OFFICE OF THE GOVERNOR

KAY IVEY
GOVERNOR

STATE CAPITOL
MONTGOMERY, ALABAMA 36130

(334) 242-7100

STATE OF ALABAMA

MEMORANDUM

To: All State Department /Agency Heads

From: Governor Kay Ivey

Date: January 20, 2025

Re: Emergency Closures of State Offices and Buildings

Due to the State of Emergency, I am directing that all State offices and buildings in the following counties be closed on Tuesday, January 21 and Wednesday, January 22:

Autauga, Baldwin, Barbour, Bibb, Bullock, Butler, Chambers, Chilton, Choctaw, Clarke, Coffee, Conecuh, Coosa, Covington, Crenshaw, Dale, Dallas, Elmore, Escambia, Geneva, Greene, Hale, Henry, Houston, Lee, Lowndes, Macon, Marengo, Mobile, Monroe, Montgomery, Perry, Pike, Randolph, Russell, Sumter, Tallapoosa, Washington, and Wilcox.

Weather conditions are expected to be both extreme and severe and travel in many areas may be restricted.

In all other counties, each State and local agency head is authorized to make closure determinations based on local weather conditions. Just one to three degrees could dramatically change the setup of safety conditions so agency heads should be vigilant in monitoring changing surroundings. Because the safety of State employees is of overriding concern, each agency/department director is authorized to advise his or her employees that – subject to the requirements of their positions – if dangerous conditions exist, employees will not be required to report to work and will not be charged leave. I direct agency heads to report closures to local media outlets.

Each State agency head is reminded that this authority is to be exercised based upon the specific need to protect the health and safety of individual employees. This authority should be exercised judiciously and not necessarily in blanket fashion, taking into account the level of risk of severe weather in the locality of the winter weather.

Departments providing safety and direct care services must plan and schedule their activities accordingly, with the heads of those agencies/departments determining staffing needs and work requirements to ensure the continued operation of essential and emergency services.

I urge you to communicate with your employees and please stay connected with my office for further updates and developments.

MINUTES
Monthly Meeting
MEDICAL LICENSURE COMMISSION OF ALABAMA
Meeting Location: 3300 Cahaba Road
Suite 320, 3rd Floor
Birmingham, Alabama 35223

January 24, 2025

MEMBERS PRESENT IN PERSON

Paul M. Nagrodzki, M.D., Vice-Chairman
Kenneth W. Aldridge, M.D.
Craig H. Christopher, M.D.
Howard J. Falgout, M.D.
Pamela Varner, M.D.

MEMBERS NOT PRESENT

MEMBERS PRESENT VIRTUALLY

Jorge Alsip, M.D., Chairman
L. Daniel Morris, Esq
Nina Nelson-Garrett, M.D

MLC STAFF

Aaron Dettling, General Counsel, MLC
Rebecca Robbins, Operations Director (Recording)
Nicole Roque, Administrative Assistant (Recording)
Heather Lindemann, Licensure Assistant

OTHERS PRESENT

BME STAFF

Sam Aikens, Investigator
Amy Dorminey, Director of Operations
Jason Green, Investigator
Alicia Harrison, Associate General Counsel
Chris Hart, Technology
Matt Hart, Special Legal Counsel
Effie Hawthorne, Associate General Counsel
Wilson Hunter, General Counsel
Roland Johnson, Physician Monitoring
Winston Jordan, Technology
Sally Knight, Physician Monitoring
William Perkins, Executive Director
Tiffany Seamon, Director of Credentialing

Call to Order: 11:00 a.m.

Prior notice having been given in accordance with the Alabama Open Meetings Act, and with a quorum of eight members present, Commission Chairman, Jorge Alsip, M.D. convened the monthly meeting of the Alabama Medical Licensure Commission.

OLD BUSINESS

Minutes December 18, 2024

Commissioner Christopher made a motion that the Minutes of December 18, 2024, be approved with changes as directed by the Commission. A second was made by Commissioner Nelson-Garrett. A roll call vote was taken. The votes were: Aldridge, aye; Alsip, aye; Falgout, aye; Morris, aye; Nagrodzki, aye; and Varner, aye.

NEW BUSINESS

Full License Applicants

	Name	Medical School	Endorsement
1.	Asma Iram Ahmed	Midwestern University, Downers Grove	COMLEX/NY
2.	Laith Fawaz Abed Allah Ali	University of Jordan	USMLE/IL
3.	Nkechi Christiana Arinze	Nnamdi Azikiwe University	USMLE/NE
4.	Patrick Assi	University of Balamand	USMLE/OR
5.	Kristin Marie Ates Hicks	Augusta University	USMLE
6.	Maya Augustine	All Saints University School of Medicine	USMLE
7.	Ankit Bansal	UAB	USMLE
8.	Luanna Lettieri Beauchamp	Texas Tech Uni Health Sci Center	FLEX/NY
9.	Shaira Bedi	Bharati Vidyapeeths Medical College	USMLE
10.	Sirine Belaid	Jordan University of Science & Technology	USMLE/PA
11.	Belinda Carrie Bell	Mercer University School of Medicine	USMLE
12.	Sarah Catherine Bertrand	LSU Medical Center Shreveport	USMLE
13.	Sandeep Bhattarai	Kathmandu Medical College	USMLE/NH
14.	Johnrick Pierce Bishop	Edward Via College of Osteo Med Auburn	COMLEX/KY
15.	Hunter Slaton Boudreau	UAB	USMLE
16.	Tyler Scott Briley	Saint Georges University	USMLE/FL
17.	Catherine Valentine Brown	UAB	USMLE/OH
18.	Paul Sherman Brown Jr.	Saint Louis University School of Medicine	NBME/IL
19.	Caleb Michael Carroll	UAB	USMLE
20.	Lalit Shankar Chaube	King Georges Medical University	USMLE/OH
21.	Orlando Acosta Collado	De La Salle Univ Health Sciences Campus	USMLE/CA
22.	Ryan James Coram	Ohio University College of Osteo Med	COMLEX/OH

	Name	Medical School	Endorsement
23.	Katlyn Sides Cummings	Edward Via College of Osteo Med Louisiana	COMLEX
24.	Marco Mauro De Santis	Lake Erie College of Osteopathic Medicine	COMLEX/IN
25.	David Jeffrey Deuth	Liberty University College of Osteo Med	COMLEX/TX
26.	Brian Arthur Ferguson	Des Moines Univ of Osteo Medical Center	COMLEX/IN
27.	Renato A Ferrandiz Espadin	Cayetano Heredia University	USMLE
28.	Bridget Leanne Forbes	Edward Via College of Osteo Med Auburn	COMLEX
29.	Stefan Vincent Franciosa	Philadelphia College of Osteo Medicine	COMLEX/PA
30.	Twila Leah Margaret Gaston	LSU School of Medicine New Orleans	USMLE
31.	Jordan Austin George	UAB	USMLE
32.	Cyrus Amir Golshani	George Washington University	USMLE/OH
33.	Michelle Elaine Gordon	Western U College of Osteo Med of Pacific	COMLEX/NY
34.	Frederick Allen Hauser	A T Still Univ School of Osteopathic Med	COMLEX/GA
35.	Kenzie Britt Hendrix	William Carey Univ College of Osteopathic	COMLEX
36.	Angela Chung Hon	University of Costa Rica	FLEX/NY
37.	Hobie Lakeland Hughes	Alabama College of Osteopathic Medicine	COMLEX
38.	Hassan Imtiaz	Rawalpindi Med College, Univ of the Punjab	USMLE/MI
39.	Sabih Iqbal	American U of Integ Sci, St. Maarten Sch of Med	USMLE/FL
40.	Rebecca John	Kannur Medical College	USMLE
41.	Richard Aaron Martin Johnson	Saint Georges University	USMLE/MI
42.	Christopher Warren Johnson III	USA	USMLE
43.	Jorge Luis Jorge	Ross University	USMLE/FL
44.	Palak Kachhadia	Ross University	USMLE/VA
45.	Tyler Chase Kilburn	Lincoln Mem U Debusk College of Osteo Med	COMLEX
46.	Jonathan Caleb King	West Virginia University School of Medicine	USMLE/SC
47.	Gopal Kumar	Guru Teg Bahadur Hospital, Univ of Delhi	USMLE/OH
48.	Pamela Melissa Levine	Icahn School of Medicine at Mount Sinai	USMLE/NJ
49.	Hayley Brooke Lewis	Edward Via College of Osteo Med Auburn	COMLEX
50.	Danielle Elizabeth Lewis	University of Oklahoma Health Science Center	USMLE/OK
51.	Ommaya Maimoona	Alfaisal University College of Medicine	USMLE
52.	Harry D Marty Vigo	Ponce School of Medicine	USMLE/LA
53.	Daniel James McConnell	Columbia Univ College of Physicians & Surgeons	USMLE/NY
54.	John Everett McGann V	Edward Via College of Osteo Med Auburn	COMLEX
55.	Javardo Howard McIntosh	University of The West Indies, Jamaica	USMLE/MI
56.	Melanie Truesdale McMinn	George Washington University	USMLE/NC
57.	Jose Rodolfo Menendez	Nova Southeastern, Dr. Patel C of Osteo Med	COMLEX/MS
58.	Ibrahim Nabeel Ibrahim Muhsen	Alfaisal University College of Medicine	USMLE/TX
59.	Steven Samuel Murrell	Medical University of the Americas (Nevis)	USMLE/OK
60.	Ricardo Andres Najera	Baylor College of Medicine	USMLE
61.	David Gilbert Nesbitt	USA	USMLE/VA
62.	Bao Minh Nguyen	Edward Via College of Osteo Med Auburn	COMLEX
63.	Zoha M N Nizami	Maharashtra Institute of Medical Sciences	USMLE
64.	Hanny Hemantkumar Patel	American University of Antigua	USMLE
65.	Melissa Anne Patton	University of Texas Houston Medical School	USMLE/TX
66.	Daniel Brett Perkins	Augusta University	USMLE/FL

	Name	Medical School	Endorsement
67.	Elizabeth Pineiro Mendez	Univ of Medical Science of Havana	USMLE
68.	Lauren Ashley Powell	Lincoln Mem Debusk College of Osteo Med	COMLEX/MS
69.	Matthew Scott Proctor	University of Miami Miller School of Med	USMLE/LA
70.	Tania Raygoza	Autonomous Univ of Guadalajara	USMLE
71.	Daniel Raza	Tulane University School of Medicine	USMLE
72.	Ashley Rizzieri	Edward Via College of Osteo Med Auburn	COMLEX
73.	Porsha Roache-Robinson	Touro U College of Osteopathic Medicine	COMLEX/FL
74.	Haley Rasmussen Roberts	UAB	USMLE
75.	Haneen Thabit Jameel Salah	Alfaisal University College of Medicine	USMLE
76.	Mirica Artine Sanders	Ohio University College of Osteo Med	COMLEX/OH
77.	Muhammad Shah Zaib	Nishtar Medical College, B. Zakaria Univ	USMLE/DE
78.	David Lamar Spencer	UAB	USMLE/MS
79.	Sawyer John Stevens	Univ of S. Dakota School of Med Vermillion	USMLE
80.	Irakli Tskhakaia	Tbilisi State Medical University	USMLE
81.	Seth Mitchell Tuwiner	Technion Israel Institute of Technology	USMLE/CA
82.	Syed Abdullah Uddin	UCLA Riverside School of Medicine	USMLE
83.	Nicole Jamie Van Groningen	UCLA David Geffen School of Medicine	USMLE/NY
84.	Vijay Sairaj Vobbilisetty	USA College of Medicine	USMLE
85.	Ann Andee Wang	Northwestern University Medical School	USMLE/CA
86.	Matthew Eric Wells	Lake Erie College of Osteopathic Medicine	COMLEX/MO
87.	Eric Riley Whalen-Kelly	Alabama College of Osteopathic Medicine	COMLEX
88.	Whitney Morgan Winham	University of Arkansas College of Medicine	USMLE/AR
89.	Sara Kim Yang	SUNY Stonybrook School of Medicine	USMLE/CA
90.	Mahijeeth Yetukuri	Saint Louis University School of Medicine	USMLE
91.	David L Goldblatt	University of Texas Rio Grande Valley School of Med	USMLE
92.	Jimmy Ari Saravia	LSU School of Medicine New Orleans	USMLE
93.	*Nitheesha Alapati	Texas A&M Univ Health Science Center College of Med	USMLE
94.	*Poushali Bhattacharjee	University of Texas Medical School at Galveston	USMLE/MA
95.	*John Hofheins	University of Alabama School of Medicine Birmingham	USMLE
96.	Aaron Chen	University of North Texas School of Medicine	COMLEX/TX
97.	*Wade L Fischer	Tulane University School of Medicine	FLEX/LA
98.	Elliott Jay Wagner	New York University School of Medicine	NBME/MD
99.	Jeffrey Lee	Lake Erie College of Osteopathic Medicine	USMLE/PA
100.	Thomas A Ostergard	Case Western Reserve University School of Medicine	USMLE

**Approved pending acceptance and payment of NDC issued by the BME.*

A motion was made by Commissioner Morris with a second by Commissioner Falgout to approve applicant numbers one through one hundred (1-100) for full licensure. A roll call vote was taken. The votes were: Aldridge, aye; Alsip, aye; Christopher, aye; Nagrodzki, aye; Nelson-Garrett, aye; and Varner, aye.

Limited License Applicants

	Name	Medical School	Endorsement	Location	License
1.	Qasim M Amjad	Allama Iqbal Medical College	LL/AL	Mobile Infirmary IM	R
2.	Katie Lynn Carr	U of Med & Health Sciences, St. Kitts	LL/AL	UA Tuscaloosa FM	R
3.	Bhawana Chhetri	Nepal Medical College	LL/AL	Mobile Infirmary IM	R
4.	Danielle W S Elmore	Edward Via C of Osteo Med Auburn	LL/AL	Brookwood Baptist IM	R
5.	Jack Gordon Mason	Univ of Mississippi Sch of Medicine	LL/AL	Brookwood Baptist General Surgery	R
6.	Carolina Ricaurte Carmona	Universidad De Antioquia	LL/AL	NAMC IM	R

A motion was made by Commissioner Christopher with a second by Commissioner Nelson-Garrett to approve applicant numbers one through six (1-6) for limited licensure. A roll call vote was taken. The votes were: Aldridge, aye; Alsip, aye; Falgout, aye; Morris, aye; Nagrodzki, aye; and Varner, aye.

Retired Senior Volunteer Applicants

	Name	Location
1.	Robert Milton Combs Jr.	Medical Outreach Ministries, Montgomery

A motion was made by Commissioner Christopher with a second by Commissioner Nelson-Garrett to approve applicant number one (1) for retired senior volunteer licensure. A roll call vote was taken. The votes were: Aldridge, aye; Alsip, aye; Falgout, aye; Morris, aye; Nagrodzki, aye; and Varner, aye.

IMLCC Report

The Commission received as information a report of the licenses that were issued via the Interstate Medical Licensure Compact from December 1, 2024, through December 31, 2024. A copy of this report is attached as Exhibit "A".

REPORTS

Physician Monitoring Report

The Commission received as information the physician monitoring report dated January 16, 2025. A copy of the report is attached as Exhibit "B".

APPLICANTS FOR REVIEW

Rashaeda Brimley, M.D.

A motion was made by Commissioner Christopher with a second by Commissioner Nagrodzki to approve Dr. Brimley's application for full licensure. A roll call vote was taken. The votes were: Aldridge, aye; Alsip, aye; Falgout, aye; Morris, aye; Nelson-Garrett, aye; and Varner, aye.

David Carrington, MD.

A motion was made by Commissioner Christopher with a second by Commissioner Nelson-Garrett to approve Dr. Carrington's application for full licensure. A roll call vote was taken. The votes were: Aldridge, aye; Alsip, aye; Falgout, aye; Morris, aye; Nagrodzki, aye; and Varner, aye.

Matthew Filos-Pope, M.D.

A motion was made by Commissioner Nagrodzki with a second by Commissioner Christopher to approve Dr. Filos-Pope's application for full licensure. A roll call vote was taken. The votes were: Aldridge, aye; Alsip, aye; Falgout, aye; Morris, aye; Nelson-Garrett, aye; and Varner, aye.

Ijeoma Hassan, M.D.

A motion was made by Commissioner Christopher with a second by Commissioner Nelson-Garrett to approve Dr. Hassan's application for full licensure. A roll call vote was taken. The votes were: Aldridge, aye; Alsip, aye; Falgout, aye; Morris, aye; Nagrodzki, aye; and Varner, aye.

Julieanne Sees, D.O.

A motion was made by Commissioner Nagrodzki with a second by Commissioner Aldridge to defer any action on Dr. Sees' application for licensure until the February 26, 2025 Commission meeting. A roll call vote was taken. The votes were: Alsip, aye; Christopher, aye; Falgout, aye; Morris, aye; Nelson-Garrett, aye; and Varner, aye.

Alexis Troncoso, II, M.D.

A motion was made by Commissioner Falgout with a second by Commissioner Nelson-Garrett to approve Dr. Troncoso's application for full licensure. A roll call vote was taken. The votes were: Aldridge, aye; Alsip, aye; Christopher, aye; Morris, aye; Nagrodzki, aye; and Varner, aye.

DISCUSSION ITEMS

BME Rules for Publication – 540-X-10, Office Based Surgery

A motion was made by Commissioner Christopher with a second by Commissioner Falgout to authorize Commission Vice Chairman Nagrodzki and Commissioner Varner to submit comments on behalf of the Commission. A roll call vote was taken. The votes were: Aldridge, aye; Alsip, aye; Morris, aye; Nagrodzki, aye; Nelson-Garrett, aye; and Varner, aye. A copy of the rule is attached hereto as Exhibit "C".

FSMB Call for Resolutions

The Commission received as information a memorandum regarding the FSMB Call for Resolutions. A copy of the memorandum is attached hereto as Exhibit "D".

USMLE Workshop for State Board Members

The Commission received as information a memorandum regarding the USMLE Workshop for State board Members. A copy of the memorandum is attached hereto as Exhibit "E".

FSMB Draft of Reentry to Practice

The Commission received as information a memorandum regarding the FSMB Draft of Reentry to Practice. A copy of the memorandum is attached hereto as Exhibit "F".

REQUESTS

Gary Bullock, D.O.

The Commission received a request filed on behalf of Dr. Bullock. A motion was made by Commissioner Nagrodzki with a second by Commissioner Aldridge to deny the request for relief. A roll call vote was taken. The votes were: Alsip, aye; Christopher, aye; Falgout, aye; Morris, aye;

Nelson-Garrett, aye; and Varner, aye. A copy of the Commission's order is attached hereto as Exhibit "G".

At 12:23 p.m., Commission Chairman Alsip, Commissioner Morris and Commissioner Nelson-Garrett remotely logged off of the meeting and the Commission entered closed session pursuant to Alabama Code § 34-24-361.1 to hear and consider the following matter:

CLOSED SESSION UNDER ALA. CODE 34-24-361.1

Steve E. Norman, M.D.

The Commission received a request to continue the hearing regarding the Administrative Complaint filed by the Alabama State Board of Medical Examiners. A motion was made by Commissioner Christopher with a second by Commissioner Nagrodzki to enter an order resetting the hearing for April 16, 2025. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "H".

Meeting adjourned at 1:00 p.m.

PUBLIC MEETING NOTICE: The next meeting of the Alabama Medical Licensure Commission was announced for Wednesday, February 26, 2025, beginning at 9:00 a.m.

JORGE ALSIP, M.D., Chairman
Alabama Medical Licensure Commission

Rebecca Robbins, Director of Operations
Recording Secretary
Alabama Medical Licensure Commission

02/26/2025
Date Signed

EXHIBIT

A

IMLCC Licenses Issued December 1, 2024 - December 31, 2024 (56)

Name	License Type	License Number	Status	Issue Date	Expiration Date	State of Principal Licensure
Wendy Schaffer	MD	50213	Active	12/5/2024	12/31/2025	Colorado
Lauren Cameron Fiske	MD	50212	Active	12/5/2024	12/31/2025	Georgia
Jay Modi	DO	3923	Active	12/5/2024	12/31/2025	Georgia
Vijaykumar Surendrakant Patel	MD	50186	Active	12/3/2024	12/31/2025	Georgia
Jason MacRae Budde	MD	50244	Active	12/17/2024	12/31/2025	Georgia
Katrina Gordon	MD	50226	Active	12/11/2024	12/31/2025	Illinois
Elizabeth Jansen	DO	3929	Active	12/13/2024	12/31/2024	Illinois
Tarek Ibrahim Hassaballa	MD	50240	Active	12/13/2024	12/31/2025	Illinois
Matthew Patrick Stewart	MD	50190	Active	12/3/2024	12/31/2025	Indiana
Francisco Alvarado	MD	50237	Active	12/13/2024	12/31/2025	Indiana
Nicholas Jake Foto Jr.	MD	50165	Active	12/2/2024	12/31/2025	Louisiana
Pavan Narra	MD	50235	Active	12/12/2024	12/31/2025	Louisiana
Kiran Samindla	MD	50185	Active	12/3/2024	12/31/2025	Maryland
Abhinav Kumar Misra	MD	50168	Active	12/2/2024	12/31/2024	Maryland
Ebony Clarissa Harpool	MD	50236	Active	12/12/2024	12/31/2025	Michigan
Neetu Sharma	MD	50232	Active	12/12/2024	12/31/2024	Michigan
John Paul Joseph Sosa	MD	50169	Active	12/2/2024	12/31/2025	Michigan
Timothy Buel Beatty	DO	3918	Active	12/3/2024	12/31/2025	Michigan
Geoffrey Milton Gray	MD	50196	Active	12/3/2024	12/31/2025	Michigan
Michael Paul Betler	DO	3919	Active	12/3/2024	12/31/2025	Michigan
Jennis Uzoamaka Iruke	MD	50173	Active	12/2/2024	12/31/2024	Minnesota
Michael Burch Morrison	MD	50195	Active	12/3/2024	12/31/2025	Mississippi
Corinne Sundar Rao	MD	50188	Active	12/3/2024	12/31/2024	Missouri
Neel Tapryal	MD	50198	Active	12/3/2024	12/31/2025	Nevada
Shelley-Ann Pennycooke	DO	3924	Active	12/6/2024	12/31/2024	New Jersey
Kamalesh Shah	MD	50192	Active	12/3/2024	12/31/2024	New Jersey
David Chinedu Okonkwo	MD	50225	Active	12/11/2024	12/31/2025	North Dakota
Mayukh C. Babu	MD	50199	Active	12/3/2024	12/31/2025	Ohio
Jeremy David Theisen	MD	50233	Active	12/12/2024	12/31/2025	Oklahoma
Mayur Khosla	MD	50194	Active	12/3/2024	12/31/2024	South Dakota
Arthelma Chenee Tyson	MD	50227	Active	12/11/2024	12/31/2025	South Dakota
Neal Weston Langdon	MD	50171	Active	12/2/2024	12/31/2025	Tennessee
Joseph Houston Sherer	DO	3917	Active	12/3/2024	12/31/2024	Tennessee

Arindam Bagchi	MD	50197	Active	12/3/2024	12/31/2025	Tennessee
Luis Edgardo Torres	MD	50243	Active	12/16/2024	12/31/2025	Tennessee
Michael Reinhart Farmer	MD	50229	Active	12/11/2024	12/31/2025	Tennessee
Holger Louis Gieschen	MD	50238	Active	12/13/2024	12/31/2025	Tennessee
Ijeoma Ibeanu	MD	50231	Active	12/12/2024	12/31/2024	Texas
David Tyler King	DO	3928	Active	12/12/2024	12/31/2024	Texas
Ferhad Feroze Bashir	MD	50234	Active	12/12/2024	12/31/2024	Texas
Carlos Andres Flores	MD	50239	Active	12/13/2024	12/31/2024	Texas
Kristie Lee Miller	MD	50214	Active	12/5/2024	12/31/2025	Texas
Juleen Min	MD	50217	Active	12/6/2024	12/31/2025	Texas
Michael Garrett Swaby	MD	50166	Active	12/2/2024	12/31/2025	Texas
Michael Joseph Boyd	MD	50170	Active	12/2/2024	12/31/2025	Texas
Alex Dalke	MD	50184	Active	12/3/2024	12/31/2025	Texas
Stephen Myhre Paulson	MD	50189	Active	12/3/2024	12/31/2024	Texas
Jennifer Lee Nadel	MD	50206	Active	12/4/2024	12/31/2025	Utah
Christian Blake Morris	MD	50187	Active	12/3/2024	12/31/2025	Utah
Elizabeth Chandler Williams Hughes	MD	50191	Active	12/3/2024	12/31/2025	Washington
Noel Armand Dunn	MD	50172	Active	12/2/2024	12/31/2025	Washington
Robin William Page-Echols	DO	3927	Active	12/11/2024	12/31/2025	Washington
Nathalie Jean	MD	50228	Active	12/11/2024	12/31/2024	Wisconsin
Michael J Connolly	MD	50193	Active	12/3/2024	12/31/2025	Wisconsin
Anthony Walton Thrasher	DO	3926	Active	12/11/2024	12/31/2025	Wisconsin
Leart Neziri	MD	50167	Active	12/2/2024	12/31/2024	Wisconsin

**Total licenses issued since April 2017 - 4,953*

EXHIBIT

B

STATE *of* ALABAMA

MEDICAL LICENSURE COMMISSION

To: Medical Licensure Commission

From: Nicole Roque

Subject: January Physician Monitoring Report

Date: 1/16/2025

The physicians listed below are currently being monitored by the MLC.

Physician:	**Scott Hull Boswell, M.D.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	12/1/2014
License Status:	Active
Requirements:	Check PDMP
Received:	PDMP Compliant

Physician:	**Gary M. Bullock, D.O.**
Order Type:	MLC
Due Date:	6/27/2024
Order Date:	8/25/2023
License Status:	Active-Probation
Requirements:	Administrative Cost ($27,460.27) Administrative Fine ($20,000) No Prescribing
Received:	PDMP Compliant *Last payment received 8/14/2023

Physician:	**Ronald Edwin Calhoun, M.D.**
Order Type:	BME/MLC
Due Date:	Quarterly
Order Date:	3/25/2014
License Status:	Active
Requirements:	APHP Report
Received:	Waiting for APHP report

Physician:	**Jerry Hankins, M.D.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	9/2/2016
License Status:	Active
Requirements:	Limited Practice/Prescribing
Received:	PDMP Compliant

Physician:	**Barry Neal Lumpkins, M.D.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	No order in place
License Status:	Active
Requirements:	Check PDMP Quarterly
Received:	PDMP Compliant

Physician:	**Shakir Raza Meghani, M.D.**
Order Type:	BME/MLC
Due Date:	Monthly
Order Date:	11/20/2023
License Status:	Active
Requirements:	Check PDMP Monthly
Received:	PDMP Compliant

Physician:	**Farhaad Riyaz, M.D.**
Order Type:	MLC
Due Date:	Other
Order Date:	8/24/2022
License Status:	Active-Probation
Requirements:	APHP Report
Received:	Waiting for APHP report

Physician:	**Frances Delaine Salter, M.D.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	10/4/2005
License Status:	Active
Requirements:	APHP Report
Received:	Waiting for APHP report

Physician:	**Hobert James Sharpton, D.O.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	No order in place
License Status:	Active
Requirements:	Check PDMP Quarterly
Received:	PDMP Compliant

Physician:	**Janie T. Bush Teschner, M.D.**
Order Type:	BME/MLC
Due Date:	Other
Order Date:	4/19/2023
License Status:	Active-Probation
Requirements:	APHP Report Practice Plan Limited Practice (Pending practice place approval) Therapist Report AA/NA Meetings CME
Received:	Waiting for APHP report

EXHIBIT

C

ALABAMA STATE BOARD OF MEDICAL EXAMINERS
WILLIAM M. PERKINS, EXECUTIVE DIRECTOR

P.O. BOX 946
MONTGOMERY, ALABAMA 36101-0946
848 WASHINGTON AVE.
MONTGOMERY, ALABAMA 36104

TELEPHONE: (334) 242-4116
E MAIL: bme@albme.gov

MEMORANDUM

To: Medical Licensure Commission

From: Mandy Ellis

Date: December 12, 2024

Re: Administrative Rules Approved for Publication

The Board of Medical Examiners, at its meeting December 12, 2024, approved the following rules to be published for public comment in the *Alabama Administratively Monthly*:

- Administrative Rules, Chapter 540-X-10, *Office-Based Surgery*

Amends the existing Office-Based Surgery rules to enhance patient safety in Alabama. Most of the rule chapter is being revised; however, a few key concepts include requiring accreditation of OBS facilities, setting standards for training of practitioners, requiring the formulation and utilization of patient-selection criteria, requiring quality assurance by disinterested third parties, mandating transfer agreements with hospitals, and requiring practitioners to be credentialed to perform any OBS procedure in a nearby hospital or ASC.

With an expected publication date of December 31, 2024, the public comment period ends February 4, 2025. The anticipated effective date is May 15, 2025.

Attachments: Draft of Administrative Rules, Chapter 540-X-10, *Office-Based Surgery*

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RULES OF THE
ALABAMA BOARD OF MEDICAL EXAMINERS

CHAPTER 540-X-10
OFFICE-BASED SURGERY

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540-X-10-.01 Preamble.

(1) Office-based surgery is surgery performed outside of a hospital or outpatient facility licensed by the Alabama Department of Public Health. It is the position of the Board that any physician performing office-based surgery is responsible for providing a safe environment. Surgical procedures in medicine have changed over the

generations from procedures performed at home or at the surgeon's office to the hospital and, now, often back to outpatient locations. However, the premise for the surgery remains unchanged: that it be performed in the best interest of the patient and under the best circumstances possible for the management of disease and well-being of the patient. Surgery that is performed in a physician's office at this time varies from a simple incision and drainage with topical anesthesia to semi-complex procedures under general anesthesia. It is imperative that the surgeon evaluate the patient, advise and assist the patient with a decision about the procedure and the location for its performance and, to the best of the surgeon's ability, ensure that the quality of care be equal no matter the location. If the physician performs surgery in the physician's office, it is expected that the physician will require standards similar to those at other sites where the physician performs such procedures. It is also expected that any physician who performs a surgical procedure is knowledgeable about sterile technique, the need for pathological evaluation of certain surgical specimens, any drug that the physician administers or orders administered, and about potential untoward reactions, complications, and their treatment. Recognizing that there have been serious adverse events in office surgical settings, both in Alabama and in other states, the Board, in conjunction with an *ad hoc* committee representing various medical and surgical specialties, has developed guidelines for physicians who perform office-based surgeries. These guidelines are intended to remind the physician of the minimal requirements for various levels of surgery in the office setting. While the physician must decide on a case-by-case basis the location and level of service

that is best for the physician's particular patient and procedure, this decision must always be made with the patient's best interest in mind.

(2) These rules shall not apply to an oral surgeon licensed to practice dentistry who is also a physician licensed to practice medicine if the procedure is exclusively for the practice of dentistry. An oral surgeon licensed to practice dentistry who is also a physician licensed to practice medicine and who performs office-based surgery other than the practice of dentistry shall comply with the requirements of these regulations for those procedures which fall outside the scope of practice of dentistry.

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540-X-10-.02 Definitions

(1) Deep Sedation / Analgesia. A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Reflex withdrawal from painful stimulation is **NOT** considered a purposeful response. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway,

and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

(2) General Anesthesia. A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

(3) Local Anesthesia. The administration of an agent which produces a localized and reversible loss of sensation in a circumscribed portion of the body.

(4) Minimal Sedation (anxiolysis). A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

(5) Moderate Sedation / Analgesia ("Conscious Sedation"). A drug-induced depression of consciousness during which a patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from painful stimulation is **NOT** considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

(6) Office-based surgery. Any surgical or invasive medical procedure performed outside a hospital or outpatient facility licensed by the Alabama Department of Public Health.

(7) Physician Office. A facility, office, or laboratory where a registered physician performs office-based surgery.

(8) Registered Physician. A physician registered to perform office-based surgery.

(9) Surgery. A medical procedure which involves the revision, destruction, incision, or structural alteration of human tissue performed using a variety of methods and instruments, is a discipline that includes the operative and non-operative care of individuals in need of such intervention, and which demands pre-operative assessment, judgment, technical skills, post-operative management, and follow-up.

(10) Regional Anesthesia (A major conduction blockade) is considered in the same category as General Anesthesia.

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540-X-10-.03 General Requirements

(1) Every physician who performs or proposes to perform office-based surgery or procedures shall be trained to perform the surgery or procedure. The criteria for

evaluating a physician's training to perform a certain surgery or procedure include, but are not limited to:

(a) Completion of an accredited residency or fellowship relating to the surgery or procedure to be performed;

(b) Specialty board certification;

(c) An active, unrestricted medical license;

(d) Possession of credentialing to perform the same surgery or procedure at a nearby hospital or ambulatory care facility with whom the physician has an emergency transfer agreement;

(e) Formal didactic training in the procedures to be performed; and

(f) Accreditation by a credentialing body which, in the opinion of the Board, is qualified to assess a physician's training and competency.

(2) Evidence of the physician's training and continuing medical education shall be documented and readily available to patients and the Board.

(3) When a physician proposes to provide a new office-based surgical procedure, he or she shall conduct specific training for all personnel involved in the care of patients prior to performing the procedure. Education must be specifically tailored to the new procedure and must include, at a minimum:

(a) Formal training regarding a basic understanding of the procedure being introduced, including risks and benefits of the procedure;

(b) Signs and symptoms of postoperative complications; and

(c) A basic understanding of the management and care of patients by a review of the office's policies and protocols.

(4) Physicians performing office-based surgery shall have qualified call coverage at all times by a physician who is responsible for the emergency care of his or her patients in his or her absence.

(a) The physician providing call coverage must be trained to manage the full range of complications associated with the procedures being performed.

(b) Transfer agreements can be used to supplement call coverage but cannot be used as a substitute for a call schedule.

(5) Medical Record Maintenance and Security: Each physician office shall have a procedure for initiating and maintaining a health record for every patient evaluated or treated. The record shall include a procedure code or suitable narrative description of the procedure and must have sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the outcome and required follow-up care. For procedures requiring patient consent, there shall be a documented informed written consent. If analgesia/sedation, minor or major conduction blockade, or general anesthesia are provided, the record shall include documentation of the type of anesthesia used, drugs (type, time and dose) and fluids administered, the record of monitoring of vital signs, level of consciousness during the procedure, patient weight, estimated blood loss, duration of the procedure, and any complications related to the procedure or anesthesia. Procedures shall also be established to ensure patient confidentiality and security of all patient data and information.

(6) Infection Control Policy: Each physician office shall comply with state and federal regulations regarding infection control. For all surgical procedures, the level of sterilization shall meet current OSHA requirements. There shall be a procedure and schedule for cleaning, disinfecting, and sterilizing equipment and patient care items. Personnel shall be trained in infection control practices, implementation of universal precautions, and disposal of hazardous waste products. Protective clothing and equipment must be readily available.

(7) Federal and State Laws and Regulations: Federal and state laws and regulations that affect the practice shall be identified and procedures developed to comply with those requirements. The following are some of the key requirements upon which office-based practices should focus:

(a) Non-Discrimination (see Civil Rights statutes and the Americans with Disabilities Act).

(b) Personal Safety (see Occupational Safety and Health Administration information).

(c) Controlled Substance Safeguards.

(d) Laboratory Operations and Performance (CLIA).

(e) Personnel Licensure Scope of Practice and Limitations.

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540-X-10-.04 Emergency Plan

(1) Every physician who performs office-based surgery shall maintain on-site a written emergency plan.

(2) The emergency plan shall include, but not be limited to, emergency medicines, emergency equipment, and transfer protocols that ensure the continuity of a patient's care remains uninterrupted during any adverse event or transfer.

(a) Age-appropriate emergency supplies, equipment, and medication shall be provided in accordance with the scope of surgical and anesthesia services provided at the physician's office.

(b) In a physician office where anesthesia services are provided to infants and children, the required emergency equipment must be appropriately sized for a pediatric population, and personnel must be appropriately trained to handle pediatric emergencies, which shall include up to date training and certification in Pediatric Advanced Life Support ("PALS") or Advanced Pediatric Life Support ("APLS").

(c) At least one physician currently trained in Advanced Cardiac Life Support ("ACLS") must be immediately and physically available until the last patient is past the first stage of recovery. A practitioner who is qualified in resuscitation techniques and emergency care, including ACLS, APLS, or PALS, as appropriate, must be present and

available until all patients having more than local anesthesia or minor conductive block anesthesia have been discharged from the physician office

(3) All physicians and support personnel shall be trained and capable of recognizing and managing complications related to the procedures and anesthesia that they perform. In the event of anesthetic, medical, or surgical emergencies, personnel must be familiar with the procedures and plan to be followed and able to take the necessary actions. All personnel must be familiar with a documented plan for the timely and safe transfer of patients to a nearby hospital. This plan must include arrangements for emergency medical services, if necessary, or when appropriate, escorting the patient to the hospital by an appropriate practitioner. If advanced cardiac life support is instituted, the plan must include immediate contact with emergency medical services.

(4) The emergency plan shall include objective criteria that shall be used when evaluating a patient for activation of the emergency plan, the provision of emergency medical care, or the safe and timely transfer of a patient to a nearby hospital should hospitalization become necessary.

(5) Every registered physician shall possess admitting privileges to a nearby hospital equipped to accept transfer and treatment of the full range of complications that may be experienced by his or her patients.

540-X-10-.05 Patient Evaluation and Selection

(1) Patients must be individually evaluated using objective and subjective criteria for each procedure to determine if the physician office is an appropriate setting for the anesthesia required and for the surgical procedure to be performed. Patient selection

shall occur pursuant to written criteria which shall be available for inspection by the Board or any credentialing entity. These criteria shall include both inclusionary and exclusionary criteria.

(2) Patients undergoing office-based surgery must have an appropriately documented history and physical examination as well as other indicated consultations and studies, all occurring not more than thirty (30) days prior to the surgical procedure.

(3) Procedure-specific patient selection criteria must be submitted in writing to the Board at the time of registration and prior to performing any office-based surgery. A registered physician must submit in writing to the Board new procedure-specific patient selection criteria whenever he or she proposes to engage in a new procedure.

(4) Patient selection criteria must include the following categories:

(a) Exclusion of all intra-abdominal and intra-thoracic procedures.

(b) Criteria for the inclusion and exclusion of pediatric patients.

(c) Exclusion of patients with a history of solid organ transplant, excepting kidney transplant.

(d) Exclusion of any patient with an American Society of Anesthesiologists Physical Status Classification ("ASA") greater than or equal to four (4).

(e) Criteria for excluding patients with a body mass index exceeding an upper limit based on the risks of the procedure.

(f) Utilization of evidence-based frailty scoring tools and accompanying procedure-specific exclusion criteria.

540-X-10-.06 Accreditation and Quality Assurance

(1) All office-based surgery shall occur in a physician office that is appropriately equipped, registered with the Board, and maintained to ensure patient safety through accreditation or certification and in good standing from an accrediting entity approved by the Board.

(2) The Board may approve an accrediting entity that demonstrates to the satisfaction of the Board that it has all of the following:

(a) Standards pertaining to patient care, recordkeeping, equipment, personnel, facilities, and other related matters that are in accordance with acceptable and prevailing standards of care as determined by the Board;

(b) Processes that ensure a fair and timely review and decision on any applications for accreditation or renewals thereof;

(c) Processes that ensure a fair and timely review and resolution of any complaints received concerning accredited or certified physician offices; and

(d) Resources sufficient to allow the accrediting entity to fulfill its duties in a timely manner.

(3) A physician may perform procedures under this rule in a physician office that is not accredited or certified, provided that the physician office has submitted an application for accreditation by a Board-approved accrediting entity, and that the physician office is appropriately equipped and maintained to ensure patient safety such that the physician office meets the accreditation standards. If the physician office is not accredited or certified within one year of the physician's performance of the first

procedure under this rule, the physician must cease performing procedures until the physician office is accredited or certified.

(4) Proof of accreditation shall be kept on file with the Board and on site at the physician office. If a physician office loses its accreditation or certification and is no longer accredited or certified by at least one Board-approved entity, the physician shall immediately cease performing procedures in that physician office. Any changes to a physician office's accreditation status shall be reported to the Board within three (3) business days.

(5) Each physician office shall implement a quality assurance program to periodically review the physician office's procedures and quality of care provided to patients.

(a) A physician office shall engage its quality assurance program every six months at a minimum.

(b) Quality assurance shall include peer review by qualified physicians who are not affiliated with the practice or physician office.

(c) A quality assurance program may be administered by the physician office's accrediting entity or may be established by:

1. A cooperative agreement with a hospital-based performance or quality-improvement program; or

2. A cooperative agreement with another physician office to jointly conduct quality assurance activities; or

3. A cooperative agreement with a peer review organization, a managed care organization, specialty society, or other appropriate organization approved by the Board.

(6) A quality assurance program shall include, but not be limited to:

(a) Review of all mortalities;

(b) Review of the patient selection, appropriateness, and necessity of procedures performed;

(c) Review of all emergency transfers;

(d) Review of surgical and anesthetic complications;

(e) Review of outcomes, including postoperative infections;

(f) Analysis of patient satisfaction surveys and complaints;

(g) Identification of undesirable trends, including diagnostic errors, poor outcomes, follow-up of abnormal test results, medication errors, and system problems; and

(h) Tracking of all deviations from the patient selection and procedure protocols, including identification of the patient, the basis for the deviation, a description of the medical decision-making supporting the deviation, a description of the outcome, and any remedial measures taken.

(7) Quality assurance program findings shall be documented and incorporated into the physician office's educational programming, protocols, and planning, as appropriate.

(8) Each physician shall attest in writing to the Board that a compliant quality assurance program has been implemented prior to performing any office-based surgery. Each physician shall be responsible for producing the plan to the Board upon demand.

540-X-10-.07 Standards for Preoperative Assessment.

(1) A medical history, a physical examination consistent with the type and level of anesthesia and/or analgesia and the level of surgery to be performed, and the appropriate laboratory studies must be performed by a practitioner qualified to assess the impact of co-existing disease processes on surgery and anesthesia. A pre-anesthetic examination and evaluation must be conducted immediately prior to surgery by the physician or by a qualified person who will be administering or directing the anesthesia. If a qualified person will be administering the anesthesia, the physician shall review with the qualified person the pre-anesthetic examination and evaluation. The data obtained during the course of the pre-anesthesia evaluations (focused history and physical, including airway assessment and significant historical data not usually found in a primary care or surgical history that may alter care or affect outcome) must be documented in the medical record.

(2) Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation must be able to rescue patients whose level of sedation becomes deeper than initially intended. Individuals administering Moderate Sedation / Analgesia ("Conscious Sedation") must be able to rescue patients who enter a state of Deep Sedation /

Analgesia, while those administering Deep Sedation / Analgesia must be able to rescue patients who enter into a state of general anesthesia.

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540-X-10-.08 Standards for Local Anesthesia.

(1) Equipment and supplies: Oral airway positive pressure ventilation device, epinephrine, and atropine must be available.

(2) Training required: The physician is expected to be knowledgeable in proper drug dosages and recognition and management of toxicity or hypersensitivity to local anesthetic and other drugs. The physician must be currently trained in Basic Cardiac Life Support ("BCLS").

(3) Assistance of other personnel: No other assistance is required, unless dictated by the scope of the surgical procedure.

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540-X-10-.09 Standards for Minimal Sedation.

(1) Equipment and supplies: Oral airway positive pressure ventilation device, epinephrine, and atropine must be available.

(2) Training required: The physician is expected to be knowledgeable in proper drug dosages and recognition and management of toxicity or hypersensitivity to local anesthetic and other drugs. The physician must be currently trained in Basic Cardiac Life Support ("BCLS").

(3) Assistance of other personnel: Anesthesia may be administered only by licensed, qualified, and competent practitioners who have training and experience appropriate to the level of anesthesia administered and function in accordance with their scope of practice. Practitioners must have documented competence and training to administer local anesthesia with sedation and to assist in any support or resuscitation measures as required. Scrub or Circulating nurse(s) and/or assistant(s) must be trained in their specific job skills as determined by the registered physician.

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540-X-10-.10 Standards for Moderate Sedation / Analgesia.

(1) Physician Registration Requirement: The Board requires each physician who offers office-based surgery that requires moderate sedation, as defined in these rules, to register with the Board.

(2) Equipment and supplies: Emergency resuscitation equipment, emergency life-saving medications, suction, and a reliable source of oxygen with a backup tank must be readily available. When medication for sedation and/or analgesia is administered intravenously (IV), monitoring equipment must include: blood pressure apparatus, stethoscope, pulse oximetry, continuous EKG, and temperature monitoring for procedures lasting longer than thirty (30) minutes. The patient's vital signs, oxygen saturation, and level of consciousness must be documented prior to the procedure, during regular intervals throughout the procedure, and prior to discharge. The physician office, in terms of general preparation, must have adequate equipment and supplies, provisions for proper record keeping, and the ability to recover patients after anesthesia.

(3) Training required: The physician and at least one assistant must be currently trained in ACLS.

(4) Assistance of other personnel: Anesthesia may be administered only by licensed, qualified, and competent anesthesiologists, certified registered nurse anesthetists (CRNAs), and anesthesiologist assistants (AAs) who have documented competence and training to administer moderate sedation/analgesia and to assist in any support or resuscitation measures as required. The individual administering moderate sedation/analgesia and/or monitoring the patient must be someone other than the physician performing the surgical procedure, nor can this person assist in the actual performance of the procedure. Scrub or Circulating nurse(s) and/or assistant(s) must be trained in their specific job skills as determined by the registered physician. At least one physician currently trained in ACLS must be immediately and physically available until the last patient is past the first stage of recovery. At least one practitioner currently trained in ACLS must be immediately and physically available until the last patient is discharged from the physician office.

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540-X-10-.11 Standards for Deep Sedation / Analgesia.

(1) Physician Registration Requirement: The Board requires each physician who offers office-based surgery that requires deep sedation or general anesthesia, as defined in these rules, to register with the Board.

(2) Equipment and supplies: Emergency resuscitation equipment, emergency life-saving medications, suction, and a reliable source of oxygen with a backup tank must be readily available. Monitoring equipment must include: blood pressure apparatus, stethoscope, pulse oximetry, continuous EKG, and temperature monitoring for procedures lasting longer than thirty (30) minutes. The patient's vital signs, oxygen saturation, and level of consciousness must be documented prior to the procedure, during regular intervals throughout the procedure, and prior to discharge. The physician office, in terms of general preparation, must have adequate equipment and supplies, provisions for proper record keeping, and the ability to recover patients after anesthesia.

(3) Training required: The physician and at least one assistant must be currently trained in Advanced Cardiac Life Support (ACLS).

(4) Assistance of other personnel: Anesthesia may be administered only by licensed, qualified, and competent anesthesiologists, certified registered nurse anesthetists (CRNAs), and anesthesiologist assistants (AAs) who have documented competence and training to administer deep sedation/analgesia and to assist in any support or resuscitation measures as required. The individual administering deep sedation/analgesia and/or monitoring the patient must be someone other than the physician performing the surgical procedure, nor can this person assist in the actual performance of the procedure. Scrub or Circulating nurse(s) and/or assistant(s) must be

trained in their specific job skills as determined by the registered physician. At least one physician currently trained in ACLS must be immediately and physically available until the last patient is past the first stage of recovery. At least one practitioner currently trained in ACLS must be immediately and physically available until the last patient is discharged from the physician office.

Authors: Alabama Board of Medical Examiners *ad hoc* Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G. Chambers, III, M.D.; Craig H. Christopher, M.D.; Alcus Ray Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.
Statutory Authority: Code of Alabama '34-24-53
History: Approved/Adopted: Approved for Publication January 15, 2003. Published in 1/31/03 *Alabama Administrative Monthly.* Amended/Approved for Publication: May 21, 2003. Published in 5/30/03 *Alabama Administrative Monthly.* Amended/Approved for Publication: August 20, 2003. Published in 8/29/03 *Alabama Administrative Monthly.* Approved/Adopted: October 15, 2003. Effective Date: November 21, 2003.

540-X-10-.12 Standards for General and Regional Anesthesia.

(1) Physician Registration Requirement: The Board requires each physician who offers office-based surgery that requires general or regional anesthesia, as defined in these rules, to register with the Board.

(2) Equipment and supplies: Emergency resuscitation equipment, suction, and a reliable source of oxygen with a backup tank must be readily available. When triggering agents are in the office, at least twelve (12) ampules of dantrolene sodium must be readily available within ten (10) minutes with additional ampules available from another source. Monitoring equipment must include: blood pressure apparatus, stethoscope, pulse

oximetry, continuous EKG, capnography, and temperature monitoring for procedures lasting longer than thirty (30) minutes. Monitoring equipment and supplies must be in compliance with currently adopted ASA standards. The physician office, in terms of general preparation, must have adequate equipment and supplies, provisions for proper record keeping, and the ability to recover patients after anesthesia.

(3) Training required: The physician and at least one assistant must be currently trained in Advanced Cardiac Life Support (ACLS).

(4) Assistance of other personnel: Anesthesia may be administered only by licensed, qualified, and competent anesthesiologists, certified registered nurse anesthetists (CRNAs), and anesthesiologist assistants (AAs) who have documented competence and training to administer general and regional anesthesia and to assist in any support or resuscitation measures as required. The individual administering general and regional anesthesia and/or monitoring the patient must be someone other than the physician performing the surgical procedure, nor can this person assist in the actual performance of the procedure. Scrub or Circulating nurse(s) and/or assistant(s) must be trained in their specific job skills as determined by the registered physician. Direction of the sedation/analgesia component of the medical procedure must be provided by a physician who is immediately and physically present, who is licensed to practice medicine in the state of Alabama, and who is responsible for the direction of administration of the anesthetic. The physician providing direction must ensure that an appropriate pre-anesthetic examination is performed, ensure that qualified practitioners participate, be available for diagnosis, treatment, and management of anesthesia related complications

or emergencies, and ensure the provision of indicated post anesthesia care. At least one physician currently trained in ACLS must be immediately and physically available until the last patient is past the first stage of recovery. At least one practitioner currently trained in ACLS must be immediately and physically available until the last patient is discharged from the physician office.

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540-X-10-.13 Monitoring Requirements for the Recovery Area and Assessment for Discharge with Moderate & Deep Sedation / General Anesthesia.

Monitoring in the recovery area shall be performed by a **dedicated** person, trained in their specific job skills as determined by the registered physician, and must include pulse oximetry and non-invasive blood pressure measurement. The patient must be assessed periodically for level of consciousness, pain relief, or any untoward complication. Each patient must meet discharge criteria as established by the practice prior to leaving the physician office. Documented recovery from anesthesia must include the following: 1) vital signs and oxygen saturation stable within acceptable limits; 2) no

more than minimal nausea, vomiting, or dizziness; and 3) sufficient time (up to two (2) hours) must have elapsed following the last administration of reversal agents to ensure the patient does not become sedated after reversal effects have worn off. The patient shall be given appropriate discharge instructions and discharge under the care of a responsible third party after meeting discharge criteria. Discharge instructions shall include: 1) the procedure performed; 2) information about potential complications; 3) telephone numbers to be used by the patient to discuss with the registered physician complications or questions that may arise; 4) instructions for medications prescribed and pain management; 5) information regarding the follow-up visit date, time, and location; and 6) designated treatment facility in the event of an emergency.

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History: Approved/Adopted: Approved for Publication January 15, 2003. Published in 1/31/03 *Alabama Administrative Monthly*. Amended/Approved for Publication: May 21, 2003. Published in 5/30/03 *Alabama Administrative Monthly*. Amended/Approved for Publication: August 20, 2003. Published in 8/29/03 *Alabama Administrative Monthly*. Approved/Adopted: October 15, 2003. Effective Date: November 21, 2003.

540-X-10-.14 Tumescent Liposuction and Similarly Related Procedures.

(1) In the performance of liposuction when infiltration methods such as the tumescent technique are used, they should be regarded as regional or systemic anesthesia because of the potential for systemic toxic effects.

(2) When infiltration methods such as the tumescent technique are used in the performance of liposuction, the Standards for General and Regional Anesthesia stated in Rule 540-X-10-.12 must be met, including the physician registration requirement, the equipment and supplies requirement, the training requirement, and the assistance of other personnel requirement.

(3) When infiltration methods such as the tumescent technique are used in the performance of liposuction, the monitoring requirement found in Rule 540-X-10-.13, Monitoring Requirements for the Recovery Area and Assessment for Discharge with Moderate and Deep Sedation/General Anesthesia, must be met.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Alabama 34-24-53
History: Approved/Adopted: September 21, 2011. Effective Date: October 25, 2011.

540-X-10-.15 Reporting Requirements.

(1) Reporting to the Board is required within three (3) business days of the occurrence and will include all surgical related deaths, and all events directly related to a procedure(s) that resulted in complications requiring an emergency transfer of the surgical patient to the hospital, anesthetic or surgical events requiring CPR, unscheduled hospitalization related to the surgery, and surgical site deep wound infection. However, the transfer of a patient to a more acute setting or a hospital as a result of the physician's findings during the diagnostic portion of a procedure does not need to be reported.

(2) Each physician office shall execute agreements with its accrediting or certifying entities requiring the entity to report any suspension, restriction, termination, or

adverse accreditation action, the findings of any surveys and complaint or incident investigations, and any data requested by the Board.

(3) Each registered physician shall report to the Board annually in writing a comprehensive list of all procedures performed at each location and the outcome data for all procedures performed. This report shall be filed with the Board on or before January 31 following renewal of the physician's registration and shall report outcome data for the prior calendar year.

(4) A physician office where more than one registered physician performs office-based surgery may make reports on behalf of the physicians.

540-X-10-.16 Registration of Physicians and Physician Offices.

(1) Prior to performing any office-based surgery as defined in this rule, registration is required of any physician who is licensed to practice medicine in Alabama, who maintains a practice location in Alabama, and who performs or offers to perform the following:

(a) Any surgery performed in a physician office which offers moderate sedation, deep sedation, or general anesthesia, as defined in these rules, or

(b) Liposuction when infiltration methods such as the tumescent technique are used, or

(c) Any procedure in which diprivan is administered, given, or used, or

(d) Any procedure involving major upper or lower extremity nerve blocks, or

(e) Magnetic resonance imaging studies and other imaging studies that involve the patient receiving moderate sedation, deep sedation, or general anesthesia.

(2) Registration shall be accomplished on a form provided by the Board. After initially registering a physician office, it shall be the obligation of the registered physician to advise the Board of any change in the practice location within the State of Alabama or any other information required to be reported.

(3) The form for registration of an office-based surgery physician is incorporated as Appendix D to these rules. Registration shall not be automatic and must be approved by the Board, subject to compliance with these rules and all other applicable laws. A practice may register more than one physician using a form incorporated as Appendix E to these rules. The practice must identify a physician who shall be responsible for the accuracy of the registration and all reporting requirements under these rules.

(4) In July 2025, the Board shall cause a notice to be transmitted to every physician who is licensed in the State of Alabama notifying them of the requirements contained in this Chapter.

(5) Annual registration shall be due by January 31 of each year, and registration shall be by electronic means.

Authors: Alabama Board of Medical Examiners *ad hoc* Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G. Chambers, III, M.D.; Craig H. Christopher, M.D.; Alcus Ray Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.
Statutory Authority: Code of Alabama §§ 34-24-53, 34-24-53.1
History: Approved/Adopted: Approved for Publication January 15, 2003. Published in 1/31/03 Alabama Administrative Monthly. Amended/Approved for Publication: May 21, 2003. Published in 5/30/03 Alabama Administrative Monthly. Amended/Approved for Publication: August 20, 2003. Published in

8/29/03 Alabama Administrative Monthly. Approved/Adopted: October 15, 2003. Effective Date: November 21, 2003. Amended/Approved: July 20, 2011. Approved/Adopted: September 21, 2011. Effective Date: October 25, 2011. Amended/Approved: June 20, 2018. Effective Date: October 1, 2018. Amended/Approved: November 19, 2020. Certified Rule Filed: February 18, 2021. Effective Date: April 12, 2021.

540-X-10-.17 Denial of Registration: Process and Grounds.

(1) If, after examination of a physician's registration, and after consideration of any information developed by the Board pursuant to an investigation into the qualifications of the physician for registration, the Board determines that there is probable cause to believe there exist grounds upon which the registration may be denied, the Board shall take the following actions:

(a) Defer final decision on the registration; and

(b) Notify the physician of the grounds for possible denial of the registration and the procedure for obtaining a hearing before the Board.

(2) The failure to request a hearing within the time specified in the notice shall be deemed a waiver of such hearing.

(3) If requested by the physician, a hearing shall be set before the Board on the registration.

(4) In the event that a hearing is not requested, the Board shall take action to approve or deny the registration.

(5) All hearings under this rule shall be conducted in accordance with the Alabama Administrative Procedure Act, Ala. Code §§ 41-22-1 et seq. and Ala. Admin. Code Chapter 540-X-6. A decision rendered by the Board at the conclusion of the hearing shall constitute final administrative action of the Board of Medical Examiners for the

purposes of judicial review under Ala. Code § 41-22-20. The registering physician shall have the burden of demonstrating to the reasonable satisfaction of the Board that he or she meets all qualifications and requirements for registration to practice office-based surgery.

(6) The Board may deny a registration on the grounds that:

(a) The registering physician does not meet a requirement of this rule;

(b) The registering physician has failed to provide any information required under this rule;

(c) The registering physician, in the opinion of the Board, is not qualified to perform a specific surgery or is not qualified to perform office-based surgery with reasonable skill and safety to his or her patients;

(d) The registering physician has committed any of the acts or offenses constituting grounds to discipline the applicant in this state pursuant to, but not limited to, Ala. Code §§ 16-47-128, 34-24-360, and 34-24-57; or

(e) The registering physician has submitted or caused to be submitted false, misleading, or untruthful information to the Board in connection with his or her application.

Authors: Alabama Board of Medical Examiners *ad hoc* Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G. Chambers, III, M.D.; Craig H. Christopher, M.D.; Alcus Ray Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.
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540-X-10-.18 Penalties.

(1) A physician may be guilty of unprofessional conduct within the meaning of Ala. Code § 34-24-360(2) if he or she fails to comply with the requirements of these rules or fails to make any mandatory report.

(2) A physician who has been found to be not in compliance with the requirements of Chapter 540-X-10 may have his or her license revoked, suspended, fined, or otherwise disciplined by the Medical Licensure Commission.

(3) The Board may restrict, modify, suspend, deny issuance or renewal, or revoke a physician's registration based on a finding of non-compliance or violation of these rules.

Authors: Alabama Board of Medical Examiners *ad hoc* Committee: Arthur F. Toole, III, M.D.; Jorge A. Alsip, M.D.; James G. Chambers, III, M.D.; Craig H. Christopher, M.D.; Alcus Ray Hudson, M.D.; Pamela D. Varner, M.D.; James E. West, M.D.; and Task Force Sub-Committee: Jeff Plagenhoef, M.D.; Eric Crum, M.D.; Dan J. Coyle, Jr., M.D.; Gary Monheit, M.D.; Robert Hurlbutt, IV, M.D.; C. Paul Perry, M.D.; W. Guinn Paulk, M.D.; Mark McIlwain, D.M.D., M.D.; Jerald Clanton, D.M.D., M.D.; Patrick J. Budny, M.D.; James W. Northington, M.D.; David Franco, M.D.; Thomas E. Moody, M.D.
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EXHIBIT
D

STATE *of* ALABAMA
MEDICAL LICENSURE COMMISSION

MEMORANDUM

To: Medical Licensure Commission

From: Rebecca Robbins

Date: December 31, 2024

Subject: FSMB Call for Resolutions

Member Medical Boards may submit resolutions for consideration by the FSMB House of Delegates, the FSMB's official public policy-making body, at its April 26, 2025, annual business meeting, scheduled in conjunction with the FSMB's Annual Meeting in Seattle, Washington, April 24 – 26, 2025. The deadline for receiving resolutions is February 21, 2025.

If the Commission does not wish to submit a resolution, this item should be received as information.

Rebecca Robbins

Subject: FW: FSMB Call for Resolutions
Attachments: FY 2025 Call for Resolutions FINAL.pdf

From: Lauren Mitchell (FSMB) <lmitchell@fsmb.org>
Sent: Monday, December 23, 2024 11:25 AM
Subject: FSMB Call for Resolutions

Dear Colleagues,

FSMB member medical boards play a crucial role in the FSMB's policy-making process by identifying issues of importance to medical regulation and then submitting resolutions for consideration by the FSMB's House of Delegates, the organization's official policy-making body.

Issues identified by boards in recent years have led to the development of new policies and programs that have helped enhance public protection across the country. We encourage you to discuss with colleagues at your medical board what new policies could be beneficial to the entire medical regulatory community.

Resolutions should be submitted by February 21, 2025. The House of Delegates will meet in April, in conjunction with the FSMB's Annual Meeting in Seattle, Washington. Please see the attached to learn more about the FSMB's policy-making process and to view a sample resolution.

Kind regards,
Lauren

Lauren Mitchell
Manager, Board of Directors Liaison and Governance Support

Federation of State Medical Boards
400 Fuller Wiser Rd | Euless, TX 76039
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fsmb *Integrity in Medical Regulation.* ***Trust in Care.***

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FEDERATION OF STATE MEDICAL BOARDS

CALL FOR RESOLUTIONS
2024-2025

Member Medical Boards wishing to submit resolutions for consideration at the FSMB's April 26, 2025 House of Delegates annual business meeting are requested to forward all proposed resolutions to the FSMB.

Resolution Deadline

Member Medical Boards wishing to submit a resolution(s) for consideration by the 2025 House of Delegates must do so no later than **February 21, 2025.**

Drafting of Resolutions

When drafting resolutions for submission, please give close attention to the following:

- As stated in the FSMB Bylaws, "...the right to introduce resolutions is restricted to Member Medical Boards and the Board of Directors and the procedure for submission of such resolutions shall be in accordance with FSMB Policy."
- The title of the resolution should appropriately and concisely reflect the action for which it calls.
- The date on which the resolution was approved by the Member Medical Board should appear beneath the title.
- Information contained in the resolution should be checked for accuracy.
- The "resolved" portions should stand alone, since the House adopts only the "resolved" portions and the "whereas" portions are not subject to adoption.

A sample resolution can be found on pages 2-3.

Some Useful Information

The FSMB's Public Policy Compendium that includes the policies adopted by the House of Delegates in previous years is attached following the sample resolution.

Resolution Submission

Resolutions will need to be submitted **electronically to Lauren Mitchell, Manager, Board of Directors Liaison and Governance Support at lmitchell@fsmb.org. If submitting more than one resolution, please do so in one email.**

A confirmation acknowledging receipt of the document(s) will be sent within two business days. If you do not receive a confirmation, or for questions, please contact Ms. Mitchell by email or at 817-868-4060.

Resolution 24-3

Federation of State Medical Boards
House of Delegates Meeting
April 20, 2024

Subject: Medical Directors of Health Insurers Making Medical Necessity Determinations

Introduced by: Oregon Medical Board

Approved: February 16, 2024

Whereas, State medical boards are responsible for protecting the health, safety, and wellbeing of patients within their states by ensuring they have equitable access to quality care; and

Whereas, An estimated one-third of Americans have medical debt, and communities of color and families below the poverty level are disproportionately impacted by medical debt; and

Whereas, Patients may delay or defer care due to the inability to pay for medical services, which disproportionately affects disadvantaged communities and can exacerbate disparities in health outcomes; and

Whereas, More than 65% of Americans have private health insurance according to the U.S. Census Bureau's Report, "Health Insurance Coverage in the United States: 2022;" and

Whereas, Health insurers employ medical directors to make medical necessity determinations; and

Whereas, A medical director's medical necessity determinations are *de facto* determinations of whether patients will have access to needed treatments and medical services; and

Whereas, A medical director's role is not clearly within the definition of "practicing medicine" in state Medical Practice Acts, and state medical boards may not have authority to review their decision making in medical necessity determinations; and

Whereas, Medical directors are not required to meet standard qualifications or criteria by a particular government or regulatory authority, and medical directors are not required to specialize in the type of care they review; and

Whereas, There is a lack of transparency regarding each medical director's education, training, experience, and standing; and

Whereas, Medical directors may have a history of discipline by a state medical board, employer, or government agency or other malpractice or conduct reported to the National Practitioner Data Bank; and

Whereas, Peer-to-peer discussions between the treating physician and the medical director are administratively burdensome and contribute to physician burnout; and

Whereas, State medical boards aim to reduce causes of burnout in order support and retain a thriving workforce who can provide quality medical care for patients;

Therefore, be it hereby

Resolved: that the FSMB will research the current regulatory oversight for Medical Directors of health insurance companies; and be it further

Resolved: that the FSMB will publish a report articulating the impact of health insurance Medical Directors on patient care and providing recommendations to improve the quality of medical necessity determinations.

FEDERATION OF STATE MEDICAL BOARDS

Federation of State Medical Boards
Public Policy Compendium
2024-25

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190.16 Model Guidelines for the Use of Complementary and Alternative Therapies in Medical Practice (HD)
190.17 Report of the Special Committee on Quality of Care and Maintenance of Physician Competence (HD)
190.18 Remedial Education (HD)
190.19 Post-Licensure Assessment System (PLAS) (HD)
190.20 Report of the Special Committee on Managed Care (HD)
190.21 Report of the Special Committee on Questionable and Deceptive Health Care Practices HD)
190.22 Position in Support of Adoption of Pain Management Guidelines
190.23 Position on Partial Birth Abortion Ban Acts
190.24 Report of the American Medical Association and the FSMB: Ethics and Quality of Care (HD)

Reentry

200.1 Report of the Special Committee on Reentry for the Ill Physician (HD)
200.2 Report of the Special Committee on Reentry to Practice (HD)

Scope of Practice

210.1 Advocacy Efforts in Response to Antitrust Concerns of State Medical Boards (HD)
210.2 Scope of Practice Information for Non-Physician Health Care Professionals (HD)
210.3 Use of "Doctor" Title in Clinical Settings (HD)
210.4 Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety
210.5 Delegation of Medical Functions to Unlicensed Individuals (HD)
210.6 Participation in the National Commission on Certification of Physician Assistants (NCCPA) (BD)
210.7 Non-physician Duties and Scope of Practice (BD)
210.8 National Commission on Certification of Physician Assistants (NCCPA) Examination (BD)

Specialty Board Certifications

220.1 License Restriction/Board Certification (HD)
220.2 License Restrictions and Specialty Board Certification (HD)

220.3 Licensure by Specialty (HD)

State Medical Boards: Relationships with Other Agencies

230.1 JMR to Key State Decision Makers (HD)
230.2 Quality Improvement Organizations (BD)
230.3 Memorandum of Understanding for Sharing Information Between the Department of Defense Medical System and State Medical Boards (HD)
230.4 Drug Enforcement Agency (DEA) (BD)
230.5 Federal Facilities (HD)

Telemedicine/License Portability

240.1 The Appropriate Use of Telemedicine Technologies in the Practice of Medicine
240.2 Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (HD)
240.3 Development of an Interstate Compact to Expedite Medical Licensure and Facilitate Multi-State Practice (HD)
240.4 Definition of Telemedicine (HD)
240.5 License Portability During a Public Health Emergency (HD)
240.6 Report of the Special Committee on License Portability (HD)
240.7 Disaster Preparedness and Licensing (HD)
240.8 Interstate Mobility of Physicians (HD)
240.9 Report of the Ad Hoc Committee on Telemedicine

Policies

BOARD STRUCTURE AND FUNCTION

100.1 **Guidelines for the Structure and Function of a State Medical and Osteopathic Board**
The FSMB adopts as policy the Guidelines for the Structure and Function of a State Medical and Osteopathic Board, superseding the previous edition.
HD, April 2024

100.2 **Emergency Preparedness and Response**
The FSMB adopts as policy the recommendations contained in the Report of the FSMB Workgroup on Emergency Preparedness and Response.
HD, April 2022

100.3 **Report of the FSMB Workgroup on Emergency Preparedness and Response**
The FSMB adopts as policy the recommendations contained in the Report of the FSMB Workgroup on Emergency Preparedness and Response.
HD, May 2021

100.4 **Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards**
The FSMB adopts as policy Regulatory Strategies for Achieving Greater Cooperation and Collaboration Among Health Professional Boards.
HD, April 2017

100.5 **Innovations in State Based Licensure**
The FSMB adopts as policy the recommendation contained in the Report of the Workgroup on Innovations in State-based Licensure that sports team physicians are held exempt from the state licensure requirement.
HD, April 2014

100.6 Collateral Consequences of Board Actions

The FSMB will continue to communicate with credentialing bodies, and other entities that use public board action reports as a basis for their actions to explore ways to accomplish their missions while taking measured, appropriate and proportionate action in response to public board actions involving a physician.
HD, April 2014

100.7 Reporting of Drug Diversion by Healthcare Employers

The FSMB will cooperate with other stakeholders, including similar associations of health professional regulatory boards, to study the feasibility of drafting model legislation addressing the duty of all healthcare workplace employers to report any discipline based on such diversion to health licensing boards and be it further that the FSMB support state medical boards in the study and development of legislation addressing the duty of healthcare workplace employers to report such diversion by healthcare licensees to the respective HLBS.
HD, April 2013

100.8 Report of the Workgroup to Define a Minimal Data Set

The FSMB adopts as policy the framework for a minimal physician data set as recommended in the Report of the Workgroup to Define a Minimal Data Set.
HD, April 2012

100.9 Report of the Workgroup to Examine Composite Action Index (CAI) and Board Metrics

The FSMB adopts as policy the recommendations contained in the Report of the Workgroup to Examine Composite Action Index (CAI) and Board Metrics.
HD, April 2012

100.10 Reporting Withdrawals of Licensure Applications to the FSMB

The FSMB will undertake, at the earliest possible opportunity, a thorough review of the reporting of withdrawals by each member board and draft a policy to ensure consistent reporting of these or any level of withdrawals by each member board that will advise member boards of a physician's history of withdrawals in other states.
HD, May 2009

100.11 Information Exchange Between Boards

The FSMB policy adopted in 1998 and reaffirmed in the Report of the Special Committee on License Portability encourages member boards to share investigative information at the early stages of a complaint investigation in order to reduce the likelihood that a licensee may become licensed in one state while under investigation in another state. The FSMB will collaborate with other interested organizations and agencies in addressing communication barriers resulting from variances in state confidentiality laws. The FSMB will maintain and distribute information related to state confidentiality laws to its member medical boards.
HD, April 2002

100.12 Report of the Special Committee on Physician Profiling

The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on Physician Profiling.
HD, April 2000
HD, April 2002, Revised

100.13 Policy Comment Period

The FSMB shall include a comment period on draft reports of special committees, as feasible, so that the comments received from member medical boards and other interested parties may be taken into consideration prior to submission to the Board of Directors for approval and recommendation to the House of Delegates.
HD, April 2001

100.14 **State Medical Board Representation**

The FSMB reaffirms FSMB as the organization representing state medical boards in the legislative, policy development and spokesperson arenas.

BD, February 1998

100.15 **Maintaining State-based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession**

The FSMB adopts as policy the recommendations contained in Maintaining State-based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession from the Special Committee on Uniform Standards and Procedures.

HD, April 1998 (Archived, available upon request by contacting dcarlson@fsmb.org)

100.16 **Funding**

The FSMB urges state legislatures to provide their state medical licensing boards adequate resources to properly discharge their responsibilities and duties.

BD, January 1980

CONDUCT AND ETHICS

110.1 **Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice**

The FSMB adopts as policy the principles and recommendations in Navigating the Responsible and Ethical Incorporation of Artificial Intelligence into Clinical Practice.

HD, April 2024

110.2 **Report of the FSMB Ethics and Professionalism Committee: Considerations for Identifying Standards of Care**

The FSMB adopts as policy the recommendations contained in the Report of the FSMB Ethics and Professionalism Committee: Considerations for Identifying Standards of Care.

HD, May 2023

110.3 **Professional Expectations Regarding Medical Misinformation and Disinformation**

The FSMB adopts as policy the recommendations contained in the Report of the FSMB Ethics and Professionalism Committee.

HD, April 2022

110.4 **Position Statement on Treatment of Self, Family Members and Close Relations** (HD)

The FSMB adopts as policy the position contained in the Treatment of Self, Family Members and Close Relations.

HD, May 2021

110.5 **Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct**

The FSMB adopts as policy the Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct, superseding the policy Addressing Sexual Boundaries: Guidelines for State Medical Boards (2006).

HD, April 1996

HD, April 2006, Revised

HD, May 2020, Revised

110.6 **Report of the Ethics and Professionalism Committee: Social Media and Electronic Communications**

The FSMB adopts as policy the guidelines and recommendations contained in the Report of the Ethics and Professionalism Committee: Social Media and Electronic Communications, superseding the Model Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice (2012).

HD, April 2012

HD, April 2019, Revised

110.7 **Position Statement on Practice Drift**

The FSMB adopts as policy the Position Statement on Practice Drift.

HD, April 2016

110.8 **Position Statement on Duty to Report**
The FSMB adopts as policy the Position Statement on Duty to Report.
HD, April 2016

110.9 **Position Statement on Sale of Goods by Physicians and Physician Advertising**
The FSMB adopts as policy the Position Statement on Sale of Goods by Physicians and Physician Advertising.
HD, April 2016

110.10 **Best Practices in the Use of Social Media by Medical and Osteopathic Boards**
At its 2016 Annual Meeting, the FSMB shall present information on current uses of social media by regulatory agencies and collect and disseminate information on best practices for regulatory agencies to follow in using social media and other forms of communication to publicize Board news and information, including public disciplinary actions.
HD, April 2015

110.11 **Report of the Special Committee on Professional Conduct and Ethics**
The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on Conduct and Ethics.
HD, April 2000

CONTINUING MEDICAL EDUCATION

120.1 **Interprofessional Continuing Education (IPCE)**
The FSMB adopts a resolution supporting and recognizing Interprofessional Continuing Education for physicians that is identified by IPCE credit and is accredited by the Joint Accreditation system launched by the Accreditation Council for Continuing Medical Education, the Accreditation Council for Pharmacy Education and the American Nurses Credentialing Center, as an additional means of satisfying continuing medical education requirements for medical license renewal.
HD, April 2018

120.2 **Participation in ABMS MOC and AOA BOS OCC Programs to Meet CME Requirements for License Renewal**
The Federation of State Medical Boards (FSMB) supports the use of, and encourages state boards to recognize, a licensee's participation in an ABMS MOC and/or AOA BOS OCC program as an acceptable means of meeting CME requirements for license renewal.
HD, April 2012

120.3 **Point of Care Learning**
The FSMB recommends that continuing medical education credits be given for point of care learning, described as practice-based learning that takes place in support of specific patient care and that publishers and vendors of information resources be encouraged to incorporate time-keeping or automated use-recording into their products.
HD, May 2005

120.4 **Post-residency Skills and Procedures-based Retraining**
The FSMB will assist state medical boards in identifying and developing—in conjunction with other organizations—new post-residency skills and procedures retraining programs in specialties dependent on skills and procedures competencies.
HD, April 1996

120.5 **Formation of Accreditation Council for Continuing Medical Education (ACCME)**
The FSMB Board of Directors approved the formation of the ACCME, its budget, Essentials, and bylaws.
BD, October 1980

120.6 Mandating Continuing Medical Education

The FSMB believes mandatory continuing medical education is a matter reserved for the individual state jurisdictions.
HD, April 1980

ELECTRONIC HEALTH RECORDS

130.1 Framework on Professionalism in the Adoption and Use of Electronic Health Records

The FSMB adopts as policy the Framework on Professionalism in the Adoption and Use of Electronic Health Records as contained in the Report of the Committee on Ethics and Professionalism in the Adoption and Use of Electronic Health Records.
HD, April 2014

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EXAMINATIONS

140.1 Single Examination for Medical Licensure

The FSMB reaffirms its commitment to establish a single examination for medical licensure in collaboration with other concerned organizations and adopts as an official FSMB position paper the document, A Proposal for a Single Examination for Medical Licensure.
HD, April 1989

The FSMB reaffirms its policy that USMLE be the single pathway to licensure for all U.S. allopathic physicians.
HD, April 1999
HD, April 2012, Revised

140.2 Report of Committee to Evaluate the USMLE Program (CEUP) (HD)

The member boards of the Federation of State Medical Boards resolve:

To adopt the Final Report and Recommendations of CEUP as a conceptual framework for the continued improvements in the USMLE examination program;

To make a clear commitment to incorporate into the USMLE program the following enhancements (described in CEUP Recommendations 1, 2, and 3) at such point when models and methodologies have been developed and tested and the results of this testing indicate that such enhancements will provide assessments that meet reasonable standards of validity, reliability, and practicality;

Enhancement 1: The USMLE program shall be a series of assessments that are specifically intended to support decisions about a physician's readiness to provide patient care at each of two patient-centered points: a) at the interface between undergraduate and graduate medical education (supervised practice), b) at the beginning of independent (unsupervised) practice.
Enhancement 2: USMLE shall adopt a general competencies schema (such as the six general competencies identified by the Accreditation Council on Graduate Medical Education) for the overall design, development, and scoring of USMLE, using a model consistent with national standards. Further, as the USMLE program evolves, it should foster a research agenda that explores new ways to measure those general competencies important to medical practice and licensure which are difficult to assess using current methodologies.
Enhancement 3: USMLE shall emphasize the importance of the scientific foundations of medicine in all components of the assessment process. The assessment of these foundations should occur within a clinical context or framework, to the greatest extent possible.

To make a clear commitment to support the development of methodologies and instruments to enhance testing methods to assess clinical skills, as reflected in CEUP Recommendation #4, and to consider approaches to for design and implementation of a testing format to assess an examinee's ability to recognize and define a clinical problem, to access appropriate reference resources in order to find the scientific and clinical information needed to address the problem ,and to interpret and apply that information in an effective manner, consistent with CEUP Recommendation #5;

To delegate monitoring and final approval of such enhancements to the Composite Committee and the Board of Directors of the Federation of State Medical Boards in concert with the Executive Board of the National Board of Medical Examiners; and

To affirm the principle that the parents recognize that such enhancements will require shared investment of financial resources and that this investment will be recovered via revenues generated by the USMLE program over time.

HD, May 2009

140.3 Examination History

The FSMB receives a request from any state for examination history; the FSMB will attach a Physician Data Center (formally Board Action Data Bank) report to all transcripts that contain a disciplinary history.

In reporting the results from all queries of the FSMB Data Bank, the board action history report will include licensing history as a standard informational element on all reports, in addition to any reportable disciplinary history when it exists for an individual physician.

HD, April 1984

HD, May 2009, revised

140.4 Common Examination System

The FSMB recognizes the USMLE and COMLEX-USA as valid exams for their intended purposes. To assure the public that all physicians are meeting a uniform standard for purposes of medical licensure, the FSMB may collaborate with interested parties to develop a common licensing examination system that advances both osteopathic and allopathic medical licensure while maintaining the distinctiveness of both professions.

HD, April 2001

HD, May 2008, Revised

140.5 Evaluation of Licensure Examinations

The FSMB will develop a mechanism for continuous evaluation of the evidence developed by the USMLE and COMLEX-USA programs to support the validity of decisions being made by state medical boards on the basis of test scores, and that reports regarding the outcomes of such evaluation be provided to the membership on a regular basis.

HD, May 2004

140.6 Inclusion of Pain, Pain Assessment and Pain Management Questions on National Standardized Licensure Examinations

The FSMB will encourage the NBME, the NBOME and other appropriate organizations to ensure that questions related to pain mechanisms, pain assessment, and pain management be included in all standardized medical licensing examinations, emphasizing the importance of appropriate pain management in quality medical care.

HD, April 2002

140.7 Release of SPEX Score Reports

The FSMB endorses the release of SPEX score performance profile information, including information regarding limitations of the performance information, to the examinee and the sponsoring state medical boards.

HD, April 1998

140.8 English Administration of Licensing Exams

The FSMB reaffirms its policy that licensing examinations for U.S. jurisdictions be administered in English only.

BD, May 1979

BD, October 1995, Revised

140.9 Enhancement of the USMLE

The FSMB endorses the Strategic Plan for Enhancement of the USMLE adopted by the USMLE Composite Committee.

HD, April 1995

140.10 **Hybrid Examination Combinations**

The FSMB approves the following guidelines relevant to FLEX 1 and 2:

Candidates, who passed FLEX Component 1 before 1994 and pass the USMLE Step 3 within seven years of the original FLEX pass, will be recommended as having met acceptable licensing examination requirements.

Candidates (likely only international medical graduates) who have passed NBME Part I or USMLE Step 1 and NBME Part II or USMLE Step 2 before 1994, and who pass FLEX Component 2 before 1994, will be recommended as having met acceptable licensing examination requirements.

BD, February 1992

140.11 **Clinical Skills Assessment as Part of Licensure Process**

The FSMB supports and encourages the development and use of an evaluation of clinical skills as a component of the physician licensure process for all medical students.

BD, October 1987

140.12 **Special Purpose Examination (SPEX) Use Statement**

The FSMB accepts as policy the following statement for SPEX use:

"SPEX is a cognitive examination to assist licensing jurisdictions in their assessment of current competence requisite for general, specialty-undifferentiated medical practice by physicians who hold or have held a valid unrestricted license in a United States or Canadian jurisdiction."

BD, April 1987

IMPAIRMENT

150.1 **Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health** (HD)

The FSMB adopts the Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health, superseding the Policy on Physician Impairment (HOD 2011).

HD, May 2021

150.2 **Report of the Workgroup on Physician Wellness and Burnout**

The FSMB adopts as policy the recommendations contained in the Report of the Workgroup on Physician Wellness and Burnout.

HD, April 2018

150.3 **AMA Report on the Use of Alcohol by Physicians**

The FSMB supports the guidelines established by the American Medical Association (AMA) regarding physicians' ingestion of alcohol and patient care (H-30.960 Physician Ingestion of Alcohol and Patient Care).

HD, April 1993

HD, April 2012, Revised

150.4 **Policy on Physician Impairment**

The FSMB adopts the Policy on Physician Impairment, superseding the Report on Physician Impairment (HOD 1995).

HD, April 2011 (Archived, available upon request by contacting dcarlson@fsmb.org)

150.5 **Credit Against License Suspensions or Restrictions**

The FSMB recommends to all member boards that, for cases of license suspension or restriction, any time during which a disciplined physician practices in another jurisdiction without comparable restriction should not be credited as part of the period of suspension or restriction.

HD, April 1993

LICENSURE REQUIREMENTS

160.1 **Setting Higher Standards for Unrestricted Licensure**

The FSMB will, in collaboration with other stakeholders, examine the benefits as well as the potential harms and unintended

consequences that could occur because of requiring all applicants for licensure to have completed 36 months of progressive postgraduate medical training.
HD, April 2013

160.2 Federation Credentials Verification Service (FCVS) and Educational Commission for Foreign Medical Graduates (ECFMG) to Expedite Licensure

The FSMB, through the FCVS, pursue cooperative efforts with the ECFMG to reduce duplication of efforts and redundancy in primary source verification.
HD, April 2003

160.3 Criminal Record Check

The FSMB reaffirms its policy that all state medical boards conduct criminal record checks as part of the licensure application process. The FSMB encourages all state medical boards to require any applicant with a criminal history report to appear before the board for questioning to evaluate the applicant's degree of risk to the public in determining fitness for licensure. The FSMB will develop legislative or administrative approaches that will assist member boards who wish to have the authority to require criminal background checks for applicants for professional licensure.
HD, April 2001

160.4 Requirements Unrelated to the Practice of Medicine

The FSMB opposes enactment by any jurisdiction of requirements for initial physician licensure not reasonably related to the qualifications and fitness of individuals to practice medicine, and, instead, have in view the implementation of social, economic or political policies of the jurisdiction at a particular moment, however well-intentioned or justified those policies may appear.
HD, April 1987
HD, April 1997, Revised

160.5 Military/Government Employed Physicians

All physicians, other than those in training, be required to have a full and unrestricted license in at least one state and that exemptions not be made for physicians in the armed forces, Public Health Service or other governmental agencies.
BD, December 1977
BD, July 1996, Revised

160.6 Liability Insurance

Professional liability insurance is an economic issue, not to be linked with medical licensure.
HD, April 1995

160.7 Report of the Ad Hoc Committee on Licensure by Endorsement

The FSMB adopts as policy the recommendations contained in the report Licensure by Endorsement, developed by the Ad Hoc Committee on Licensure by Endorsement.
HD, April 1995 (Archived, available upon request by contacting dcarlson@fsmb.org)

MEDICAL EDUCATION

170.1 Regulation of Physicians in Training

The FSMB adopts as policy the recommendations contained in Regulation of Physicians in Training.
HD, April 2024

170.2 Shortening Undergraduate Medical Education

The FSMB will work in collaboration with the AAMC, AACOM, AMA and the AOA to study the value of shortening the duration of undergraduate medical education from four years to three years and its impact collectively on access to care, patient outcomes, patient safety and medical student indebtedness.
HD, 2013

170.3 Medical Education in Substance Abuse

The FSMB will develop methods and/or modules of information to be used to educate medical students, residents and practicing physicians regarding the identification of substance use disorders, intervention and the proper prescribing of controlled substances.
HD, May 2007

170.4 Report of the Special Committee on the Evaluation of Undergraduate Medical Education

The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on the Evaluation of Undergraduate Medical Education.
HD, April 2006

170.5 Credentials Verification for International Medical Graduates

The FSMB shall continue to monitor and encourage the progress of the FCVS/ECFMG initiative, and for the FSMB and its member boards to strongly recommend that International Medical Graduates establish an FCVS profile for securing and protecting their medical school credentials for a lifetime of license portability and practice.
HD, April 2006

170.6 Education of Medical Students, Interns, Residents and Related Faculty on Licensure and Attendant Good Conduct Requirements

The FSMB shall continue to provide access to new and existing presentation materials for boards to use to educate medical students, interns, residents and appropriate faculty on medical licensure and regulation. The FSMB shall seek funding for the development of educational modules to be used in medical schools and residency programs.
HD, April 2003

170.7 International Association of Medical Regulatory Authorities (IAMRA)

The FSMB and its representatives to the IAMRA are encouraged to seek opportunities to share information with the international community on matters related to education, training and licensure for both osteopathic and allopathic physicians in the United States. At the time that a formal membership structure is established, the IAMRA Office of the Secretariat forward information regarding associate membership to the AMA, AOA, ACGME, LCME, ABMS and other appropriate organizations.
HD, April 2001

170.8 Medical Students Attending Board Meetings

The FSMB recommends that medical students enrolled in an approved medical school be encouraged to attend either their state medical board meeting or a meeting sponsored by their state medical board for educating medical students regarding the responsibilities as a licensed physician and the specific ramifications of violating medical regulations.
HD, April 2000

170.9 Position in Support of Postgraduate Training and Licensure Standards

The FSMB adopts as policy the position in support of postgraduate training and licensure standards.
HD, 1998 (Archived, available upon request)

170.10 Report on Licensure of Physicians Enrolled in Postgraduate Training Programs

The FSMB approves as policy the recommendations contained in the Report on Licensure of Physicians Enrolled in Postgraduate Training Programs, developed by the FSMB's Legislative and Legal Advisory Committee.
HD, April 1996 (Archived, available upon request by contacting dcarlson@fsmb.org)

170.11 Medical School Curriculum

The FSMB opposes attempts by legislative bodies to mandate specific details of the curriculum of accredited medical schools in the United States and Canada. This should remain the responsibility of the faculties of these schools and the accrediting body,

to permit and encourage adaptation of medical student education to the future challenges medical students will face as physicians in the rapidly changing practice of medicine.
HD, April 1985

170.12 **Clinical Clerkships for Foreign Medical Graduates**
The FSMB encourages all member boards to bring rules into effect or to encourage enactment of laws authorizing the respective state boards of medical examiners or appropriate state agency to regulate the clinical clerkships of those students from medical schools not approved by the Liaison Committee on Medical Education or the American Osteopathic Association, where such rules or laws are not already in effect.
HD, April 1985

170.13 **Verifying Credentials of Physicians in Postgraduate Training Programs**
The FSMB urges its member boards to bring reasonable procedures and rules into effect or encourage enactment of laws which would ensure thorough verification and authentication of the credentials of all medical school graduates in training programs and who do not hold a full and unrestricted license to practice medicine.

The FSMB recommends that, in those jurisdictions that provide for credentials verification by the directors of medical education of the training institutions, deans of the medical schools, hospital administrators, or other responsible individuals involved with medical school graduates, such verification be certified to the state medical board or, where the state medical board has no authority, to an appropriate state agency.
HD, April 1985

NATIONAL DATA BANKS
180.1 **Reporting to the Physician Data Center (formally Board Action Data Bank)**
The FSMB encourages all state medical boards to report all board actions to the FSMB's Physician Data Center (formally Board Action Data Bank), including denials and/or withdrawals for cause, as quickly as possible but no later than 30 days after actions are taken.
HD, April 1996

The FSMB encourages all member boards to include disclosure language in all board orders.
BD, October 1997

All state licensing boards report all formal board actions to Physician Data Center, including non-prejudicial actions.
BD, January 1980

The FSMB will expand its database to include all licensed physicians.
BD, October 1997

The FSMB encourages all state medical boards enacting emergency actions to immediately contact the FSMB Physician Data Center to provide information on individuals who are subject to these actions. The FSMB encourages state medical boards taking emergency action to immediately transmit a copy of the emergency order to the FSMB Physician Data Center so that notification can be immediately transmitted to all other states wherein the physician is licensed, applying for licensure, or in post-graduate training and/or residency.

The FSMB Physician Data Center will provide timely notification to member boards of disciplinary actions taken by other state medical boards through a Disciplinary Alert Report. The FSMB encourages all state medical boards to provide data files and timely updates to the FSMB Physician Data Center, so that there will exist a national database comprised of current and complete information which can be accessed by all states in which a physician is licensed or seeking licensure. The FSMB encourages the executive directors of all medical boards in states enacting emergency actions to immediately determine all other states of licensure for individuals subject to such emergency actions. The director of the board enacting the emergency

action shall then immediately advise those directors of other boards where the licensee is known to hold another medical license about the emergency action. This contact should occur as close to the same day of the board action as is possible. This will ensure optimal public protection and the most timely notification possible while processes for drafting, serving and disseminating legal orders for the emergency action take place.
HD, April 2001

180.2 **Public Access**
The FSMB approves an initiative to develop a means to provide public access to national physician data base information.
BD, February 1998

180.3 **National Practitioner Data Bank (NPDB)**
The FSMB supports continued monitoring of the progress and development of the National Practitioner Data Bank (NPDB) and continued dialogue with the Health Resources Services Administration staff regarding potential future modifications in the NPDB.
BD, April 1991

180.4 **Centralized Database of Licensing Profiles**
The FSMB recognizes the need for a centralized database displaying the licensing profile of all practicing physicians and the need of the individual state medical boards for ready access to such a file, as well as the value of such a centralized database for analysis of practice trends, especially designation and distribution of physicians and the dynamics of geographical distributional changes of physicians.

The FSMB endorses efforts in conjunction with the NBME to obtain appropriate funding to design and engage in a process leading to the development and implementation of a computerized national tracking system containing longitudinal data relevant to the licensure status of all physicians within the licensing jurisdictions of the United States.

Representatives of the constituent medical boards of the FSMB endorse the concept of the centralized computerized database and express their intent to participate in the implementation of the process by the individual state medical boards.
HD, April 1980

QUALITY OF CARE

190.1 **Strategies for Prescribing Opioids for the Management of Pain**
The FSMB adopts as policy Strategies for Prescribing Opioids for the Management of Pain, superseding Guidelines for the Chronic Use of Opioid Analgesics (2017).
HD, April 1998, Revised
HD, April 2004, Revised
HD, April 2013, Revised
HD, April 2017, Revised
HD, April 2024

190.2 **Position Statement on Access to Evidence-Based Treatment for Opioid Use Disorder**
The FSMB adopts as policy the Position Statement on Access to Evidence-Based Treatment for Opioid Use Disorder, superseding Model Policy on the DATA 2000 and Addiction Treatment in the Medical Office (2013).
HD, 2013, Revised
HD, April 2024

190.3 **Diversity, Equity and Inclusion in Medical Regulation and Patient Care**
The FSMB adopts as policy the recommendations included in the Interim Report of the FSMB Workgroup on Diversity, Equity and Inclusion in Medical Regulation and Patient Care.
HD, April 2022

190.4 Acute Opioid Prescribing Workgroup and Guidelines

The FSMB will perform a comprehensive review of acute opioid prescribing patterns, practices, federal laws and guidance (including Centers for Disease Control and Prevention guidelines), state rules and laws across the United States, available data, and present a report to the House of Delegates at the Annual Meeting in 2019.
HD, April 2018

190.5 Report of the Workgroup on Prescription Drug Monitoring Programs (PDMPs)

The FSMB adopts as policy the recommendations contained in the Report of the Workgroup on Prescription Drug Monitoring Programs (PDMPs).
HD, April 2018

190.6 Report of the Workgroup to Study Regenerative and Stem Cell Therapy Practices

The FSMB adopts as policy the recommendations contained in the Report of the Workgroup to Study Regenerative and Stem Cell Therapy Practices.
HD, April 2018

190.7 Model Guidelines for the Recommendation of Marijuana in Patient Care (HD)

The FSMB adopts as policy the recommendations contained in Model Guidelines for the Recommendation of Marijuana in Patient Care.
HD, April 2016

190.8 Physicians Use of Marijuana

Given the lack of data supporting clinical efficacy and the difficulty of evaluating impairment, the FSMB adopted a resolution that state medical boards advise their licensees to abstain from the use of marijuana, for medical or recreational purposes, while actively engaged in the practice of medicine.
HD, April 2016

190.9 Incorporating Quality Improvement Principles into Disciplinary Actions

The FSMB will investigate ways in which medical boards can incorporate quality improvement principles into disciplinary actions when appropriate to do so, as part of their mission to protect the public and improve patient care.
HD, April 2013

190.10 Report of the Maintenance of Licensure (MOL) Workgroup on Clinically Inactive Physicians

The FSMB adopts as policy the recommendations contained in the Report of the MOL Workgroup on Clinically Inactive Physicians.
HD, April 2013 (Additional policies related to Maintenance of Licensure are archived and available by contacting dcarlson@fsmb.org)

190.11 Prevention of HIV/HBV Transmission to Patients

The state medical and osteopathic practice acts, other appropriate statutes and/or the rules of the state medical or osteopathic board should include provisions dealing with preventing the transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HVC) to patients. These statutes or rules should be consistent with the following recommendations:

A. Persons under the jurisdiction of the Board should comply with the guidelines established by the Centers for Disease Control and Prevention for preventing the transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HVC) to patients.
B. State medical boards should have the powers and responsibilities:
    1. to encourage physicians and other health care providers to know their HIV and HBV status;
    2. to require reporting to the state board and/or the state public health department of HIV- and HBV -infected healthcare workers who perform invasive procedures;

3. to ensure confidentiality of those reports received by the state board and/or state public health
4. department under (2) above;
5. to establish practice guidelines for HIV- and HBV-infected practitioners; and
6. to monitor or to assist the state public health department to monitor the practices and health of HIV and HBV - infected practitioners who perform invasive procedures.

C. The state board should be authorized to discipline all persons under its jurisdiction who violate the statue(s) or rule(s) establishing or otherwise implementing requirements related to preventing transmission of HIV and HBV to patients.

HD, April 1992
HD, April 1996, Revised
HD, April 2012, Revised

190.12 **Communication Between Physicians and Patients**
The FSMB supports continued and improved effective means of communication between patients and physicians. The FSMB will develop an inventory of resources that promotes effective communication to provide to patients and professional communities.
HD, May 2009

190.13 **Continued Competence**
State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking relicensure.
HD, May 2004

190.14 **Review of FSMB Model Guidelines for the Use of Controlled Substances for the Treatment of Pain**
The FSMB will develop a process for review of its policy Model Guidelines for the Use of Controlled Substances for the Treatment of Pain and consider whether it might be strengthened in the light of new medical insights during the past five years, particularly focusing on issues surrounding the undertreatment of pain.
HD, April 2003

190.15 **Report of the Special Committee on Outpatient (Office-based) Surgery**
The FSMB adopts as policy the Report of the Special Committee on Outpatient (Office-based) Surgery.
HD, April 2002

190.16 **Model Guidelines for the Use of Complementary and Alternative Therapies in Medical Practice**
The FSMB adopts as policy the Model Guidelines for the Use of Complementary and Alternative Therapies in Medical Practice.
HD, April 2002

The FSMB reaffirms its recommendation, as stated in the "Report of the Special Committee on Managed Care," to encourage state medical boards to communicate with state agencies responsible for regulating managed care organizations on issues relating to quality of care.
HD, April 2001

190.17 **Report of the Special Committee on Quality of Care and Maintenance of Physician Competence**
The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on Quality of Care and Maintenance of Physician Competence.
HD, April 1998
HD, April 1999, Revised

190.18 **Remedial Education**
The FSMB will identify available remedial educational resources and publish a comprehensive directory of such resources for its

member boards; foster regional expansion of assessment centers throughout the country in support of member boards' efforts; and encourage development of centers capable of assessing specialty practice performance.
HD, April 1999

190.19 **Post-Licensure Assessment System**
When physician competence is called into question, state medical regulatory boards should consider using the Post-Licensure Assessment System (PLAS) established by the FSMB and National Board of Medical Examiners. State medical regulatory boards should work with relevant medical organizations in their states to encourage development of educational programs designed to address physicians' learning needs as identified through assessment programs. The FSMB, when requested, will assist and support any member board in its effort to utilize PLAS, including, but not limited to, providing informational resources, research studies and suggested policies on identifying and referring physicians for assessment, evaluating assessment programs, stimulating development of need-based educational programs and continuing improvement of the post-licensure assessment and education effort.
HD, April 1999

190.20 **Report of the Special Committee on Managed Care**
The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on Managed Care.
HD, April 1998 (Archived, available upon request by contacting dcarlson@fsmb.org)

190.21 **Report of the Special Committee on Questionable and Deceptive Health Care Practices**
The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on Questionable and Deceptive Health Care Practices, previously published as the Report on Health Care Fraud.
HD, April 1997
HD, April 1999, Revised

190.22 **Position in Support of Adoption of Pain Management Guidelines**
The FSMB adopts as policy the position in support of adoption of pain management guidelines.
HD, 1998 (Archived, available upon request by contacting dcarlson@fsmb.org)

190.23 **Position on Partial Birth Abortion Ban Acts**
The FSMB adopts as policy the position on partial-birth abortion ban acts.
HD, 1997 (Archived, available upon request by contacting dcarlson@fsmb.org)

190.24 **Report of the AMA and the FSMB: Ethics and Quality of Care**
The FSMB adopts as policy the recommendations contained in Ethics and Quality of Care: Report of the American Medical Association and the Federation of State Medical Boards.
HD, April 1995 (Archived, available upon request by contacting dcarlson@fsmb.org)

REENTRY

200.1 **Report of the Special Committee on Reentry for the Ill Physician**
The FSMB adopts as policy the five recommendations contained in the Report of the Special Committee on Reentry for the Ill Physician.
HD, April 2013

200.2 **Report of the Special Committee on Reentry to Practice**
The FSMB adopts as policy the 12 recommendations contained in the Report of the Special Committee on Reentry to Practice.
HD, April 2012

SCOPE OF PRACTICE

210.1 **Advocacy Efforts in Response to Antitrust Concerns of State Medical Boards**
The FSMB adopts a resolution calling for advocacy against the expanded application of antitrust principles that may

compromise patient safety, and for FSMB to assist state boards facing litigation alleging antitrust violations.
HD, April 2016

210.2 Scope of Practice Information for Non-Physician Health Care Professionals

The FSMB will maintain information on scopes of practice of licensed non-physician health care professionals and make the information available to member medical boards.
HD, April 2000
HD, April 2012, Revised

210.3 Use of "Doctor" Title in Clinical Settings

The FSMB work with the Scope of Practice Partnership and other stakeholders, including associations of health professional regulatory boards and patient advocacy groups, in supporting state legislation to provide transparency for patients seeking a health care professional;

The FSMB, through its advocacy network, support the Healthcare Truth and Transparency Act of 2010 or similar federal legislation designed to assure patients receive accurate information about the qualifications and licensure of health care professionals; and,

Adopted the following policy statement: Health care practitioners who provide health services to consumers and are legally authorized to use the term "doctor" or "physician" or any abbreviation thereof, should be required to simultaneously and clearly disclose and identify which branch of the healing arts for which they are licensed. Such disclosure should apply to written advertisements, identification badges, and any other form of practitioner/patient communications.
HD, May 2009
HD, April 2011

210.4 Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety

The FSMB adopts the policy Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety.
HD, April 2005

210.5 Delegation of Medical Functions to Unlicensed Individuals

The FSMB will maintain new and existing legislation/regulations and other information on the delegation of medical functions and make the information available to member medical boards and other interested parties.
HD, April 2003

210.6 Participation in the National Commission on Certification of Physician Assistants (NCCPA)

The FSMB supports continued participation on the NCCPA Board of Directors and encourages and supports the NCCPA.
BD, October 1990

210.7 Non-physician Duties and Scope of Practice

A non-physician should be permitted to provide medical services delegated to him or her by a supervising physician consistent with state law, as long as those medical services are within his or her training and experience, form a usual component of the supervising physician's practice of medicine, and are provided under the direction of the supervising physician.
BD, July 1998

210.8 National Commission on Certification of Physician Assistants (NCCPA) Examination

The FSMB urges state boards that regulate physician assistants to formulate rules and regulations that would permit acceptance of the examination of the NCCPA in the authorization of physician assistants in their respective states.
BD, February 1976

SPECIALTY BOARD CERTIFICATIONS

220.1 License Restriction/Board Certification

It is the position of the FSMB that a physician who has a restricted license and is allowed to practice clinical medicine under board supervision and is complying with all the terms and conditions of his/her license restriction, should be allowed to be a candidate for specialty board certification, re-certification or Maintenance of Certification.
HD, April 1992
HD, May 2005, Revised

220.2 License Restrictions and Specialty Board Certification

The FSMB shall establish an ongoing dialogue with allopathic and osteopathic specialty boards regarding restrictions on medical licenses due to a mental or physical disability and specialty board certification. The primary purpose would be to develop mechanisms allowing physicians with physical or mental disabilities to obtain and maintain specialty board certification without compromising public protection.
HD, April 1998

The FSMB will continue discussions with the American Board of Medical Specialties and the American Osteopathic Association regarding the issue of eligibility for specialty recertification of physicians with licensure restrictions. The FSMB will explore the possibility of developing alternate mechanisms which would allow physicians to be eligible for specialty recertification while preserving medical board oversight of their recovery program.
HD, April 1999

220.3 Licensure by Specialty

The FSMB opposes licensure by specialty.
HD, April 1982

STATE MEDICAL BOARDS: RELATIONSHIPS WITH OTHER AGENCIES

230.1 Journal of Medical Regulation (JMR) to Key State Decision Makers

The FSMB encourages each state medical and osteopathic board to assess their budgets to consider sending the JMR (at a reduced rate subscription) to their respective legislators and Governor.
HD, April 2014

230.2 Quality Improvement Organizations

The FSMB encourages state boards to cooperate with state quality improvement organizations on issues of medical discipline.
BD, February 1990
BD, April 2012, Revised

230.3 Memorandum of Understanding for Sharing Information Between the Department of Defense Medical System and State Medical Boards (HD)

The Federation of State Medical Boards (FSMB) shall initiate dialogue and pursue a Memorandum of Understanding or other means with the Department of Defense Medical System and other uniformed health services to facilitate the sharing of information necessary to state medical and osteopathic boards in fulfilling their regulatory responsibilities.
HD, April 2011

230.4 Drug Enforcement Agency (DEA)

The FSMB strongly urges the DEA to promptly report all violations by physicians to the Board(s) of Medical Examiners of the state in which the physician practices and to the FSMB's Physician Data Center (formally Board Action Data Bank).
BD, February 1965
BD, October 1995, Revised

230.5 Federal Facilities

The FSMB encourages the federal government to have federal facilities use state boards of medical examiners in the states in

which such facilities are located to ensure that fraudulent or incompetent physicians are not allowed to practice at those facilities; encourages states to require federally-employed physicians to possess a current active license in a state or territory; and recommends that within each state or territorial possession in which a federal facility exists, a liaison committee be established consisting of a representative of the federal facility and the state licensing board.
HD, April 1988

TELEMEDICINE and LICENSE PORTABILTY

240.1 **The Appropriate Use of Telemedicine Technologies in the Practice of Medicine**
The FSMB adopts as policy the Report of the FSMB Workgroup on Telemedicine, superseding the Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (2014).
HD, April 2022

240.2 **Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine**
The FSMB adopts as policy the Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine, superseding the Model Guidelines for the Appropriate use of the Internet in Medical Practice (HD, 2002).
HD, April 2014

240.3 **Development of an Interstate Compact to Expedite Medical Licensure and Facilitate Multi-State Practice**
The FSMB will convene representatives from state medical boards and special experts as needed to aggressively study the development of an Interstate Compact model to facilitate license portability, hereinafter known as the Medical License Portability Interstate Compact model, and be it further that this be initiated no later than July 2013.
HD, April 2013

240.4 **Definition of Telemedicine**
"Telemedicine" is the practice of medicine using electronic communication, information technology or other means between a physician in one location and a patient in another location with or without an intervening health care provider.
HD, May 2009

240.5 **License Portability During a Public Health Emergency**
Resolved that state medical boards cooperate and support each other to further license portability in the event of a public health emergency and assist FSMB in verifying licensure and qualifications by regularly providing FSMB with licensure and contact information on all licensees; and that the FSMB study issues relative to license portability during an emergency including, but not limited to, joining with other organizations or entities to determine the best manner to provide necessary medical care and maintain licensure autonomy for the individual states.
HD, April 2006

240.6 **Report of the Special Committee on License Portability**
The FSMB adopts as policy the recommendations contained in the Report of the Special Committee on License Portability.
HD, April 2002 (Archived, available upon request by contacting dcarlson@fsmb.org)

240.7 **Disaster Preparedness and Licensing**
The FSMB will cooperate with federal and state legislators, agencies, and organizations in facilitating the movement of properly licensed physicians among FSMB member licensing jurisdictions in support of necessary emergency medical response.
HD, April 2002

240.8 **Interstate Mobility of Physicians**
Resolved, that the Federation of State Medical Boards take steps to assist its member boards in evaluating their own statutes, rules and regulations and where necessary and appropriate modify those statutes, rules and regulations to provide for the rapid research, training or unique clinical care.

240.9 **Report of the Ad Hoc Committee on Telemedicine**

The FSMB adopts as policy the Report of the Ad Hoc Committee on Telemedicine HD, April 1996 (Archived, available upon request by contacting dcarlson@fsmb.org)

EXHIBIT
E

STATE *of* ALABAMA
MEDICAL LICENSURE COMMISSION

MEMORANDUM

To: Medical Licensure Commission

From: Rebecca Robbins

Date: January 13, 2025

Subject: USMLE Workshop for State Board Members

The USMLE is hosting a state board member workshop on March 14, 2025, at the FSMB offices in Euless, TX. There is a virtual option available.

The workshop provides an overview and updates on the USMLE and provides an avenue for the USMLE to increase its database of interested candidates who are current or former board members to serve on the USMLE test development committee and/or other USMLE committees and activities.

Any Commission members interested in attending should contact Rebecca Robbins.

Recommendation: If no comments, this item should be received as information.

Rebecca Robbins

From: Frances Cain (FSMB) <FCain@fsmb.org>
Sent: Friday, January 10, 2025 11:06 AM
To: Frances Cain (FSMB)
Cc: Andrea Ciccone
Subject: Invitation to USMLE workshop for state board members - March 14, 2025

Dear State Board Executive Directors,

Happy New Year! I hope you are well!

On behalf of the United States Medical Licensing Examination (USMLE) program, I would like to invite your board members to attend a workshop on the USMLE. The USMLE program is working to increase its database of potential candidates to serve on USMLE test development committees and/or other USMLE committees and activities. In particular, we are striving to increase the number of physicians in our database who have **experience as *current or former members* of a state medical board.**

The meeting will be held on March 14, 2025, at FSMB offices in Euless, Texas.

In addition to providing an overview and updates on USMLE from program staff, we will also have time allotted for attendees to discuss any issues that state medical boards are seeing or addressing.

All travel expenses (i.e., airfare, lodging, food) will be covered by the USMLE program.

Interested board members can contact me directly to confirm their interest, and I will then provide them with details about attending in person or virtually.

Thank you in advance for your assistance. We look forward to hopefully seeing a member of your board on March 14!

Take care,
Frances

Frances Cain, MPA
Director, Assessment Services

Federation of State Medical Boards
400 Fuller Wiser Road | Euless, TX 76039
o. 817-868-4022 | fcain@fsmb.org | www.fsmb.org

EXHIBIT
F

STATE *of* ALABAMA
MEDICAL LICENSURE COMMISSION

MEMORANDUM

To: Medical Licensure Commission

From: Rebecca Robbins

Date: January 13, 2025

Subject: FSMB Draft of Rentry to Practice

The Federation of State Medical Boards is seeking comment and feedback on its draft amendment to its *Reentry to Practice* policy. Following consideration of any comments received, the final document and recommendations will be presented to the House of Delegates at the 2025 Annual Meeting.

Comments are due by **February 21, 2025**. If the Commission has no comments, this item should be received as information.

EXHIBIT

G

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,

Complainant,

v.

GARY MORGAN BULLOCK, D.O.,

Respondent.

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

CASE NO. 2020-100

ORDER

This matter is before the Medical Licensure Commission of Alabama on Respondent's e-mailed request, of December 27, 2024, that the Commission permit him to renew his Alabama medical license without paying all outstanding administrative fines, with an anticipated "agreement being reached for fine repayment starting in the new year." This request is denied. *See* Ala. Code § 34-24-383.

DONE on this the 28th day of January, 2025.

THE MEDICAL LICENSURE COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.
on 2025-01-28 14:20:33 CST

Jorge A. Alsip, M.D.
its Chairman

EXHIBIT

H

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,

Complainant,

v.

STEVE ENNIS NORMAN, M.D.,

Respondent.

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

CASE NO. 2024-260

ORDER

This matter is before the Medical Licensure Commission of Alabama on Respondent's e-mailed request, of January 7, 2025, for a continuance of the hearing in this matter. The Board agreed not to oppose a continuance of the hearing, provided that Respondent executes a waiver of the 120-day limitation on the summary suspension of his medical license. On January 13, 2025, Respondent did execute a valid waiver of the 120-day limitation. For good cause shown, therefore, the hearing in this matter previously scheduled for January 22, 2025, is continued and re-set for Wednesday, April 16, 2025, at 10:00 a.m., at 848 Washington Avenue, Montgomery, Alabama.

DONE on this the 28th day of January, 2025.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Jorge Alsip, M.D.
on 2025-01-28 14:21:44 CST

Jorge A. Alsip, M.D.
its Chairman