (a) A physician assistant license must be renewed biennially on the date set by the department.

(b) An application for renewal must be made on the form provided by the department and must include

(1) payment of the renewal fee established in 12 AAC 02.250;

(2) documented evidence that the applicant has met the continuing medical education and recertification requirements of the NCCPA, including the NCCPA recertification examination, and is currently certified by NCCPA;

(3) verification on a form provided by the department of each authorization to practice issued before September 1, 2007 under which the physician assistant is practicing.

Authority: AS 08.64.100 AS 08.64.107 AS 08.64.315

12 AAC 40.473. INACTIVE PHYSICIAN ASSISTANT LICENSE. (a) A physician assistant who is not practicing in the state may hold an inactive license that may be renewed.

(b) A physician assistant may apply for an inactive license at the time of license renewal by

(1) indicating on the form for license renewal that the physician assistant is requesting an inactive license; and

(2) paying the inactive biennial license fee established in 12 AAC 02.250.

(c) A physician assistant licensed as inactive may not practice as a physician assistant in the state.

(d) A physician assistant licensed as inactive who wishes to resume active practice as a physician assistant in the state must

(1) submit a completed renewal application form indicating request for reactivation;

(2) pay the physician assistant biennial license renewal fee established in 12 AAC 02.250, less any inactive license fee previously paid for the same licensing period;

(3) submit a copy of a current certificate issued by the National Commission on Certification of Physician Assistants; and

(4) request a clearance report from the Federation of State Medical Boards' Board Action Data Bank be sent directly to the board.

(e) Notwithstanding (a) and (b) of this section, the board may refuse to reactivate a physician assistant authorization for the same reasons that it may impose disciplinary sanctions against a licensee under AS 08.64.326 and this chapter.

Authority: AS 08.64.100 AS 08.64.240 AS 08.64.313
AS 08.64.107

12 AAC 40.475. LAPSED PHYSICIAN ASSISTANT LICENSE. (a) A physician assistant license that has been lapsed for at least 60 days but less than one year will be reinstated if the applicant submits

(1) a complete renewal application form;

(2) documentation that the continuing medical education requirements of 12 AAC 40.470(b)(2) have been met; and

(3) the renewal fees required by 12 AAC 02.250.

(b) A physician assistant license that has been lapsed for at least one year but less than five years will be reinstated if the applicant submits

(1) a complete renewal application on a form provided by the department;

(2) documentation that the continuing medical education requirements of 12 AAC 40.470(b)(2) have been met for the entire period that the authorization has been lapsed;

(3) verification of licensure from the appropriate licensing authority in each state, territory, or province where the applicant holds or has ever held a license as a physician assistant or other health care professional;

(4) clearance from the Federation of State Medical Boards sent directly to the division;

(5) clearance from the federal Drug Enforcement Administration (DEA); and

(6) the applicable fees required in 12 AAC 02.250.

(c) Notwithstanding (a) and (b) of this section, the board may refuse to reinstate a physician assistant license for the same reasons that it may impose disciplinary sanctions against a licensee under AS 08.64.326 and this chapter.

Authority: AS 08.01.100 AS 08.64.100 AS 08.64.107

or counted

12 AAC 40.480. EXEMPTIONS. (a) Nothing in this chapter prevents or regulates the use of a community health aid in the usual and customary manner in the rural areas of the State of Alaska.

(b) Nothing in this chapter regulates, restricts, or alters the functions of a person traditionally employed in an office, by a physician, performing duties not regulated by the State Medical Board under AS 08.64.

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.490. GROUNDS FOR SUSPENSION, REVOCATION, OR DENIAL OF LICENSE. The board, after compliance with the Administrative Procedure Act (AS 44.62), will, in its discretion, suspend, revoke or deny the license of a physician assistant who

(1) fails to pay the fees established in 12 AAC 02.250;

(2) has obtained, or attempted to obtain, a license or authorization to practice as a physician assistant by fraud, deceit, material misrepresentation, or false statement;

(3) habitually abuses alcoholic beverages, or illegally uses depressants, hallucinogenic or stimulant drugs as defined by AS 17.12.150(3) or uses narcotic drugs as defined by AS 17.10.230(13);

(4) consistently fails to comply with 12 AAC 40.460;

(5) practices without the required collaborative plan as required by 12 AAC 40.410;

(6) represents or uses any signs, figures, or letters to represent himself or herself as a physician, surgeon, doctor, or doctor of medicine;

(7) violates any section of this chapter;

(8) is found to have demonstrated professional incompetence as defined in 12 AAC 40.970;

(9) in a clinical setting,

(A) fails to clearly identify oneself as a physician assistant to a patient;

(B) uses or permits to be used on the physician assistant's behalf the term "doctor," "Dr.," or "doc"; or

(C) holds oneself out in any way to be a physician or surgeon;

(10) practices without maintaining certification by the National Commission on Certification of Physician Assistants (NCCPA).

Authority: AS 08.64.100 AS 08.64.107

ARTICLE 6.
GENERAL PROVISIONS.

Section

12 AAC 40.905. MEETINGS. (a) Subject to available funds and consideration of travel costs, the board may hold at least four in-person meetings each year at times and places designated by the board, in as many separate geographical areas of the state as possible.

(b) Subject to available funds and consideration of travel costs, special meetings may be held upon the call of the president or a majority of the members of the board, at the time and place as may be designated in the call.

Authority: AS 08.64.085 AS 08.64.100 AS 08.64.101

12 AAC 40.910. DELEGATION OF AUTHORITY TO THE BOARD'S DESIGNEE. (a) At least once each year, at a scheduled meeting of the board, the board will take formal action to identify the board's primary designee to perform duties that may be delegated to that designee under AS 08.64. The board will identify an alternative designee, either a single board member, the executive secretary, or another employee of the division who may act as the board's designee in the absence of the primary designee.

(b) The board may designate another employee of the division to issue temporary permits to applicants who meet the requirements of 12 AAC 40.035, 12 AAC 40.036, 12 AAC 40.058, or 12 AAC 40.405.

Authority: AS 08.64.075 AS 08.64.100 AS 08.64.101

12 AAC 40.920. STANDARDS FOR DELEGATION OF ROUTINE DUTIES. (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.

(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.

(g) The provisions of this section apply only to the delegation of routine medical duties by a physician, podiatrist, osteopath, or physician assistant licensed under AS 08.64; they do not apply when 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 health care provider licensed under AS 08, who has authority to delegate routine duties.

Authority: AS 08.64.100 AS 08.64.106 AS 08.64.107 AS 08.64.170 AS 08.64.326 AS 08.64.336 AS 08.64.380

12 AAC 40.930. REQUIREMENTS FOR REPORTING THE OUTCOME OF MALPRACTICE CLAIMS OR ACTIONS. (a) A person licensed under this chapter shall submit to the board a signed, notarized report on a form provided by the department, explaining the outcome of each malpractice claim or action against the licensee in which damages have been or are to be paid, whether by judgement or settlement. Reports shall be submitted to the board within 30 days of the date of the resolution of the claim or action.

(b) Malpractice reports shall include the

(1) name and address of the licensee;

(2) telephone number of the licensee;

(3) date of the occurrence;

(4) summary of the alleged malpractice;

(5) summary of the licensee's response to the allegations;

(6) case, claim, or court number of the malpractice claim or action; if a court action was not filed, the medical record or chart number, and the location of the records relating to the alleged malpractice;

(7) amount of the award or settlement paid or to be paid by or on behalf of the licensee;

(8) date of award or settlement;

(9) following type of resolution of the claim or action:

(A) court or jury award;

(B) settlement following initiation of civil court action;

(C) settlement before the initiation of civil court action;

(D) other private compromise.

(c) Failure to submit a malpractice report required by this section constitutes unprofessional conduct under 12 AAC 40.967 and is subject to disciplinary action by the board.

Authority: AS 08.64.100 AS 08.64.130 AS 08.64.200 AS 08.64.209 AS 08.64.345

12 AAC 40.940. STANDARDS OF PRACTICE FOR RECORD KEEPING. (a) A physician or physician assistant licensed by the board shall maintain adequate records for each patient for whom the licensee performs a professional service.

(b) Each patient record shall meet the following minimum requirements:

(1) be legible;

(2) contain only those terms and abbreviations that are or should be comprehensible to similar licensees;

(3) contain adequate identification of the patient;

(4) indicate the dates that professional services were provided to the patient;

(5) reflect what examinations, vital signs, and tests were obtained, performed, or ordered concerning the patient and the findings and results of each;

(6) indicate the chief complaint of the patient;

(7) indicate the licensee's diagnostic impressions of the patient;

(8) indicate the medications prescribed for, dispensed to, or administered to the patient and the quantity and strength of each medication;

(9) reflect the treatment provided to or recommended for the patient;

(10) document the patient's progress during the course of treatment provided by the licensee.

(c) Each entry in the patient record shall reflect the identity of the individual making the entry.

(d) Each patient record shall include any writing intended to be a final record. This subsection does not require the maintenance of preliminary drafts, notes, other writings, or recordings once this information is converted to final form and placed in the patient record.

not counted → (e) The patient records for a physician or physician assistant practicing under AS 08.64.364 must comply with the requirements of this section and include

(1) the physical location of the patient and the physician or physician assistant when the patient care was provided;

(2) a description of the method of the communication between the physician or physician assistant and patient;

(3) the name, location, and phone number, state of licensure and license number of the physician, physician assistant, or other licensed health care provider available to provide follow-up care; and

(4) if the prescribing physician or physician assistant is not the patient's primary care provider, documentation of the patient's consent to sending a copy of all records of the encounter to the patient's primary care provider, and if the patient consents, confirmation that the records were sent to the patient's primary care provider.

Authority: AS 08.64.100 AS 08.64.107 AS 08.64.364

12 AAC 40.943. STANDARDS OF PRACTICE FOR TELEMEDICINE. (a) The guiding principles for telemedicine practice in the American Medical Association (AMA), *Report 7 of the Council on Medical Service (A-14), Coverage of and Payment for Telemedicine*, dated 2014, and the Federation of State Medical Boards (FSMB), *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine*, dated April 2014, are adopted by reference as the standards of practice when providing treatment, rendering a diagnosis, prescribing, dispensing, or administering a prescription or controlled substance without first conducting an in-person physical examination under AS 08.64.364.

(b) During a public health emergency declared by the governor or commissioner of health, an appropriate licensed health care provider need not be present with the patient to assist a physician or physician assistant with examination, diagnosis, and treatment if the physician or physician assistant is prescribing, dispensing, or administering buprenorphine to initiate or continue treatment for opioid use disorder and the physician or physician assistant

(1) is a waived practitioner under 21 U.S.C 823(g)(2) (Drug Addiction Treatment Act (DATA));

(2) documents all attempts to conduct a physical examination under AS 08.64.364(b), the reason why the examination cannot be performed, and the reason why another health care provider cannot be present with the patient; and

(3) requires urine or oral toxicology screening as part of the patient's medication adherence plan.

Authority: AS 08.64.100 AS 08.64.101 AS 08.64.364

Editor's note: A copy of *Report 7 of the Council on Medical Service (A-14), Coverage of and Payment for Telemedicine*, adopted by reference in 12 AAC 40.943, may be obtained from the American Medical Association, AMA Plaza, 330 N. Wabash Ave. Suite 39300, Chicago, IL 60611-5885, or on the association's Internet website at https://www.ama-assn.org/about-us/council-medical-service-reports. A copy of the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine*, adopted by reference in 12 AAC 40.943, may be obtained from the Federation of State Medical Boards, 400 Fuller Wiser Road, Euless, TX 76039, or on the Federation's Internet website at https://www.fsmb.org/policy/advocacy-policy/policy-documents.

12 AAC 40.945. PERFORMANCE OF INDEPENDENT MEDICAL EVALUATIONS. Except as provided in AS 08.64.370, a physician who comes to this state for the purpose of performing an independent medical evaluation that involves a face-to-face physical examination, regardless of the purpose of the evaluation, is practicing medicine and is required to be licensed in this state.

Authority: AS 08.64.100 AS 08.64.170 AS 08.64.370

12 AAC 40.946. APPLICATION MADE UNDER OATH OR AFFIRMATION; DISCIPLINARY SANCTIONS. The applicant must sign the application and swear to or affirm the truth of its contents. False or misleading statements or information on the application, whether or not made knowingly, are grounds for denial of approval to take an examination under AS 08.64 or for disciplinary sanctions under AS 08.64.331.

Authority: AS 08.64.100 AS 08.64.190 AS 08.64.326
AS 08.64.107

12 AAC 40.950. CONTRACT FOR IMPAIRED PROFESSIONALS PROGRAM. The contract to establish an impaired medical professionals program under AS 08.64.101(6) must address the following areas:

(1) qualifications of the contracting agency or agent;

(2) record keeping;

(3) responsibility to report to the board;

(4) confidentiality;

(5) chemical and behavioral monitoring components; and

(6) costs.

Authority: AS 08.64.100 AS 08.64.101

12 AAC 40.955. ETHICAL STANDARDS. (a) The 2016 edition of the *Code of Medical Ethics,* of the American Medical Association are adopted by reference as the ethical standards for physicians and applies to all physicians subject to this chapter.

(b) The 2016 edition of the *Code of Ethics of the American Osteopathic Association* is adopted by reference as the ethical standards for osteopaths and applies to all osteopaths subject to this chapter.

(c) The 2017 edition of the *Code of Ethics of the American Podiatric Medical Association* is adopted by reference as the ethical standards for podiatrists and applies to all podiatrists subject to this chapter.

(d) The 2013 edition of the Guidelines for Ethical Conduct for *the Physician Assistant Profession of the American Academy of Physician Assistants* is adopted by reference as the ethical standards for physician assistants and applies to all physician assistants subject to this chapter

(e) Repealed 5/5/2023.

Authority: AS 08.01.070 AS 08.64.107 AS 08.64.326
AS 08.64.100

Editor's note: Copies of the *Code of Medical Ethics of the American Medical Association, Code of Ethics of the American Osteopathic Association, American Podiatric Medical Association Code of Ethics, and Guidelines for Ethical Conduct for the Physician Assistant Profession of the American Academy of Physician Assistants* described in 12 AAC 40.955, are available for inspection at and may be obtained at the Department of Commerce, Community, and Economic Development, Division of Corporations, Business and Professional Licensing, P.O. Box 110806, Juneau, AK 99811-0806.

12 AAC 40.960. CURRENT ADDRESS. A licensee shall maintain a current, valid mailing address on file with the division at all times. The latest mailing address on file for an active, inactive or lapsed license is the address of the licensee for official communications, notifications and service of legal process.

Authority: AS 08.64.100 AS 08.64.107

12 AAC 40.963. APPLICATION FORM AND VERIFICATIONS FOR LICENSURE. (a) If, upon receipt by the division of the last document required to complete an application file, the file contains an application form or verification that has a postmark date that is more than 12 months old, the document will be considered to be stale and the applicant must resubmit the document or cause the document to be resubmitted as appropriate before the application will be considered by the board or the board's designee.

(b) Verifications from medical schools and postgraduate training programs will not be considered stale under (a) of this section.

(c) An applicant whose license application has been approved pending receipt of the license fee must submit the license fee to the department within six months after being notified that the license application was approved. An applicant who does not submit the license fee to the department within six months after being notified that the license application was approved must reapply for licensure.

(d) In this section, "application form or verification" means

(1) an application for a license or permit;

(2) a verification of licensure from an appropriate licensing authority in a state, territory, province, or other country;

(3) a clearance report from the Federation of State Medical Board's Board Action Data Bank;

(4) a clearance from the federal Drug Enforcement Administration (DEA).

Authority: AS 08.64.100

12 AAC 40.965. REINSTATEMENT OF A SURRENDERED LICENSE. (a) A license issued under this chapter that was voluntarily surrendered under AS 08.64.334 will be reinstated, if

(1) the board determines that

(A) the requirements of AS 08.64.334 have been met;

(B) the applicant continues to qualify under AS 08.64 and this chapter for the license requested to be reinstated;

(C) the applicant has committed no grounds for imposition of disciplinary sanction under AS 08.64.326 or this chapter; and

(D) the applicant has satisfied any conditions imposed by the board to accept the surrendered license; and

(2) the applicant submits

(A) a new and complete application as required by 12 AAC 40.010, documenting compliance with

(i) AS 08.64.200 and AS 08.64.250, if a physician applicant;

(ii) AS 08.64.209 and AS 08.64.250, if a podiatrist applicant;

(iii) AS 08.64.205, if an osteopath applicant; or

(iv) AS 08.64.107, if a physician assistant;

(B) evidence of at least 50 hours of continuing medical education credits earned within the two years immediately before the date of application for reinstatement of the surrendered license for a physician, a podiatrist, or an osteopath;

(C) evidence of at least 120 hours of continuing medical education credits earned within the two years immediately before the date of application for reinstatement of the surrendered license for a physician assistant;

(D) for a physician assistant, evidence of current certification issued by the National Commission on Certification of Physician Assistants; and

(E) at the request of the board,

(i) a report of medical or psychiatric examination from a physician or another practitioner of the healing arts appointed by the board indicating that, at the time of the examination, the applicant is mentally and physically capable to resume practice under this chapter; and

(ii) any other report that the board determines is necessary to evaluate whether the applicant is competent to resume practice under this chapter.

(b) If the board determines that a limitation or condition on an applicant's license is necessary for the applicant to be competent to resume practice, the board will require that the applicant for reinstatement under this section enter into an agreement with the board to limit or condition the applicant's license.

(c) If the board determines that probation is necessary to evaluate or monitor the practice for competency under this chapter of an applicant whose license is reinstated under this section, the board will impose a period of probation and notify the applicant of the terms to be met to successfully complete the probation.

Authority: AS 08.01.075 AS 08.01.100 AS 08.64.100 AS 08.64.107 AS 08.64.331 AS 08.64.334

12 AAC 40.967. 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;

(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.

Authority: AS 08.01.070 AS 08.64.326 AS 08.64.380
AS 08.64.100 AS 08.64.364 AS 17.30.200
AS 08.64.101

12 AAC 40.970. PROFESSIONAL INCOMPETENCE. As used in AS 08.64 and these regulations, "professional incompetence" means lacking sufficient knowledge, skills, or professional judgement in that field of practice in which the physician or physician assistant concerned engages, to a degree likely to endanger the health of his or her patients.

Authority: AS 08.64.100 AS 08.64.326

12 AAC 40.975. PRESCRIBING CONTROLLED SUBSTANCES. When prescribing a drug that is a controlled substance, an individual licensed under this chapter shall

(1) create and maintain a complete, clear, and legible written record of care that includes

(A) a patient history and evaluation sufficient to support a diagnosis;

(B) a diagnosis and treatment plan for the diagnosis;

(C) a plan for monitoring the patient for the primary condition that necessitates the drug, side effects of the drug, and results of the drug, as appropriate;

(D) a record of each drug prescribed, administered, or dispensed, including the type of drug, dose, and any authorized refills;

(2) review the information from the controlled substance prescription database under AS 17.30.200 before initially dispensing, prescribing, or administering a controlled substance designated schedule II or III under federal law to the patient, and at least once every 30 days for up to 90 days, and at least once every three months if a course of treatment continues for more than 90 days; the requirement under this paragraph will not apply if the licensee is not required under AS 17.30.200 to review the information in the controlled substance prescription database before dispensing, prescribing, or administering the controlled substance to the patient;

(3) comply with the maximum dosage for opioid prescriptions under AS 08.64.363; the maximum daily dosage for an initial opioid prescription issued under AS 08.64.363(a) may not exceed 50 morphine milligram equivalents;

(4) practice pain management

(A) with sufficient knowledge, skills, and training, and in accordance with specialty board practice standards;

(B) in accordance with the Federation of State Medical Boards (FSMB) Guidelines for the Chronic Use of Opioid Analgesics, dated April 2017, and the Centers for Disease Control (CDC) Guidelines for Prescribing Opioids for Chronic Pain, dated March 2016, which are adopted by reference as the standards of practice for prescribing controlled substances for pain management;

(C) or refer a patient to a pain management physician.

Authority: AS 08.64.100 AS 08.64.326 AS 08.64.380
AS 08.64.107 AS 08.64.363 AS 17.30.200

Editor's note: A copy of the *Guidelines for the Chronic Use of Opioid Analgesics* adopted as policy by the Federation of State Medical Boards (FSMB), dated April 2017, adopted by reference in 12 AAC 40.975, may be obtained from the Federation of State Medical Boards, 400 Fuller Wiser Road, Euless, TX 76039, or website at https://www.fsmb.org/policy/advocacy-policy/policy-documents. A copy of the *CDC Guidelines for Prescribing Opioids for Chronic Pain*, dated March 2016, adopted by reference in 12 AAC 40.975, may be obtained from the Centers for Disease Control and Prevention, 1600 Clifton Road, Atlanta, GA 30329, or website at https://www.cdc.gov/drugoverdose/prescribing/guideline.html.

12 AAC 40.976. REGISTRATION AND REPORTING WITH THE PRESCRIPTION DRUG MONITORING PROGRAM CONTROLLED SUBSTANCE PRESCRIPTION DATABASE. A physician or physician assistant licensed under this chapter who holds a federal Drug Enforcement Administration (DEA) registration number must

(1) register and comply with the prescription drug monitoring program (PDMP) controlled substance prescription database not later than 30 days after initial licensure or registration with the DEA, whichever is later; and

(2) comply with the requirements of AS 17.30.200 and 12 AAC 52.865.

Authority: AS 08.64.100 AS 08.64.326 AS 08.64.380
AS 08.64.107 AS 08.64.363 AS 17.30.200

12 AAC 40.980. COLLABORATING PHYSICIAN. Repealed 9/1/2007.

12 AAC 40.981. FEDERAL LICENSURE EXEMPTIONS FOR PERSONS WHO PRACTICE IN AN ALASKA TRIBAL HEALTH PROGRAM. (a) A person who practices medicine, podiatry, or osteopathy, or who practices as a physician assistant in a tribal health program in this state must be licensed by the board unless they notify the board that they are practicing under another license in accordance with 25 U.S.C. 1621t (sec. 221, Indian Health Care Improvement Act). Notice required under this section must be received not later than 14 days after employment at a tribal health program in this state, and must include

(1) proof of a current active license in another state;

(2) proof of employment by a tribal health program that is operating under an agreement with the federal Indian Health Service under 25 U.S.C. 450 – 458ddd-2 (Indian Self-Determination and Education Assistance Act).

(b) A person practicing under the exemption may not practice beyond the scope of the other state license.

Authority: AS 08.64.107 AS 08.64.170 AS 08.64.313

12 AAC 40.983. COOPERATIVE PRACTICE AGREEMENTS WITH PHARMACISTS. (a) A physician may enter into a cooperative practice agreement with a pharmacist licensed under AS 08.80 as provided in this section. The initial agreement may not exceed two years and is subject to renewal under (j) of this section.

(b) A physician planning to enter into a cooperative practice agreement with a pharmacist must submit to the board a written proposed agreement that meets the requirements of this section. The proposed agreement must be approved by the board before cooperative practice under the agreement, if approved, begins. A proposed modification to an agreement must be submitted to the board for approval, before the modification, if approved, is implemented. The board will approve a proposed agreement or modification if it is medically appropriate and provides for the safety of the patient. If the board disapproves a proposed agreement or modification, the board shall state the reasons for its action.

(c) A cooperative practice agreement between a physician and a pharmacist must include

(1) the physician's authorization to a pharmacist or group of pharmacists to manage a patient's medication therapy;

(2) the full name, medical license number, date of issuance of license, and specialty, if any, of each physician who is a party to the agreement;

(3) the full name, place of employment, mailing address, pharmacist license number, and date of issuance of license, of each pharmacist who is a party to the agreement;

(4) a statement of the duration of the agreement, which may not exceed two years;

(5) the types of cooperative practice decisions that the physician is authorizing the pharmacist to make under the agreement, including

(A) types of diseases, medications, or medication categories involved and the type of cooperative authority to be exercised in each case; and

(B) procedures, decision criteria, or plans the pharmacist must follow when making therapeutic decisions, particularly when initiating or modifying medication;

(6) requirements that a pharmacist must follow when exercising cooperative authority, including documentation of decisions made, and a plan for communication and feedback to the physician concerning specific decisions made;

(7) a plan for the physician to review the decisions made by the pharmacist at least once every three months;

(8) a plan for providing to the physician patient records created under the agreement;

(9) a provision that allows the physician to override the agreement if the physician considers it medically necessary or appropriate;

(10) an acknowledgement that the physician will not receive any compensation from a pharmacist or pharmacy as a result of the care or treatment of any patient under the agreement;

(11) a prohibition on the administration or dispensing of any schedule I, II, III, or IV controlled substances.

(d) The physician, or a physician assistant under the supervision of the physician, must physically examine and evaluate a patient before that patient may be included under a cooperative practice agreement to which that physician is a party. The physician must issue a prescription or medication order for each patient valid for up to one year. The physician, or a physician assistant under the supervision of the physician, must conduct a physical examination of a patient at least once a year while that patient is included under a cooperative practice agreement to which that physician is a party. The requirements of this subsection do not apply to a cooperative practice agreement allowing the administration of emergency contraception, immunizations of persons 18 years of age or older, and those immunizations recommended to be given on a yearly basis by the United States Department of Health and Human Services Centers for Disease Control and Prevention.

(e) Only a physician in active practice in this state may enter into a cooperative practice agreement under this section. An authority authorized by a physician must be within the physician's current scope of practice.

(f) A physician who enters into a cooperative practice agreement shall keep a copy of the written agreement and the records of all patients treated under it during the period of the agreement. The physician shall retain the agreement and records required by this subsection for at least seven years after the termination of the agreement.

(g) A cooperative practice agreement is terminated upon written notice by either the physician or the pharmacist. The physician shall notify the board in writing within 30 days after an agreement is terminated.

(h) The board may periodically review cooperative practice agreements approved under this section.

(i) The requirements of this section do not apply to cooperative practice agreements adopted by the physicians on medical staff of a hospital or nursing facility licensed under AS 47.32 for treatment of patients of that facility.

(j) The physician may seek renewal of a cooperative practice agreement for additional two-year periods.

(k) Notwithstanding the requirements of (b) of this section, a physician who, before June 1, 2006, has entered into a collaborative practice agreement with a pharmacist that has been approved under 12 AAC 52.240 and is still current, must obtain the board's approval of that agreement under this section not later than December 1, 2006. After that time, a physician may not participate in a cooperative practice agreement with a pharmacist except as allowed under this section.

(*l*) In this section, "cooperative practice agreement" means an agreement between a physician and a pharmacist by which a physician authorizes the pharmacist to manage a patient's medication therapy as specified in the agreement.

Authority: AS 08.64.100 AS 08.64.326

12 AAC 40.985. GENERAL ANESTHETIC. A commercially prepared mixture of 50 percent oxygen and 50 percent nitrous oxide, when self-administered by a patient as a part of the outpatient care provided by a licensed podiatrist, is an analgesic and not a general anesthetic referred to in AS 08.64.380(9)(B).

Authority: AS 08.64.100 AS 08.64.107 AS 08.64.380(9)

12 AAC 40.986. WITHDRAWAL OF APPLICATION. (a) An application for a permit or license may be withdrawn from consideration by the board at the applicant's request. To withdraw an application, the applicant must submit a request for withdrawal in writing signed by the applicant. The request for withdrawal must be received by the division no later than five business days before the board's meeting where the application is to be initially considered.

(b) The board will not approve a request for the withdrawal of an application under this section for an application that has been reviewed and considered by the board, or considered abandoned under 12 AAC 02.910.

(c) An application approved for withdrawal under this section will be reported to the Federation of State Medical Boards's Board Action Data Bank.

(d) An application that is approved for withdrawal under this section will be retained on file in the department for at least 10 years after the date of withdrawal and will be returned to the board if the applicant reapplies for a permit or license.

Authority: AS 08.64.100

12 AAC 40.987. RETENTION OF ABANDONED APPLICATIONS. (a) An application that is abandoned under 12 AAC 02.910 will be retained on file in the department for at least 10 years after the date of abandonment. If an applicant with an abandoned application reapplies for a permit or license, that abandoned application will be returned to the board for review and consideration.

(b) The application of an applicant who has been issued a temporary permit before abandoning the application under 12 AAC 02.910 will be reported to the Federation of State Medical Boards as denied without prejudice.

Authority: AS 08.01.050 AS 08.64.100

12 AAC 40.990. DEFINITIONS. (a) In this chapter

(1) "acceptable moral character" means having not been convicted of a felony or any morally reprehensible crime during the five years immediately preceding application;

(2) "board" means State Medical Board;

(3) "certified true copy" means a copy of a document that includes a statement of certification, signed under penalty of unsworn falsification before a notary public, that the document is a true copy of the original document;

(4) "collaborating physician" means a person who is actively licensed in the state as a physician or osteopath, who enters into a consultative relationship with a nonphysician health care provider who undertakes the practice of medicine, medical diagnosis and treatment;

(5) "collaborative relationship" means a consultative relationship between a physician and nonphysician health care provider which uses their respective areas of expertise to meet the common goal of providing comprehensive care for the patient;

(6) "department" means the Department of Commerce, Community, and Economic Development;

(7) "flex examination" means the written examination prepared by the Federation of State Medical Boards of the United States, Inc.;

(8) repealed 5/5/2023;

(9) repealed 5/5/2023;

(10) "NBME examination" means the written examination prepared by the National Board of Medical Examiners;

(11) "pharmacological agents" means saline, glucose, prostglandins and pitocin;

(12) "physician" means a person licensed under AS 08.64 to practice medicine or surgery;

(13) "physician assistant" means a person specially trained to perform many of the functions and duties of the physician, including examination, diagnosis, and treatment, and who is licensed under this chapter to do so;

(14) repealed 5/5/2023;

(15) repealed 5/5/2023;

(16) repealed 3/12/89;

(17) repealed 3/12/89;

(18) repealed 3/12/89;

(19) repealed 3/12/89;

(20) "USMLE" means the United States medical licensing examination sponsored jointly by the Federation of State Medical Boards of the United States, Inc. and the National Board of Medical Examiners;

(21) "controlled substance" has the meaning given controlled substance in AS 11.71.900;

(22) "division" means the division assigned occupational licensing functions in the department;

(23) "COMLEX examination" means the Comprehensive Osteopathic Medical Licensing Examination administered by the National Board of Osteopathic Medical Examiners;

(24) "post-graduate training" for physicians includes internship, residency, and advanced forms of residency including fellowships;

(25) "health care professional" includes chiropractors, mental health counselors, social workers, dental hygienists, dentists, health aides, nurses, nurse practitioners, certified nurse aides, occupational therapists, occupational therapy assistants, optometrists, osteopaths, naturopaths, physical therapists, physical therapy assistants, physicians, physician assistants, psychiatrists, psychologists, psychological associates, audiologists licensed under AS 08.11, hearing aid dealers licensed under AS 08.55, marital and family therapists licensed under AS 08.63, religious health practitioners, acupuncturists, and surgeons;

(26) "business day" means a day other than Saturday, Sunday, or a state holiday;

(27) "DEA" means the federal Drug Enforcement Administration;

(28) "FCVS" means the Federal Credentials Verification Service of the Federation of State Medical Boards of the United States, Inc.

(b) In AS 08.64.326(a)(9),

(1) "attempted sexual contact" means engaging in conduct that constitutes a substantial step towards sexual contact;

(2) "sexual contact"

(A) means touching, directly or through clothing, a patient's genitals, anus, or female breast, or causing the patient to touch, directly or through clothing, the licensee's or patient's genitals, anus, or female breast;

(B) includes sexual penetration;

(C) does not include acts

(i) that may reasonably be construed to be normal caretaker responsibilities for a child, interactions with a child, or affection for a child; or

(ii) performed for the purpose of administering a recognized and lawful form of examination or treatment that is reasonably adapted to promoting the physical or mental health of the person being treated; in this paragraph, "sexual penetration" means genital intercourse, cunnilingus, fellatio, anal intercourse, or an intrusion, however slight, of an object or any part of a person's body into the genitals or anus of another person's body; each party to any of the acts defined as "sexual penetration" is considered to be engaged in sexual penetration; "sexual penetration" does not include acts performed for the purpose of administering a recognized and lawful form of examination or treatment that is reasonably adapted to promoting the physical health of the person being treated;

(3) "sexual impropriety" means behavior, a gesture, or an expression that is seductive, sexually suggestive, or sexually demeaning to a patient; "sexual impropriety" includes

(A) encouraging the patient to masturbate in the presence of the licensee or masturbation by the licensee while the patient is present;

(B) offering to provide controlled substances or other drugs in exchange for sexual contact;

(C) disrobing or draping practice that is seductive, sexually suggestive, or sexually demeaning to a patient, such as deliberately watching a patient dress or undress or failing to provide privacy for disrobing;

(D) making a comment about or to the patient that is seductive, sexually suggestive, or sexually demeaning to a patient, including

(i) sexual comment about a patient's body or underclothing;

(ii) sexualized or sexually-demeaning comment to a patient;

(iii) demeaning or degrading comments to the patient about the patient's sexual orientation, regardless of whether the patient is homosexual, heterosexual, or bisexual;

(iv) comments about potential sexual performance of the patient during an examination or consultation, except when the examination or consultation is pertinent to the issue of sexual function or dysfunction;

(v) requesting details of sexual history or sexual likes or dislikes of the patient if the details are not clinically indicated for the type of examination or consultation;

(E) performing an internal pelvic examination or rectal examination of the patient without the use of gloves;

(F) initiation by the licensee of conversation with a patient regarding the sexual problems, preferences, or fantasies of the licensee;

(G) using the medical or professional relationship with the patient to solicit sexual contact or a romantic relationship with the patient or another;

(H) kissing a patient in a romantic or sexual manner;

(4) "sexual misconduct" includes sexual impropriety;

(5) "in connection with the delivery of professional services to patients" includes sexual misconduct directed at patients or key third parties; in this paragraph, "key third parties" means individuals who have influence over the patient, including the patient's spouse, children, parents, legal guardian, or surrogate.

Authority: AS 08.64.100 AS 08.64.107 AS 08.64.326

APPENDIX A

CHAPTER 30.
CONTROLLED SUBSTANCES

Sec. 17.30.200. Controlled substance prescription database. (a) The controlled substance prescription database is established in the Board of Pharmacy. The purpose of the database is to contain data as described in this section regarding every prescription for a schedule II, III, or IV controlled substance under federal law dispensed in the state to a person other than under the circumstances described in (t) of this section.

(b) The pharmacist-in-charge of each licensed or registered pharmacy, regarding each schedule II, III, or IV controlled substance under federal law dispensed by a pharmacist under the supervision of the pharmacist-in-charge, and each practitioner who directly dispenses a schedule II, III, or IV controlled substance under federal law other than those dispensed or administered under the circumstances described in (t) of this section, shall submit to the board, by a procedure and in a format established by the board, the following information for inclusion in the database on at least a daily basis:

(1) the name of the prescribing practitioner and the practitioner's federal Drug Enforcement Administration registration number or other appropriate identifier;

(2) the date of the prescription;

(3) the date the prescription was filled and the method of payment; this paragraph does not authorize the board to include individual credit card or other account numbers in the database;

(4) the name, address, and date of birth of the person for whom the prescription was written;

(5) the name and national drug code of the controlled substance;

(6) the quantity and strength of the controlled substance dispensed;

(7) the name of the drug outlet dispensing the controlled substance; and

(8) the name of the pharmacist or practitioner dispensing the controlled substance and other appropriate identifying information.

(c) The board shall maintain the database in an electronic file or by other means established by the board to facilitate use of the database for identification of

(1) prescribing practices and patterns of prescribing and dispensing controlled substances;

(2) practitioners who prescribe controlled substances in an unprofessional or unlawful manner;

(3) individuals who receive prescriptions for controlled substances from licensed practitioners and who subsequently obtain dispensed controlled substances from a drug outlet in quantities or with a frequency inconsistent with generally recognized standards of dosage for that controlled substance; and

(4) individuals who present forged or otherwise false or altered prescriptions for controlled substances to a pharmacy.

(d) The database and the information contained within the database are confidential, are not public records, are not subject to public disclosure, and may not be shared with the federal government. The board shall undertake to ensure the security and confidentiality of the database and the information contained within the database. The board may allow access to the database only to the following persons, and in accordance with the limitations provided and regulations of the board:

(1) personnel of the board regarding inquiries concerning licensees or registrants of the board or personnel of another board or agency concerning a practitioner under a search warrant, subpoena, or order issued by an administrative law judge or a court;

(2) authorized board personnel or contractors as required for operational and review purposes;

(3) a licensed practitioner having authority to prescribe controlled substances or an agent or employee of the practitioner whom the practitioner has authorized to access the database on the practitioner's behalf, to the extent the information relates specifically to a current patient of the practitioner to whom the practitioner is prescribing or considering prescribing a controlled substance; the agent or employee must be licensed or registered under AS 08;

(4) a licensed or registered pharmacist having authority to dispense controlled substances or an agent or employee of the pharmacist whom the pharmacist has authorized to access the database on the pharmacist's behalf, to the extent the information relates specifically to a current patient to whom the pharmacist is dispensing or considering dispensing a controlled substance; the agent or employee must be licensed or registered under AS 08;

(5) federal, state, and local law enforcement authorities may receive printouts of information contained in the database under a search warrant or order issued by a court establishing probable cause for the access and use of the information;

(6) an individual who is the recipient of a controlled substance prescription entered into the database may receive information contained in the database concerning the individual on providing evidence satisfactory to the board that the individual requesting the information is in fact the person about whom the data entry was made and on payment of a fee set by the board under AS 37.10.050 that does not exceed $10;

(7) a licensed pharmacist employed by the Department of Health who is responsible for administering prescription drug coverage for the medical assistance program under AS 47.07, to the extent that the information relates specifically to prescription drug coverage under the program;

(8) a licensed pharmacist, licensed practitioner, or authorized employee of the Department of Health responsible for utilization review of prescription drugs for the medical assistance program under AS 47.07, to the

extent that the information relates specifically to utilization review of prescription drugs provided to recipients of medical assistance;

(9) the state medical examiner, to the extent that the information relates specifically to investigating the cause and manner of a person's death;

(10) an authorized employee of the Department of Health may receive information from the database that does not disclose the identity of a patient, prescriber, dispenser, or dispenser location, for the purpose of identifying and monitoring public health issues in the state; however, the information provided under this paragraph may include the region of the state in which a patient, prescriber, and dispenser are located and the specialty of the prescriber; and

(11) a practitioner, pharmacist, or clinical staff employed by an Alaska tribal health organization, including commissioned corps officers of the United States Public Health Service employed under a memorandum of agreement; in this paragraph, "Alaska tribal health organization" has the meaning given to "tribal health program" in 25 U.S.C. 1603.

(e) The failure of a pharmacist-in-charge or a pharmacist to register or submit information to the database as required under this section is grounds for the board to take disciplinary action against the license or registration of the pharmacy or pharmacist. The failure of a practitioner to register or review the database as required under this section is grounds for the practitioner's licensing board to take disciplinary action against the practitioner.

(f) The board may enter into agreements with (1) dispensers in this state that are not regulated by the state to submit information to and access information in the database, and (2) practitioners in this state to access information in the database, subject to this section and the regulations of the board. The board shall prohibit a dispenser that is not regulated by the state from accessing the database if the dispenser has accessed information in the database contrary to the limitations of this section, discloses information in the database contrary to the limitations of this section, or allows unauthorized persons access to the database.

(g) The board shall promptly notify the president of the senate and the speaker of the house of representatives if, at any time after September 7, 2008, the federal government fails to pay all or part of the costs of the controlled substance prescription database.

(h) An individual who has submitted information to the database in accordance with this section may not be held civilly liable for having submitted the information. Dispensers or practitioners may not be held civilly liable for damages for accessing or failing to access the information in the database.

(i) A person who has reason to believe that prescription information from the database has been illegally or improperly accessed shall notify an appropriate law enforcement agency.

(j) The board shall notify any person whose prescription information from the database is illegally or improperly accessed.

(k) In the regulations adopted under this section, the board shall provide

(1) that prescription information in the database be purged from the database after two years have elapsed from the date the prescription was dispensed;

(2) a method for an individual to challenge information in the database about the individual that the person believes is incorrect or was incorrectly entered by a dispenser;

(3) a procedure and time frame for registration with the database;

(4) that a practitioner review the information in the database to check a patient's prescription records before dispensing, prescribing, or administering a schedule II or III controlled substance under federal law to the patient; the regulations must provide that a practitioner is not required to review the information in the database before dispensing, prescribing, or administering

(A) a controlled substance to a person who is receiving treatment

(i) in an inpatient setting;

(ii) at the scene of an emergency or in an ambulance; in this sub-subparagraph, "ambulance" has the meaning given in AS 18.08.200;

(iii) in an emergency room;

(iv) immediately before, during, or within the first 48 hours after surgery or a medical procedure;

(v) in a hospice or nursing home that has an in-house pharmacy; or

(B) a nonrefillable prescription of a controlled substance in a quantity intended to last for not more than three days.

(*l*) A person

(1) with authority to access the database under (d) of this section who knowingly

(A) accesses information in the database beyond the scope of the person's authority commits a class A misdemeanor;

(B) accesses information in the database and recklessly discloses that information to a person not entitled to access or to receive the information commits a class C felony;

(C) allows another person who is not authorized to access the database to access the database commits a class C felony;

(2) without authority to access the database under (d) of this section who knowingly accesses the database or knowingly receives information that the person is not authorized to receive under (d) of this section from another person commits a class C felony.

(m) To assist in fulfilling the program responsibilities, performance measures shall be reported to the legislature annually. Performance measures

(1) may include outcomes detailed in the federal prescription drug monitoring program grant regarding efforts to

(A) reduce the rate of inappropriate use of prescription drugs by reporting education efforts conducted by the Board of Pharmacy;

(B) reduce the quantity of pharmaceutical controlled substances obtained by individuals attempting to engage in fraud and deceit;

(C) increase coordination among prescription drug monitoring program partners;

(D) involve stakeholders in the planning process;

(2) shall include information related to the

(A) security of the database; and

(B) reductions, if any, in the inappropriate use or prescription of controlled substances resulting from the use of the database.

(n) A pharmacist who dispenses or a practitioner who prescribes, administers, or directly dispenses a schedule II, III, or IV controlled substance under federal law shall register with the database by a procedure and in a format established by the board.

(o) The board shall promptly notify the State Medical Board, the Board of Nursing, the Board of Dental Examiners, and the Board of Examiners in Optometry, when a practitioner registers with the database under (n) of this section.

(p) The board is authorized to provide unsolicited notification to a pharmacist, practitioner's licensing board, or practitioner if a patient has received one or more prescriptions for controlled substances in quantities or with a frequency inconsistent with generally recognized standards of safe practice. An unsolicited notification to a practitioner's licensing board under this section

(1) must be provided to the practitioner;

(2) is confidential;

(3) may not disclose information that is confidential under this section;

(4) may be in a summary form sufficient to provide notice of the basis for the unsolicited notification.

(q) The board shall update the database on at least a daily basis with the information submitted to the board under (b) of this section.

(r) The Department of Commerce, Community, and Economic Development shall

(1) assist the board and provide necessary staff and equipment to implement this section; and

(2) establish fees for registration with the database by a pharmacist or practitioner required to register under (n) of this section so that the total amount of fees collected by the department equals the total operational costs of the database minus all federal funds acquired for the operational costs of the database; in setting the fee levels, the department shall

(A) set the fees for registration with the database so that the fees are the same for all practitioners and pharmacists required to register; and

(B) consult with the board to establish the fees under this paragraph.

(s) Notwithstanding (p) of this section, the board may issue to a practitioner periodic unsolicited reports that detail and compare the practitioner's opioid prescribing practice with other practitioners of the same occupation and similar specialty. A report issued under this subsection is confidential and the board shall issue the report only to a practitioner. The board may adopt regulations to implement this subsection. The regulations may address the types of controlled substances to be included in an unsolicited report, the quantities dispensed, the medication strength, and other factors determined by the board.

(t) A practitioner or a pharmacist is not required to comply with the requirements of (a) and (b) of this section if a controlled substance is

(1) administered to a patient at

(A) a health care facility; or

(B) a correctional facility;

(2) dispensed to a patient for an outpatient supply of 24 hours or less at a hospital

(A) inpatient pharmacy; or

(B) emergency department.

(u) This section does not apply to a schedule II, III, or IV controlled substance prescribed or dispensed by a veterinarian licensed under AS 08.98 to treat an animal.

(v) In this section,

(1) "board" means the Board of Pharmacy;

(2) "database" means the controlled substance prescription database established in this section;

(3) "knowingly" has the meaning given in AS 11.81.900;

(4) "opioid" includes the opium and opiate substances and opium and opiate derivatives listed in AS 11.71.140 and 11.71.160;

(5) "pharmacist-in-charge" has the meaning given in AS 08.80.480.

APPENDIX B

HEALTH AND SAFETY

CHAPTER 16.
REGULATION OF ABORTIONS

Sec. 18.16.010. Abortions. (a) An abortion may not be performed in this state unless
(1) the abortion is performed by a physician licensed by the State Medical Board under AS 08.64.200;

CHAPTER 23.
HEALTH CARE SERVICES INFORMATION AND REVIEW ORGANIZATIONS

Sec. 18.23.030. Confidentiality of records of review organization. (a) Except as provided in (b) of this section, all data and information acquired by a review organization in the exercise of its duties and functions shall be held in confidence and may not be disclosed to anyone except to the extent necessary to carry out the purposes of the review organization and is not subject to subpoena or discovery. Except as provided in (b) of this section, a person described in AS 18.23.020 may not disclose what transpired at a meeting of a review organization except to the extent necessary to carry out the purposes of a review organization, and the proceedings and records of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising out of the matter that is the subject of consideration by the review organization. Information, documents, or records otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during proceedings of a review organization, nor may a person who testified before a review organization or who is a member of it be prevented from testifying as to matters within the person's knowledge, but a witness may not be asked about the witness's testimony before a review organization or opinions formed by the witness as a result of its hearings, except as provided in (b) of this section.

(b) Testimony, documents, proceedings, records, and other evidence adduced before a review organization that are otherwise inaccessible under this section may be obtained by a health care provider who claims that denial is unreasonable or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.

(c) Nothing in AS 18.23.005 - 18.23.070 prevents a person whose conduct or competence has been reviewed under AS 18.23.005 - 18.23.070 from obtaining, for the purpose of appellate review of the action of the review organization, any testimony, documents, proceedings, records, and other evidence adduced before the review organization.

(d) Notwithstanding the provisions of (b) and (c) of this section, information contained in a report submitted to the State Medical Board, and information gathered by the board during an investigation, under AS 08.64.336 is not subject to subpoena or discovery unless and until the board takes action to suspend, revoke, limit, or condition a license of the person who is the subject of the report or investigation.

APPENDIX C

ALASKA RULES OF THE COURT
RULES OF EVIDENCE
ARTICLE V. PRIVILEGES

Rule 504. Physician and Psychotherapist-Patient Privilege.

(a) **Definitions.** As used in this rule:

(1) A patient is a person who consults or is examined or interviewed by a physician or psychotherapist.

(2) A physician is a person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be.

(3) A psychotherapist is (A) a person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be, while engaged in the diagnosis or treatment of a mental or emotional condition, including alcohol or drug addiction, or (B) a person licensed or certified as a psychologist or psychological examiner under the laws of any state or nation or reasonably believed by the patient so to be, while similarly engaged.

(4) A communication is confidential if not intended to be disclosed to third persons other than those present to further the interest of the patient in the consultation, examination, or interview, or persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the physician or psychotherapist, including members of the patient's family.

(b) **General Rule of Privilege.** A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of diagnosis or treatment of his physical, mental or emotional conditions, including alcohol or drug addiction, among himself, his physician or psychotherapist, or persons who are participating in the diagnosis or treatment under the direction of the physician or psychotherapist, including members of the patient's family.

(c) **Who May Claim the Privilege.** The privilege may be claimed by the patient, by his guardian, guardian ad litem or conservator, or by the personal representative of a deceased patient. The person who was the physician or psychotherapist at the time of the communication is presumed to have authority to claim the privilege but only on behalf of the patient.

(d) **Exceptions.** There is no privilege under this rule:

(1) *Condition and Element of Claim or Defense.* As to communications relevant to the physical, mental or emotional condition of the patient in any proceeding in which the condition of the patient is an element of the claim or defense of the patient, of any party claiming through or under the patient, of any person raising the patient's condition as an element of his own case, or of any person claiming as a beneficiary of the patient through a contract to which the patient is or was a party; or after the patient's death, in any proceeding in which any party puts the condition in issue.

(2) *Crime or Fraud.* If the services of the physician or psychotherapist were sought, obtained or used to enable or aid anyone to commit or plan a crime or fraud or to escape detection or apprehension after the commission of a crime or a fraud.

(3) *Breach of Duty Arising Out of Physician-Patient Relationship.* As to a communication relevant to an issue of breach, by the physician, or by the psychotherapist, or by the patient, of a duty arising out of the physician-patient or psychotherapist-patient relationship.

(4) *Proceedings for Hospitalization.* For communications relevant to an issue in proceedings to hospitalize the patient for physical, mental or emotional illness, if the physician or psychotherapist, in the course of diagnosis or treatment, has determined that the patient is in need of hospitalization.

(5) *Required Report.* As to information that the physician or psychotherapist or the patient is required to report to a public employee, or as to information required to be recorded in a public office, if such report or record is open to public inspection, or as to information or matters contained in or reasonably raised by a report submitted under AS 08.64.336, other than information that would establish the identity of a patient, unless the court finds that it is necessary to admit the identifying information in order to serve the interests of justice.

(6) *Examination by Order of Judge.* As to communications made in the course of an examination ordered by the court of the physical, mental or emotional condition of the patient, with respect to the particular purpose for which the examination is ordered unless the judge orders otherwise. This exception does not apply where the examination is by order of the court upon request of the lawyer for the defendant in a criminal proceeding in order to provide the lawyer with information needed so that he may advise the defendant whether to enter a plea based on insanity or to present a defense based on his mental or emotional condition.

(7) *Criminal Proceeding. For physician-patient communications in a criminal proceeding.* This exception does not apply to the psychotherapist-patient privilege. (Added by Supreme Court Order 364 effective August 1, 1979; amended by Supreme Court Order 850 effective January 15, 1988)

Department of Commerce Community, and Economic Development
Corporations, Business and Professional Licensing

Summary of All Professional Licensing
Schedule of Revenues and Expenditures

Medical Board	FY 18	FY 19	Biennium	FY 20	FY 21	Biennium	FY 22	FY 23	Biennium	FY 24	FY 25	Biennium
Revenue												
Revenue from License Fees	$ 347,304	$ 2,380,618	$ 2,727,922	$ 578,308	$ 2,597,830	$ 3,176,138	$ 945,106	$ 2,876,309	$ 3,821,415	$ 852,030	$ 2,690,026	$ 3,542,056
General Fund Received					$ -	-	$ 272,744	$ 173,090	445,834	$ 40,368	$ -	40,368
Allowable Third Party Reimbursements	3,517	184	3,701	$ -	$ -	-	$ -	$ -	-	$ 1,071	$ -	1,071
TOTAL REVENUE	$ 350,821	$ 2,380,802	$ 2,731,623	$ 578,308	$ 2,597,830	$ 3,176,138	$ 1,217,850	$ 3,049,399	$ 4,267,249	$ 893,469	$ 2,690,026	$ 3,583,495
Expenditures												
Non Investigation Expenditures												
1000 - Personal Services	488,823	473,122	961,945	420,810	521,976	942,786	446,216	454,584	900,800	507,288	660,375	1,167,663
2000 - Travel	17,577	15,801	33,378	13,357	-	13,357	8,875	1,471	10,346	3,442	886	4,328
3000 - Services	44,741	31,730	76,471	23,009	46,044	69,053	69,997	97,210	167,207	93,406	32,007	125,413
4000 - Commodities	2,016	1,525	3,541	1,252	1,290	2,542	3,278	3,045	6,323	2,972	3,268	6,240
5000 - Capital Outlay	-		-	-	-	-	-	-	-	-	-	-
Total Non-Investigation Expenditures	553,157	522,178	1,075,335	458,428	569,310	1,027,738	528,366	556,310	1,084,676	607,108	696,536	1,303,644
Investigation Expenditures												
1000-Personal Services	210,010	226,965	436,975	264,001	272,106	536,107	289,348	336,511	625,859	411,332	414,623	825,955
2000 - Travel		2,104	2,104	2,032	-	2,032	2,655	-	2,655	-	-	-
3023 - Expert Witness	1,700	7,577	9,277	16,050	22,775	38,825	31,350	14,000	45,350	39,107	18,209	57,316
3088 - Inter-Agency Legal	60,885	34,329	95,214	56,267	33,435	89,702	42,629	208,613	251,242	484,830	564,968	1,049,798
3094 - Inter-Agency Hearing/Mediation	9,299	28,803	38,102	18,640	911	19,551	11,870	61,195	73,065	164,138	265,356	429,494
3000 - Services other		3,348	3,348	1,919	625	2,544	1,257	2,126	3,383	1,112	1,319	2,431
4000 - Commodities		-	-	-	-	-	-	-	-	126	-	126
Total Investigation Expenditures	281,894	303,126	585,020	358,909	329,852	688,761	379,109	622,445	1,001,554	1,100,645	1,264,475	2,365,120
Total Direct Expenditures	835,051	825,304	1,660,355	817,337	899,162	1,716,499	907,475	1,178,755	2,086,230	1,707,753	1,961,011	3,668,764
Indirect Expenditures												
Internal Administrative Costs	225,669	263,046	488,715	285,614	316,771	602,385	250,301	286,502	536,803	250,148	321,608	571,756
Departmental Costs	150,736	168,176	318,912	123,361	143,500	266,861	122,427	120,114	242,541	143,482	178,470	321,952
Statewide Costs	78,101	72,595	150,696	90,219	108,989	199,208	92,456	86,033	178,489	88,909	91,726	180,635
Total Indirect Expenditures	454,506	503,817	958,323	499,194	569,260	1,068,454	465,184	492,649	957,833	482,539	591,804	1,074,343
			-			-						
TOTAL EXPENDITURES	**$ 1,289,557**	**$ 1,329,121**	**$ 2,618,678**	**$ 1,316,531**	**$ 1,468,422**	**$ 2,784,953**	**$ 1,372,659**	**$ 1,671,404**	**$ 3,044,063**	**$ 2,190,292**	**$ 2,552,815**	**$ 4,743,107**
Cumulative Surplus (Deficit)												
Beginning Cumulative Surplus (Deficit)	$ 137,265	$ (801,471)		$ 250,210	$ (488,013)		$ 641,395	$ 486,586		$ 1,864,582	$ 567,759	
Annual Increase/(Decrease)	(938,736)	1,051,681		(738,223)	1,129,408		(154,809)	1,377,996		(1,296,823)	137,210	
Ending Cumulative Surplus (Deficit)	$ (801,471)	250,210		$ (488,013)	$ 641,395		$ 486,586	$ 1,864,582		$ 567,759	$ 704,969	
Statistical Information												
Number of Licenses for Indirect calculation	7,138	8,421		9,801	12,808		8,259	9,221		7,676	10,199	

Additional information:

- *General fund dollars were received in FY21-FY24 to offset increases in personal services and help prevent programs from going into deficit or increase fees.*
- *Most recent fee change: Fee reduction FY25*
- *Annual license fee analysis will include consideration of other factors such as board and licensee input, potential investigation load, court cases, multiple license and fee types under one program, and program changes per AS 08.01.065.*

Sub Unit	(Multiple Items)
PL Task Code	MED1

Sum of Budgetary Expenditures	Object Type Name (Ex)				
Object Name (Ex)	1000 - Personal Services	2000 - Travel	3000 - Services	4000 - Commodities	Grand Total
1011 - Regular Compensation	559,210.50				559,210.50
1014 - Overtime	873.80				873.80
1021 - Allowances to Employees	432.00				432.00
1023 - Leave Taken	91,890.33				91,890.33
1028 - Alaska Supplemental Benefit	40,012.16				40,012.16
1029 - Public Employee's Retirement System Defined Benefits	44,557.65				44,557.65
1030 - Public Employee's Retirement System Defined Contribution	25,551.63				25,551.63
1034 - Public Employee's Retirement System Defined Cont Health Reim	16,258.60				16,258.60
1035 - Public Employee's Retiremnt Sys Defined Cont Retiree Medical	4,034.62				4,034.62
1037 - Public Employee's Retiremnt Sys Defined Benefit Unfnd Liab	84,317.93				84,317.93
1039 - Unemployment Insurance	1,324.40				1,324.40
1040 - Group Health Insurance	173,203.74				173,203.74
1041 - Basic Life and Travel	35.28				35.28
1042 - Worker's Compensation Insurance	2,861.12				2,861.12
1047 - Leave Cash In Employer Charge	15,039.50				15,039.50
1048 - Terminal Leave Employer Charge	8,791.93				8,791.93
1053 - Medicare Tax	9,144.19				9,144.19
1069 - SU Business Leave Bank Contributions	186.00				186.00
1077 - ASEA Legal Trust	531.65				531.65
1079 - ASEA Injury Leave Usage	40.39				40.39
1080 - SU Legal Trst	254.36				254.36
1970 - Personal Services Transfer	(3,553.99)				(3,553.99)
2000 - In-State Employee Airfare		395.80			395.80
2001 - In-State Employee Surface Transportation		121.56			121.56
2002 - In-State Employee Lodging		279.00			279.00
2003 - In-State Employee Meals and Incidentals		90.00			90.00
2012 - Out-State Employee Airfare		1,471.14			1,471.14
2970 - Travel Cost Transfer		(1,471.14)			(1,471.14)
3000 - Training/Conferences			-		-
3002 - Memberships			3,881.00		3,881.00
3023 - Expert Witness			18,209.17		18,209.17
3026 - Transcription/Record			93.77		93.77
3035 - Long Distance			133.57		133.57
3036 - Local/Equipment Charges			12.78		12.78
3045 - Postage			1,267.07		1,267.07
3057 - Structure, Infrastructure and Land - Rentals/Leases			179.52		179.52
3085 - Inter-Agency Mail			688.39		688.39
3088 - Inter-Agency Legal			588,379.95		588,379.95
3094 - Inter-Agency Hearing/Mediation			269,014.20		269,014.20
4005 - Subscriptions				3,267.50	3,267.50
Grand Total	**1,074,997.79**	**886.36**	**881,859.42**	**3,267.50**	**1,961,011.07**

1961011
0.07

Medical Regulations - Chapter 12 AAC 40 - Total # of Discretionary Requirements = 1224

Discretionary Regulatory Requirements **359** + Requirements adopted by Reference **865** = **1224**

25% Target = 306 (Requirements to elminate)

Project #	Citation / Subject	AO 360 Stakeholder request?	Proposed # of Requirements Eliminated	Comments/Suggested edits
#1	Physican Assistants: 12 AAC 40.400 - 12 AAC 40.490	No	57	Changes already approved and submitted by board
#2	Standards for Telemedicine 12 AAC 40.943	No	1	Eliminate language made obsolete by new Federal and State Law - (changes already approved and submitted by board)
#3	Continuing Medical Education & Certification of Compliance 12 AAC 40.200 / 12 AAC 40.940	Yes	(+)1	Add CME related to Nutrition / decrease opioid education or overall requirement?
#4	Cooperative Practice Agreements With Pharmacists 12 AAC 40.983	Yes	17	Changes requested by Pharmacy Assoc: Eliminate approval by the Board, physical exam, restrictions on prescribing controlled substances; plus additional changes proposed by Division
#5	License application requirements; 12 AAC 40.010; 12 AAC 40.015; 12 AAC 40.025; 12 AAC 40.033; 12 AAC 40.036; 12 AAC 40.038; 12 AAC 40.045; 12 AAC 40.023	No	12	1) Eliminate requirement to submit verfication of licensure from each state, where the applicant holds or has ever held a license (this info is contained on FMSB report); 2) Allow FCVS profile to substitute for a separate photo to of the applicant on a form provided by dept ; 3)certified copies of diploma (residency permit); 4) "direct source" verification and attestation of opioid education for podiatrists
#6	Application Checklists 12 AAC 40.058	No	5	References outdated checklist forms; not efficent to have in regulation
#7	Standard for Record Keeping 12 AAC 40.940	No	18	Recommend eliminating entire section. Is it necessary?
#8	License Exemptions for Practice in Tribal Health Program 12 AAC 40.981	No		Add language to terminate exemption upon change in status
#9	Ethical Standards 12 AAC 40.955	No	228	Professional ethics codes adopted by reference; consider eliminating Oseopath, Podiatrist and Physician Assistant codes of ethics
#10	Standards for Telemedicine 12 AAC 40.943	No	53	Consider eliminating the entire regulation - FSMB telemedicine guidance adopted by reference

Total = 384

Medical Board Adopted by Reference Discretionary Requirements:

Documents Adopted by Reference	# of Discretionary Requirements
Practice Bulletin, Number 135, June 2013, Second-Trimester Abortion, Reaffirmed 2017	59
MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE	53
Code of Ethics – American Medical Association 2016	525
Code of Ethics – American Osteopathic Association 2016	33
Code of Ethics - American Podiatric Medical Association 2017	110
Guidelines for Ethical Conduct for the Physician Assistant Profession 2013	85
Total:	**865**

Practice Bulletin, Number 135, June 2013, Second-Trimester Abortion, Reaffirmed 2017: 59

Requirement Count Summary

Here is a breakdown of the discrete regulatory-style requirements found in the document:

Section	Requirement Examples	Count
Clinical Recommendations	Cervical preparation before D&E, antibiotic prophylaxis, uterotonic use, referral facilitation, etc.	18
Box 1: Medical Abortion Regimens	Specific drug dosages and timing protocols	9
Postabortion Hemorrhage Management	Primary, secondary, tertiary treatment steps	10

Section	Requirement Examples	Count
Complication Prevention	Use of vasopressin, cervical dilation protocols, training recommendations	6
Contraceptive Guidance	Immediate IUD insertion, method eligibility	4
Summary Recommendations (Level A, B, C)	Reiterated clinical directives	12

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE: 53

Requirement Count Summary

Section	Requirement Examples	Count
Preamble & Expectations	Maintain professionalism, supervise non-physicians, protect confidentiality	5
Establishing Physician–Patient Relationship	Verify patient identity, disclose provider credentials, obtain consent	6
Licensure	Must be licensed in the patient's state	1
Evaluation & Treatment	Must conduct evaluation before treatment or prescribing	3
Informed Consent	Must obtain and document informed consent with specific elements	7

Section	Requirement Examples	Count
Continuity of Care	Must provide follow-up access and documentation	2
Emergency Services	Must provide an emergency plan and protocol	2
Medical Records	Must maintain and document all telemedicine-related records	3
Privacy & Security	Must comply with HIPAA, maintain policies, ensure secure transmission	6
Online Disclosures	Must disclose services, fees, credentials, privacy practices, etc.	10
Patient Rights	Must allow access, feedback, and complaint mechanisms	3

Code of Ethics – American Medical Association 2016: 525

Requirement Count Summary

Section	Topic Area	Approx. Count
Chapter 1	Patient–Physician Relationships	85
Chapter 2	Consent, Communication & Decision Making	70
Chapter 3	Privacy, Confidentiality, Medical Records	25

Section	Topic Area	Approx. Count
Chapter 4	Genetics & Reproductive Medicine	30
Chapter 5	End-of-Life Care	20
Chapter 6	Organ Procurement & Transplantation	15
Chapter 7	Research & Innovation	90
Chapter 8	Physicians & Public Health	65
Chapter 9	Professional Self-Regulation	40
Chapter 10	Interprofessional Relationships	35
Chapter 11	Financing & Delivery of Health Care	50

Code of Ethics – American Osteopathic Association 2016: 33

Requirement Count Summary

The AOA Code of Ethics includes 19 numbered sections, each containing at least one requirement. Some sections contain multiple discrete requirements. Here's a breakdown:

Section	Topic	Requirement Count
1–2	Confidentiality, Disclosure	2
3	Non-discrimination, Emergency Care	3
4	Abandonment	2

Section	Topic	Requirement Count
5	Competence, Continuing Education	2
6	Professional Self-Regulation	2
7	Advertising	2
8	Credentials, Representation	3
9	Consultation	1
10–11	Disputes Among Physicians	2
12	Fees, Fee Splitting	2
13	Respect for Law	2
14	Community Participation	1
15–16	Sexual Misconduct, Harassment	2
17	Gifts from Industry	3
18	Misrepresentation	1
19	Research Ethics	2

Code of Ethics - American Podiatric Medical Association 2017: 110

Requirement Count Summary

The APMA Code of Ethics is structured into three main categories:

- Medical Ethics (ME)
- Business Ethics (BE)
- Association Ethics (AE)

Each category contains multiple subsections with specific obligations. Here's the breakdown:

Section	Topic Area	Approx. Count
ME1–ME7	Professional judgment, informed consent, confidentiality, patient respect, professionalism, physician health, research ethics	45
BE1–BE7	Advertising, business transactions, referrals, supervision, legal compliance, staff respect, managed care	55
AE1–AE4	Conflicts of interest, confidentiality, commercial relationships, association conduct	10

Guidelines for Ethical Conduct for the Physician Assistant Profession 2013: 85

Requirement Count Summary

The document is organized into five major sections, each containing multiple ethical obligations:

Section	Topic Area	Approx. Count
The PA and the Patient	Role, consent, confidentiality, end-of-life, diversity, reproductive care	40
The PA and Individual Professionalism	Conflicts of interest, competency, harassment, identity	15

Section	Topic Area	Approx. Count
The PA and Other Professionals	Teamwork, impairment, supervision, illegal conduct	10
The PA and the Health Care System	Research, education, expert witness, workplace actions	10
The PA and Society	Lawfulness, executions, access to care, community well-being	10

From:	Norberg, Natalie M (CED)
To:	Campbell, Karmen L (CED); Davis, Stefanie L (CED)
Cc:	Robb, Sylvan S (CED)
Subject:	FW: Request for Board of Medicine
Date:	Friday, October 3, 2025 8:56:52 AM
Attachments:	Final Medical Board Request Letter.pdf Outlook-Logo of th.png Outlook-vu3xcmmk.png Outlook-2tj3t1xu.png

Hi, Karmen and Stefanie,
Here is a regulation change request that should be incorporated as part of the AO 360 stakeholder feedback for the Medical Board. The Med Board will be considering this request at the November 21 meeting.

Thank you!

Natalie Norberg
Executive Administrator
Alaska State Medical Board

From: Chambers, Sara C (CED) <sara.chambers@alaska.gov>
Sent: Thursday, October 2, 2025 3:49 PM
To: Norberg, Natalie M (CED) <natalie.norberg@alaska.gov>; Robb, Sylvan S (CED) <sylvan.robb@alaska.gov>
Subject: Fw: Request for Board of Medicine

Hi, Natalie & Sylvan. It looks like you already received this, but the Governor's office asked if you would include this in your stakeholder feedback for AO 360.

Thank you!

Sara Chambers

Boards and Regulations Advisor

Office of the Commissioner

sara.chambers@alaska.gov
907-465-2144

www.commerce.alaska.gov

From: Brandy Seignemartin, AKPhA Executive Director <akpharmacistsassociation@gmail.com>
Sent: Wednesday, October 1, 2025 8:52 AM
To: Norberg, Natalie M (CED) <natalie.norberg@alaska.gov>
Cc: Gallagher, Tyson C (GOV) <tyson.gallagher@alaska.gov>; Hedberg, Heidi R (DOH) <heidi.hedberg@alaska.gov>; Robb, Sylvan S (CED) <sylvan.robb@alaska.gov>; Bowles, Michael P (CED) <michael.bowles@alaska.gov>; Brittany Keener <blkeener@anthc.org>; Jordan Marshall <jm@jordanmarshallalaska.com>
Subject: Request for Board of Medicine

Greetings Natalie,

I hope you are doing well. I am writing to share a regulation change request for the Board of Medicine (please see the attached letter).

In addition, I would like to request the opportunity for myself and a colleague from the Cicero Institute to address the Board at their next quarterly meeting regarding SB 147. Could you please let me know if Chair Taylor would be open to including us on the agenda?

Thank you for your time and assistance.

Best regards,

Brandy Seignemartin, Pharm.D.

Executive Director

Alaska Pharmacy Association

3211 Providence Dr. PSB 111

Anchorage, Alaska 99508

akpharmacistsassociation@gmail.com

Office: (907) 786-0732

Cell: (509) 808-9197

October 1, 2025

Alaska State Medical Board
Department of Commerce, Community, and Economic Development – CBPL
P.O. Box 110806
Juneau, AK 99811-0806

Re: Urgent Request to Modernize Pharmacist Collaborative Practice Agreement Regulations – Compliance with Administrative Order 360

Dear Members of the Alaska State Medical Board,

On behalf of the Alaska Pharmacy Association (AKPhA), we are writing to urge you to remove antiquated regulatory restrictions that are limiting Alaskans' access to timely and affordable care. The Alaska Pharmacy Association represents pharmacists, pharmacy technicians, student pharmacists, and pharmacies statewide who, like you, serve on the front lines of patient care - often as the most accessible healthcare providers in rural and underserved areas.

Over the past three years, we have repeatedly appeared before the Board requesting regulatory reforms that would modernize collaborative practice agreements (CPAs) and allow pharmacists to practice at the top of their education and training. Now, with new evidence in hand and clear direction from the Governor's office, we believe it is both an opportune and critical moment for the Board to act.

Alaska's Low National Ranking in Pharmacist Authority & Workforce Challenges

The Cicero Institute's 2025 report, "Policy Strategies for Full Practice Authority," ranked Alaska near the bottom nationally for pharmacist scope of practice. Alaska earned just 3 points out of 10 - a near-failing letter grade - placing us among the lowest-scoring states. Nearly half of states scored higher, and five states (Idaho, Indiana, Iowa, Montana, and Colorado) earned perfect 10/10 scores. The current restrictions in place are no longer consistent with best practices and place Alaska behind the curve nationally, constraining pharmacists' ability to manage chronic disease, provide preventative care, and respond to public health needs like the opioid epidemic.

Furthermore, the recruitment and retention of pharmacists in Alaska continues to be a significant challenge, in part due to the state's restrictive collaborative practice regulations. These limitations hinder pharmacists from practicing at the top of their training, reducing professional autonomy and diminishing opportunities for clinical service delivery. As a result, many pharmacists are deterred from relocating to or remaining in Alaska, opting instead for states with more progressive practice frameworks that support expanded roles in patient care and provider collaboration.

Financial Implications: RHTP Funding Is Tied to Scope of Practice

Importantly, Alaska's low scope-of-practice score has direct financial consequences. Under the newly authorized Rural Healthcare Transformation Project (RHTP) — funded through the "One Big Beautiful Bill" - state technical scores directly determine the share of $25 billion in workload funding Alaska can receive each budget period. Scope of practice is a weighted technical score factor in this calculation.

If Alaska fails to modernize its pharmacist practice laws, we risk leaving federal dollars on the table that could otherwise strengthen rural health infrastructure, expand access, and improve care delivery statewide. Conversely, removing these regulatory barriers could boost Alaska's score, bringing more federal funding to Alaska's rural and frontier communities.

Alignment with Executive and Federal Priorities

Governor Dunleavy's Administrative Order No. 360 directs state boards to eliminate unnecessary regulatory barriers to practice. The order's stated purpose and goals are clear, including:

- Improve the quality, transparency, and efficiency of the State's regulatory environment.
- Ensure all regulations are clearly written, legally sound, and supported by a demonstrated need.
- Regularly evaluate existing regulations for effectiveness, redundancy, clarity, and impact.
- Reduce the regulatory burden on all Alaskans.

Current Board of Medicine rules around pharmacist collaborative practice create challenges that run counter to these priorities. The requirements for Board approval of each CPA, annual in-person physician exams, and restrictions on controlled substance prescribing place additional strain on limited Board and provider resources without clear evidence of added benefit.

By contrast, many states and countries have demonstrated that streamlining these processes and allowing pharmacists in all settings to practice at the top of their education and training can ease administrative workload, expand access to care, and improve efficiency. These proven models show that it is possible to ensure safety and oversight while reducing unnecessary regulatory burdens.

These reforms also align with the Trump Administration's report, "Reforming America's Healthcare System Through Choice and Competition," which called for state-level scope-of-practice modernization to increase provider supply, expand choice, and drive down healthcare costs. Modernizing Alaska's CPA regulations now would demonstrate leadership in implementing both state and federal priorities, advancing health access and fiscal responsibility at the same time.

Specific Regulatory Changes Requested

We respectfully request the Alaska State Medical Board take action to:

- **Eliminate Board pre-approval of CPAs** and instead allow agreements to be kept on file at the practice site, as is common practice in other states.
- **Remove the physician examination requirement**, allowing pharmacists to continue managing patients under CPA as clinically appropriate.
- **Lift the prohibition on pharmacist prescribing of controlled substances** under CPA, enabling pharmacists to participate in Medication-Assisted Treatment (MAT) for opioid use disorder and manage other clinically appropriate therapies.

Call to Action

We urge the Board to seize this timely opportunity to modernize Alaska's pharmacist collaborative practice regulations. These changes will:

- Improve access to care for patients in every region of Alaska.
- Strengthen our rural healthcare delivery system.
- Potentially increase Alaska's share of federal RHTP funding.
- Reduce administrative burdens on physicians and the Board itself.
- Align Alaska with proven models in other states that have safely expanded pharmacist authority to practice at the top of their education and training.

The Alaska Pharmacy Association stands ready to assist in this work by providing model language, best practice examples, and stakeholder support. We respectfully request that the Board prioritize these regulatory updates at its next meeting and work in collaboration with the Board of Pharmacy and Department of Health to implement them without delay.

Thank you for your attention to this urgent matter. Together, we can ensure that Alaska's healthcare system is ready to meet the needs of our communities now and in the future.

Sincerely,

Brandy Seignemartin, PharmD
Executive Director, Alaska Pharmacy Association

CC: The Honorable Mike Dunleavy, Governor of Alaska; *Heidi Hedberg, Commissioner, Alaska Department of Health*; *Sylvan Robb, Division Director, Corporations, Business and Professional Licensing*; *Michael Bowles, Executive Administrator, Alaska Board of Pharmacy*

From: Carrie Urena
To: Regulations and Public Comment (CED sponsored)
Subject: Regulatory Reform Written Comment
Date: Friday, November 7, 2025 2:08:57 PM
Attachments: Statement for Regulatory Reform .pdf

Hello,
I have attached written comment for regulatory reform consideration.
Respectfully,
Carrie Urena

Carrie Urena
PharmD, BCPS

THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Division of Corporations, Business and Professional Licensing
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *RegulationsandPublicComment@Alaska.Gov*
Website: *Commerce.Alaska.Gov*

Regulatory Reform Written Comment Form

Email the completed form to *RegulationsandPublicComment@Alaska.Gov* by **November 7, 2025**.

All comments submitted will be taken under advisement. If your program is governed by a board, the board will review and make determinations on implementation.

Full Name:	Carrie Urena	**Date:**	11/07/2025
Occupation:	Pharmacist		
Profession/Program:	Opioid Treatment Program Pharmacist		
Regulation Number(s): (e.g. 12 AAC 16.930)	A.S. Sec. 08.80.480(30); A.S. Sec. 08.80.168; A.S. Sec. 08.80.337; 12 AAC 52.995(c)(3)		

Comment(s):

As a pharmacist serving rural Alaska through a Tribal Health Organization (THO), I witness firsthand the devastating impact of the opioid crisis on our communities—especially in remote areas where access to care is limited. Despite the complexity of this issue, we have an opportunity to improve outcomes for countless families by removing outdated restrictions that prevent pharmacists from fully participating in the treatment of opioid use disorder (OUD). I urge our state leaders and regulatory bodies to revise outdated restrictions that prevent pharmacists from fully participating in the treatment of opioid use disorder.

Pharmacists are among the most accessible healthcare professionals in our state, yet current regulations limit our ability to provide life-saving care. I've seen patients struggle to access timely treatment, not because the medications aren't available, but because the system doesn't allow pharmacists to help in the ways we are trained to, and providers are either not available or not always willing to prescribe medications for opioid use disorder (MOUD). If Alaska truly wants to address the opioid crisis, we must empower pharmacists to use their clinical expertise to support and expand access to care.

Pharmacists earn a Doctor of Pharmacy (PharmD) degree, completing a rigorous and standardized education across all states. To become licensed, we must demonstrate clinical competence by passing the North American Pharmacist Licensure Examination (NAPLEX). Our training goes far beyond medication dispensing—it equips us to manage complex therapies, evaluate patients holistically, and make informed clinical decisions. We are trained to understand intricate drug-drug and drug-body interactions, recognize when laboratory tests are needed, interpret those results, and provide safe, effective follow-up care. The human body is a complex system, and any physiological change can alter how a drug behaves. This foundational knowledge is not peripheral—it is central to our education and clinical practice. This overview only scratches the surface of our capabilities, but it should make one thing clear: pharmacists are highly trained healthcare professionals prepared to contribute meaningfully to patient care, including in the treatment of opioid use disorder.

Across the United States—and especially here in Alaska—we continue to hear urgent calls to improve access to medications for opioid use disorder (MOUD). Yet despite this need, our state maintains outdated regulations that prevent pharmacists from contributing fully to this effort. These restrictions limit the reach of one of our most accessible and highly trained healthcare workforces. Pharmacists possess the education, clinical training, and licensure required to safely and effectively manage MOUD. We are ready and capable of helping expand access to these life-saving treatments, but we are held back by antiquated language in our laws and collaborative practice agreements. If Alaska is serious about addressing the opioid crisis, it must modernize these regulations and allow pharmacists to practice to the full extent of their training.

I submitted a formal statement to the Alaska Medical Board requesting revisions to the language used in Collaborative Practice Agreements (CPAs), which currently restrict pharmacists from prescribing controlled substances. This outdated language prevents pharmacists from using CPAs to manage medications for opioid use disorder (MOUD), despite our qualifications and the urgent need for expanded access to care. At the medical board meeting, one of Alaska's leading addiction medicine physicians voiced support for this change, yet the board continues to uphold these restrictive regulations, citing concerns about pharmacists' education. This stance is not only misinformed—it's inconsistent. Advanced Practice Registered Nurses (APRNs) are permitted to prescribe controlled substances with only 500 – 750 hours of clinical patient care, while pharmacists complete approximately 1,740 hours as part of their Doctor of Pharmacy (PharmD) training. It is time for Alaska to recognize the depth of pharmacists' clinical education and allow us to contribute fully to the fight against opioid addiction.

Pharmacists have long played a vital role in managing a wide range of disease states, consistently demonstrating that our interventions lead to improved patient outcomes. These benefits extend beyond clinical success—they also result in significant cost savings through reduced emergency room visits, fewer hospital admissions, and less time lost from work due to illness. Alaska faces a persistent shortage of physicians, and many are unwilling to practice in rural areas, leaving these communities at a severe disadvantage. This gap in care presents a clear opportunity: we should be leveraging the expertise and accessibility of our pharmacist workforce to help fill these critical service needs.

The Cicero Institute ' s 2025 report, Policy Strategies for Full Practice Authority, highlights the significant benefits of granting pharmacists full practice authority under a standard of care framework. Using statutory and regulatory analysis, the report evaluates and ranks states based on pharmacist authority—and Alaska scored just 3 out of 10. In contrast, five states earned perfect scores, including Idaho—a state with which Alaska maintains strong professional connections through our pharmacy school, Board of Pharmacy (BOP), and state pharmacy association. We have open lines of communication with key individuals who helped Idaho achieve its ranking, and their success shows that meaningful reform is both realistic and within reach. Alaska has the opportunity to follow this example and empower pharmacists to deliver essential services to communities in need. With the right policy changes, we can improve access to care, especially in underserved areas, and make real progress in addressing the opioid crisis.

If we truly want to make a difference in the devastation caused by the opioid crisis across Alaska, we must utilize every available resource—including pharmacists. While much of the nation has seen a decline in fatal opioid overdoses in recent years, Alaska has not followed that trend. In fact, we've experienced some of the highest increases in overdose deaths. We cannot afford to remain passive while this crisis continues to ravage our communities. Every data point in these "rates" represents a life lost—a person with loved ones left behind to endure unimaginable grief. This must no longer be acceptable. We must act. We must do better. By empowering pharmacists to provide the care we are trained to deliver, we can begin to heal our communities and offer hope where it's desperately needed. I sincerely hope you share this commitment to change and are willing to work toward improving the lives of the people we serve. Thank you for taking the time to listen. I look forward to the positive changes ahead—and together, we can show just how strong Alaskans truly are.

From:	Meghan Hall
To:	Regulations and Public Comment (CED sponsored)
Subject:	Alignment of PA Regulatory Workgroup Recommendations with Governor Dunleavy's Goals
Date:	Monday, October 6, 2025 1:45:11 PM
Attachments:	ASMB_PA Work Group .pdf

To the Division of Corporations, Business and Professional Licensing,

I am writing to highlight how the Alaska State Medical Board Physician Assistant (PA) Work Group's proposed regulatory updates directly advance Governor Dunleavy's priorities for regulatory reform. The Division of Corporations, Business and Professional Licensing emphasized the importance of recommendations that clarify obligations, reduce burdens, and improve efficiency, and this document accomplishes all of these. These changes were voted on by the State Medical Board and moved unanimously to the legal department for review. I believe they align with the Governor's goals and should be moved to public comment.

Key ways the recommendations meet the Governor's goals include:

- **Clarifying existing obligations:**
  The revisions eliminate redundant requirements (e.g., duplicative documentation of NCCPA certification and education hours) and update terminology (e.g., "practice agreement" rather than "collaborative plan") to provide clarity and consistency across regulations.

- **Reducing costs for the public, industry, and government:**
  Streamlining documentation—such as maintaining practice agreements at the practice level rather than filing with the state—reduces unnecessary administrative time for both licensees and regulators, lowering compliance costs.

- **Improving and streamlining procedures:**
  Proposed changes simplify application and renewal requirements by aligning them with national certification standards, reducing delays and duplication. Temporary licensing procedures are clarified and standardized, making it faster to bring qualified PAs into the workforce.

- **Reducing administrative burdens:**
  Outdated license categories (e.g., graduate PA license, student permits) are repealed, and unnecessary reporting requirements are removed. These changes ease the workload of both applicants and state staff.

- **Streamlining permitting/licensing:**
  The updated regulations provide clear checklists for temporary permits and standardized use of the Federation Credentials Verification Service (FCVS), accelerating review and approval timelines.

- **Improving communication and transparency:**
  By requiring practice agreements to be maintained at the practice level and available to the Board upon request, the process ensures transparency while eliminating unnecessary filings that slow communication.

- **Clarifying interagency roles:**
  Consistency is achieved across all licensees with regard to DEA registration, Board Action Data Bank checks, and disciplinary procedures, aligning PA requirements with physician standards and reducing confusion.

Taken together, these proposed changes modernize PA regulations in a way that promotes workforce access, reduces bureaucratic hurdles, and maintains guardrails for patient safety and quality of care—all while advancing the Governor's commitment to efficient and transparent governance. The Alaska Academy of Physician Assistants hopes that these changes can move forward to help ensure Alaska is a state where PAs choose to work!

Sincerely,

Meghan Hall, PA-C
President
Alaska Academy of Physician Assistants

Article 5

Physician Assistants

12 AAC 40.400 Physician assistant license

(a) An individual who desires to undertake medical diagnosis and treatment or the practice of medicine under AS 08.64.380(6) or AS 08.64.380(7) as a physician assistant

(1) shall apply for a permanent renewable license on a form provided by the department;

(2) shall pay the appropriate fees established in 12 AAC 02.250; and

(3) must be approved by the board or the board's designee.

(b) The application must contain documented evidence of

(1) graduation from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or, before 2001, by its predecessor accrediting agencies the American Medical Association's Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs;

~~(2) a passing score on the certifying examination administered by the National Commission on Certification of Physician Assistants;~~ [1]

(**2**) verification of current certification issued by the National Commission on Certification of Physician Assistants (NCCPA);

~~(4) compliance with continuing medical education standards established by the National Commission on Certification of Physician Assistants;~~ [2]

(**3**) verification of registration or licensure in all other states where the applicant is or has been registered or licensed as a physician assistant or any other health care professional;

~~(6) verification of successful completion of a physician assistant program that meets the requirements of (1) of this subsection; that verification must be sent directly from the program to the board;~~ [3]

(4) attestation of the applicant's completion of at least two hours of education in pain management and opioid use and addiction earned in a continuing medical education program approved by the National Commission on Certification of Physician assistants (NCCPA), a Category I continuing medical education program accredited by the American Medical Association, or a Category I or II continuing medical education program accredited by the American Osteopathic Association, for an applicant who does not currently hold a valid federal Drug Enforcement Administration registration number, the verification will be waived until the applicant applies for a valid registration

[1] Cannot be NCCPA certified without this so it is redundant
[2] Again redundant due to current NCCPA certification indicating this compliance
[3] Redundant as NCCPA certification requires this as well

number; [4]

(5) clearance from the Board Action Data Bank maintained by the Federation of State Medical Boards; and

(6) ~~clearance from the federal Drug Enforcement Administration (DEA).~~ **A true and correct attestation whether the applicant has been the subject of a revoked or restricted DEA registration.** [5]

(c) Repealed 9/1/2007

(d) Notwithstanding (b) of this section, an applicant for a physician assistant license may submit the credentials verification documents through the Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards of the United States, Inc., sent directly to the department from FCVS.

(e) attest that there is an active practice agreement in place maintained at the practice level and is available to the ASMB upon request.[6]

12 AAC 40.405. Temporary ~~license~~ **permit**. [7]

(a) A member of the board, the executive secretary, or a person designated by the board to issue temporary permits, may approve a temporary physician assistant **permits** ~~license~~ of an applicant who meets the requirements of 12 AAC 40.400 ~~or 12 AAC 40.445~~ and pays the fee set out in 12 AAC 02.250.

(b) A temporary **permit** ~~license~~ is valid for six months or until ~~the board meets and considers the application for~~ a permanent renewable license **is approved**, whichever occurs first. [8]

(c) The board may renew a temporary license once only, based on good

cause.

(d) Repealed 7/25/2008.

~~(e) An applicant who meets the requirements on the checklist established in this section has demonstrated the necessary qualifications for the temporary permit applied for and will be approved by the board, the executive secretary, or the board's designee for issuance of that permit. An applicant who does not meet the requirements on the checklist established in this section for that permit will not be issued a temporary permit unless the board further reviews the application and determines that the applicant meets the qualifications in AS 08.64 and this chapter for that permit. The form titled Alaska State Medical Board - Checklist, Temporary Permit for Physician Assistant, dated February 2018, is adopted by reference. This form is established by the board for the use by the executive secretary or another employee of the division in completing the application processing for a temporary permit under this section.~~ [9]

(e) A member of the board, the executive secretary, or a person designated by the board to

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[4] Language added to all licensee requirements to be consistent
[5] Same language that physicians have in their licensing requirements
[6] Attestation instead of filing as practice agreement maintained at the practice level
[7] Permit language used throughout all regulations for licensees
[8] Cleaning up language to be consistent
[9] Making requirements consistent across licensees

issue temporary permits, may expedite the issuance of a temporary physician assistant permit to an applicant who has on file with the division:

(1) a completed application on a form provided by the department;

(2) current practice address

(3) a completed authorization for release of records on a form provided by the department and signed by the applicant;

(4) payment of all required application and licensing fees;

(5) graduation from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or, before 2001, by its predecessor accrediting agencies the American Medical Association's Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs;

(6) verification of current certification issued by the National Commission on Certification of Physician Assistants (NCCPA);

(7) clearance from the Board Action Data Bank maintained by the Federation of State Medical Boards; and

(8) has no adverse or derogatory history including

(A) grounds for which the board may impose disciplinary sanctions under AS 08.64.326

(B) malpractice settlements or payment

(C) any criminal charge or conviction, including conviction based on guilty plea or plea of nolo contendere;

(D) any complaint, investigation, or action regarding the practice of medicine, in another state or territory of the United States, a province of Canada, a federal agency, the armed forces of the United States, or international jurisdiction;

(E) any adverse action taken by a hospital, health care facility, or health care employer.[10]

12 AAC 40.406. Locum tenens authorization to practice. Repealed.

12 AAC 40.408. Authorization to practice as a physician assistant. Repealed.

12 AAC 40.410. Collaborative relationship and **practice agreement**. [11]

(a) A licensed physician assistant may ~~not~~ practice with~~out~~ at least one collaborative relationship established under this chapter. The collaborative relationship must be documented by a practice agreement and **maintained at the practice level** ~~on a form provided by the board~~ and must include [12]

(1) the name~~,~~ license number~~, and specialty, if any, for the primary supervising physician and~~ at least one ~~alternate~~ collaborating physician; [13]

(2) the name, place of employment, and ~~both residence and~~[14] mailing addresses of the physician assistant with whom the physician intends to establish a collaborative relationship;

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[10] Added for consistency across all licensees
[11] Group felt practice agreement was better terminology. This change is made throughout the document
[12] Group felt it was much better to house practice agreement at the practice level and not file with state
[13] Specialty not important for practice agreement, alternate physician requirement removed
[14] Group felt residential address for providers was not needed in agreement

(3) the beginning date of employment under the practice agreement and the physical location of practice;

(4) compliance with 12 AAC 40.415 if the practice location is a remote practice location; and

(5) The practice agreement ~~will~~ **may include** a method of assessment between practice agreement parties. [15]

~~(6) prescriptive authority being granted to the physician assistant by the collaborating physician under the practice agreement.~~ [16]

(b) The practice agreement must be **maintained at the practice location and available to the ASMB upon request.**[17] ~~filed with the division within 14 days after the effective date of the practice agreement or within 14 days after the effective date of any change to that plan.~~

~~(c) Receipt by the board of the practice agreement will be considered documented evidence of an established practice agreement.~~ [18]

(c) Any physician assistant subject to a board order must have their **practice agreement** approved by the board or its designee in advance of the effective date of the **agreement** ~~plan~~ to ensure that the **practice agreement** ~~collaborative plan~~ conforms to the terms of the order.

~~(e) A copy of the current plan must be retained at the place of employment specified in the plan and must be available for inspection by the public.~~ [19]

~~(f) A change in a practice agreement automatically suspends a licensed physician assistant's authority to practice under that practice agreement unless the change is only to replace the primary collaborating physician with an existing alternate collaborating physician and at least one alternate collaborating physician remains in place. Any change to collaborating physicians must be reported to the board in accordance with (b) of this section.~~ [20]

(d) Nothing in this section prohibits periodic board review and assessment of the collaborating physician and the practice agreement.

(e) A physician(MD/DO/DPM) who wishes to establish a collaborative relationship with a physician assistant must hold a current, active, and unrestricted license to practice medicine in this state and be in active practice of allopathic/osteopathic/**podiatric** medicine. [21]

(f) A collaborative physician or physician assistant who has any licensing restriction placed, by any state medical board, must provide the ASMB written verification the PA has been notified of the restrictions within 48 hours. Physician assistants cannot be reprimanded for not complying with 12 AAC 40.410 during that 48 hour period. If the physician assistant does not comply with 12 AAC 40.410 immediately after notification

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[15] Allows for discretion of the employer to decide how to evaluate practice of physician assistant
[16] No longer granted in practice agreement
[17] Practice agreement is housed at the practice level and available to board upon request
[18] Not needed with agreement at practice level
[19] Redundant at that is where it will be housed
[20] See f
[21] Added podiatry

the physician assistant's ~~collaboration~~ practice agreement will be rendered void.[22]

~~***(g)** The primary collaborating physician shall maintain in the physician's records a copy of each DEA Form 222 official order form submitted by each physician assistant with whom the physician has a collaborative relationship. The primary collaborating physician is responsible for ensuring that the physician assistant complies with state and federal inventory and record keeping requirements.*~~

(h) In this section, "active practice" means at least 200 hours each year of practicing medicine with direct patient contact.

12 AAC 40.415. Remote practice location.

~~(a) To qualify to practice in a remote practice location, a physician assistant with less than two years of full-time clinical experience must work 160 hours in direct patient care under the direct and immediate supervision of the collaborating physician or alternate collaborating physician. The first 40 hours must be completed before the physician assistant begins practice in the remote practice location, and the remaining 120 hours must be completed within 90 days after the date the physician assistant starts practice in the remote practice location.~~ To qualify to practice in a remote location, a physician assistant with less than two years of full-time clinical experience must work 160 hours in direct patient care.[23]

The first 40 hours must be completed before the physician assistant begins practice in the remote practice location. The remaining 120 hours must be completed within **90 days after the physician assistant begins remote practice in the remote location with an advanced practice provider (APP) or physician onsite who has two or more years of full-time clinical experience. The physician assistant is not required to repeat the first 40 hours due to a change in the collaborating physician.** ~~This will be outlined in the practice agreement prior to initiation of the **practice agreement prior to initiation** plan and will be continued with any change of the **practice agreement except termination or violation**.~~ [24]

~~(b) A physician assistant with less than two years of full-time clinical experience who practices in a remote practice location and who has a change of collaborating physician must work 40 hours under the direct and immediate supervision of the new collaborating physician within 60 days after the effective date of the new practice agreement unless the change is only to replace the primary collaborating physician with an existing alternate collaborating physician.~~ [25]

~~(c) A physician assistant with two or more years of full-time clinical experience who applies for authorization to practice in a remote practice location shall submit with the practice agreement (1) a detailed curriculum vitae documenting that the physician assistant's previous experience as a physician assistant is sufficient to meet the requirements of the location assignment; and (2) a written recommendation and approval from the collaborating physician.~~ [26]

(b) In this section, "remote practice location" means a location in which a physician assistant practices that is ~~30~~**100** or more miles **by road from the nearest primary,**

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[22] Added to make sure that a PA isn't held liable for a physician not notifying them that their license was restricted

[23] Changed to simplify requirements for new PAs

[24] Increases flexibility for remote clinics while providing support to new remote providers

[25] Removed as it was felt that the skill/experience of the PA does not change with new practice agreement

[26] It was felt that requiring a CV was no necessary as the new PA will have support per (a)

secondary or tertiary care facility. ~~collaborating physician's primary office.~~ [27]

12 AAC 40.420. Currently practicing physician assistant. Repealed.

12 AAC 40.430. Performance and assessment of practice. [28]

~~(a) A person may perform medical diagnosis and treatment as a physician assistant only if licensed by the board and only within the scope of practice of the collaborating physician.~~

~~(b) A periodic method of assessment of the quality of practice must be established by the collaborating physician. In this subsection, "periodic method of assessment" means evaluation of medical care and clinic management.~~

(c) Repealed 3/27/2003.

(d) Repealed 3/27/2003.

~~(e) Assessments must include annual direct personal contact between the physician assistant and the primary or alternate collaborating physician, at either the physician or physician assistant's work site. The collaborating physician shall document the evaluation on a form provided by the department.~~

~~(f) Except as provided in (h) of this section, practice agreements in effect for less than two years must include at least one direct personal contact visit with the primary or alternate collaborating physician per calendar quarter for at least four hours duration.~~

~~(g) Except as provided in (h) of this section, practice agreements in effect for two years or more must include at least two direct personal contact visits with the primary or alternate collaborating physician per year. Each visit must be of at least four hours duration and must be at least four months apart.~~

~~(h) Physician assistants who practice under a practice agreement for a continuous period of less than three months of each year must have at least one direct personal contact visit with the primary or alternate collaborating physician annually.~~

~~(i) practice agreements, regardless of duration, must include at least monthly telephone, radio, electronic, or direct personal contact between the physician assistant and the primary or alternate collaborating physician during the period in which the physician assistant is actively practicing under the practice agreement. Dates of active practice under the practice agreement and monthly contact must be documented.~~

~~(j) Contacts, whether direct personal contact or contact by telephone, radio, or other electronic means, must include reviews of patient care and review of health care records.~~

~~(k) The primary collaborating physician shall maintain records of performance assessments. The board may audit those records.~~

~~(l) The primary collaborating physician shall maintain on file the completed records of assessment form for at least seven years after the date of the evaluation.~~

~~(m) If an alternate collaborating physician performs the evaluation, copies of the record of~~

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[27] Updated to better reflect the reality of remote medicine in Alaska

[28] Entire section felt to be unnecessary with practice agreement at the practice level with individual assessments being done

assessment must be provided to the primary collaborating physician for retention in the primary collaborating physician's records.

(n) The board's executive secretary may initiate audits of performance assessment records. In any one calendar year, the performance assessment records of not more than 10 percent of the actively licensed physician assistants, selected randomly by computer, will be audited. For each audit,

(1) the collaborating physician shall produce records of assessment for the past two calendar years immediately preceding the year of audit; and

(2) if the practice agreement has been in effect for at least one year, but less than two years, only one year of records will be audited; practice agreements of less than one year's duration will not be audited.

(o) Repealed 5/8/2013.

(p) Repealed 5/8/2013.

(q) Repealed 5/8/2013.

(r) During an urgent situation as determined by the board, direct personal contact as required under this section may be met by audio and video means; "urgent situation" has the meaning given in 12 AAC 40.045.

12 AAC 40.440. Student physician assistant permit. Repealed.

12 AAC 40.445. Graduate physician assistant license. [29]

(a) An applicant for a license to practice as a graduate physician assistant (1) shall apply on a form provided by the department; (2) shall pay the fees established in 12 AAC 02.250; and (3) must be approved by the board.

(b) The application must include

(1) evidence of having graduated from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or, before 2001, by its predecessor accrediting agencies the American Medical Association's Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs; and

(2) evidence of having been accepted to take the next entry level examination of the National Commission on Certification of Physician Assistants, Inc. (NCCPA) for initial certification.

(c) A graduate physician assistant license is automatically suspended on the date the board receives notice that the applicant failed to pass the NCCPA certifying examination required under (b)(2) of this section.

(d) Upon request, the board will reissue a graduate physician assistant license only if the licensee was prevented from taking a scheduled examination.

(e) A licensed graduate physician assistant must be under the continuous on-site supervision of a physician assistant licensed in this state or a physician licensed in this state.

[29] Entire section removed as it was felt this type of license is no longer needed

~~(f) When licensed, the licensee shall display a nameplate designating that person as a "graduate physician assistant."~~

~~(g) Notwithstanding (b) of this section, an applicant for a graduate physician assistant license may submit the credentials verification documents through the Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards of the United States, Inc., sent directly to the department from FCVS.~~

12 AAC 40.447. Authorization to practice as a graduate physician assistant. Repealed.

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~~ [30]

~~(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. (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 only with the authorization of the physician assistant's primary collaborating physician. The authorization must be documented in the physician assistant's current practice agreement 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 practice agreement 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 practice agreement 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.~~

~~documented in the physician assistant's current practice agreement 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 practice agreement terminates a physician assistant's authority to prescribe, order, administer, and dispense medication under that agreement.~~

[30] Changed section to make it clear that prescriptive authority is granted with license and DEA registration

(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).~~

~~12 AAC 40.460. Identification.~~

~~A licensed physician assistant authorized to practice shall conspicuously display on the licensee's clothing a nameplate identifying the physician assistant as a "Physician Assistant-Certified (PA-C)" and shall display at the licensee's customary place of employment~~

~~(1) a current state license; and~~

~~(2) a sign at least five by eight inches informing the public that documents showing the licensed physician assistant's education and a copy of the current practice agreement on file with the division are available for inspection.~~ [31]

12 AAC 40.470. Renewal of a physician assistant license.

(a) A physician assistant license must be renewed biennially on the date set by the department.

(b) An application for renewal must be made on the form provided by the department and must include

(1) payment of the renewal fee established in 12 AAC 02.250;

(2) **attestation and maintenance** of ~~documented evidence that the applicant has met the continuing medical education and recertification requirements of the NCCPA, including the NCCPA recertification examination, and is~~ **current certification** by NCCPA; [32]

~~(3) verification on a form provided by the department of each authorization to practice issued before September 1, 2007 under which the physician assistant is practicing.~~

[31] Felt to be redundant as Sec. 08.64.326 already states all licensees must present their credentials and identify themselves

[32] Keeping the language consistent with initial licensing section

(3) attestation of the applicant's completion of at least two hours of education in pain management and opioid use and addiction earned in a continuing medical education program approved by the National Commission on Certification of Physician assistants (NCCPA), a Category I continuing medical education program accredited by the American Medical Association, or a Category I or II continuing medical education program accredited by the American Osteopathic Association, for an applicant who does not currently hold a valid federal Drug Enforcement Administration registration number, the verification will be waived until the applicant applies for a valid registration number; [33]

12 AAC 40.473. Inactive physician assistant license.

(a) A physician assistant who is not practicing in the state may hold an inactive license that may be renewed.

(b) A physician assistant may apply for an inactive license at the time of license renewal by

(1) indicating on the form for license renewal that the physician assistant is requesting an inactive license; and

(2) paying the inactive biennial license fee established in 12 AAC 02.250.

(c) A physician assistant licensed as inactive may not practice as a physician assistant in the state.

(d) A physician assistant licensed as inactive who wishes to resume active practice as a physician assistant in the state must

(1) submit a completed renewal application form indicating request for reactivation;

(2) pay the physician assistant biennial license renewal fee established in 12 AAC 02.250, less any inactive license fee previously paid for the same licensing period;

(3) **attestate to** ~~submit a copy of~~ a current **and maintenance of** certificate issued by the National Commission of Certification of Physician Assistants; and [34]

(4) ~~request~~ a clearance report from the Federation of State Medical Boards's Board Action Data Bank be sent directly to the board.

(e) Notwithstanding (a) and (b) of this section, the board may refuse to reactivate a physician assistant authorization for the same reasons that it may impose disciplinary sanctions against a licensee under AS 08.64.326 and this chapter.

12 AAC 40.475. Lapsed physician assistant license.

(a) A physician assistant license that has been lapsed for at least 60 days but less than one year will be reinstated if the applicant submits

(1) a complete renewal application form;

(2) documentation that the continuing medical education requirements of 12

[33] Same language as initial license section
[34] Keeping language consistent in all sections

AAC 40.470 (b)(**2&3**) have been met;

(3) the renewal fees required by 12 AAC 02.250.

(b) A physician assistant license that has been lapsed for at least one year but less than five years will be reinstated if the applicant submits

(1) a complete renewal application on a form provided by the department;

(2) documentation that the continuing medical education requirements of 12 AAC 40.470(b) **(2&3)** have been met for the entire period that the authorization has been lapsed;

(3) verification of licensure from the appropriate licensing authority in each state, territory, or province where the applicant holds or has ever held a license as a physician assistant or other health care professional;

(4) clearance from the Federation of State Medical Boards sent directly to the division;

~~(5) clearance from the federal Drug Enforcement Administration (DEA); and~~ [35]

(**5**) the applicable fees required in 12 AAC 02.250.

(c) Notwithstanding (a) and (b) of this section, the board may refuse to reinstate a physician assistant license for the same reasons that it may impose disciplinary sanctions against a licensee under AS 08.64.326 and this chapter.

~~12 AAC 40.480. Exemptions.~~

~~(a) Nothing in this chapter prevents or regulates the use of a community health aide in the usual and customary manner in the rural areas of the State of Alaska.~~

~~(b) Nothing in this chapter regulates, restricts, or alters the functions of a person traditionally employed in an office, by a physician, performing duties not regulated by the State Medical Board under AS 08.64.106~~ [36]

12 AAC 40.490. Grounds for suspension, revocation, or denial of license.

The board, after compliance with the Administrative Procedure Act (AS 44.62), will, in its discretion, suspend, revoke, or deny the license of a physician assistant who

(1) fails to pay the fees established in 12 AAC 02.250;

(2) fails to comply with AS Sec 08.64.326 [37]

~~(2) has obtained, or attempted to obtain, a license or authorization to practice as a physician assistant by fraud, deceit, material misrepresentation, or false statement;~~

~~(3) habitually abuses alcoholic beverages, or illegally uses depressants,~~

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[35] Removed for all licensees
[36] This section did not make sense to us. Removed and await guidance from legal if needed or not
[37] It was decided that this statute applies to all licensees of the board and covers everything in this section

~~hallucinogenic or stimulant drugs as defined by AS 17.12.150(3), or uses narcotic drugs as defined by AS 17.10.230(13);~~

~~(4) consistently fails to comply with 12 AAC 40.460;~~

~~(5) practices without the required practice agreement as required by 12 AAC 40.410;~~

~~(6) represents or uses any signs, figures, or letters to represent himself or herself as a physician, surgeon, doctor, or doctor of medicine;~~

~~(7) violates any section of this chapter;~~

~~(8) is found to have demonstrated professional incompetence as defined in 12 AAC 40.970;~~

~~(9) in a clinical setting,~~

~~(A) fails to clearly identify oneself as a physician assistant to a patient;~~

~~(B) uses or permits to be used on the physician assistant's behalf the term "doctor," "Dr.," or "doc"; or~~

~~(C) holds oneself out in any way to be a physician or surgeon;~~

(**3** ~~10~~) practices without maintaining certification by the National Commission on Certification of Physician Assistants (NCCPA).[38]

[38] This could likely also be removed as it is quite redundant

Additional information that was considered by the working group:

For comparison - these are the grounds for imposition of disciplinary sanctions in the physician statutes.

Sec. 08.64.326. Grounds for imposition of disciplinary sanctions.

(a) The board may impose a sanction if the board finds after a hearing that a licensee

(1) secured a license through deceit, fraud, or intentional misrepresentation;

(2) engaged in deceit, fraud, or intentional misrepresentation while providing professional services or engaging in professional activities;

(3) advertised professional services in a false or misleading manner;

(4) has been convicted, including conviction based on a guilty plea or plea of nolo contendere, of

(A) a class A or unclassified felony or a crime in another jurisdiction with elements similar to a class A or unclassified felony in this jurisdiction;

(B) a class B or class C felony or a crime in another jurisdiction with elements similar to a class B or class C felony in this jurisdiction if the felony or other crime is substantially related to the qualifications, functions, or duties of the licensee; or

(C) a crime involving the unlawful procurement, sale, prescription, or dispensing of drugs;

(5) has procured, sold, prescribed, or dispensed drugs in violation of a law regardless of whether there has been a criminal action or harm to the patient;

(6) intentionally or negligently permitted the performance of patient care by persons under the licensee's supervision that does not conform to minimum professional standards even if the patient was not injured;

(7) failed to comply with this chapter, a regulation adopted under this chapter, or an order of the board;

(8) has demonstrated

(A) professional incompetence, gross negligence or repeated negligent conduct; the board may not base a finding of professional incompetence solely on the basis that a licensee's practice is unconventional or experimental in the absence of demonstrable physical harm to a patient;

(B) addiction to, severe dependency on, or habitual overuse of alcohol or other drugs that impairs the licensee's ability to practice safely;

(C) unfitness because of physical or mental disability;

(9) engaged in unprofessional conduct, in sexual misconduct, or in lewd or immoral conduct in connection with the delivery of professional services to patients; in this paragraph, "sexual misconduct" includes sexual contact, as defined by the board in regulations adopted under this chapter, or attempted sexual contact with a patient outside the scope of generally accepted methods of examination or treatment of the patient, regardless of the patient's consent or lack of consent, during the term of the physician-patient relationship, as defined by the board in regulations

adopted under this chapter, unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the physician-patient relationship, was in a dating, courtship, or engagement relationship with the licensee;

(10) has violated AS 18.16.010;

(11) has violated any code of ethics adopted by regulation by the board;

(12) has denied care or treatment to a patient or person seeking assistance from the physician if the only reason for the denial is the failure or refusal of the patient to agree to arbitrate as provided in AS 09.55.535(a);

(13) has had a license or certificate to practice medicine in another state or territory of the United States, or a province or territory of Canada, denied, suspended, revoked, surrendered while under investigation for an alleged violation, restricted, limited, conditioned, or placed on probation unless the denial, suspension, revocation, or other action was caused by the failure of the licensee to pay fees to that state, territory, or province; or

(14) prescribed or dispensed an opioid in excess of the maximum dosage authorized under AS 08.64.363.

(b) In a case involving (a)(13) of this section, the final findings of fact, conclusions of law and order of the authority that suspended or revoked a license or certificate constitutes a prima facie case that the license or certificate was suspended or revoked and the grounds under which the suspension or revocation was granted.